HERITAGE PROVIDER NETWORK

&

AFFILIATED MEDICAL GROUPS

UTILIZATION MANAGEMENT (UM) PROGRAM 2019

Approval Signature:

Dr. David Leece, Committee Chair

1/27/19

Date:

Contents

PHILOSOPHY

The philosophy of Heritage Provider Network, Inc. (referred to herein as HPN Utilization Management is to provide continuous quality improvement and appropriate utilization of resources to its members.

UM 1: UTILIZATION MANAGEMENT STRUCTURE

Heritage Provider Network (HPN) and its affiliates will have the UM infrastructure necessary to provide ongoing monitoring and evaluation of delegated medical management activities to address over/under utilization and coordination of medical resources; to support continuum-based case management activities, continuity-of- care; and, to maintain a systematic process for the education of HPN and its affiliates staff and providers regarding Utilization Management.

Heritage Provider Network affiliates are defined as:

An affiliate is a subsidiary medical group with operations under the control and oversight by the larger corporation, namely Heritage Provider Network.

The HPN Utilization Management Program is designed to achieve congruence with the following services:

1. Quality Health Care
2. Case Management
3. Utilization Management
4. Efficient and Effective Health Care
5. Resource Management
6. Customer Satisfaction
7. Provider Orientation and Update Regarding Utilization

The HPN Administration shall participate with its affiliates in a policy setting and interactive educational role. The HPN Administration's interest is to ensure that systems and resources of the HPN's affiliates can meet the quality of medical care and service demands of its members in a cost effective manner. The HPN Utilization Management Program will be a resource to its affiliates to ensure compliance with regulatory and accreditation agency standards, requirements of HPN Utilization Management Program, and appropriate data collection and reporting to meet the needs of employer accounts, contracted health plans and any other external customers.

All Utilization Management (UM) decision-making will be based on appropriateness of care and service.

HPN will distribute the approved UM Program and relevant policies and procedures to its affiliate's and they will be responsible for distributing to their practitioners and contracted providers at least annually to ensure that all are advised of services requiring UM pre- Service determinations such as:

1. Ambulatory
2. Inpatient
3. Emergency
4. Skilled Nursing
5. Home Health
6. Rehabilitative Services (such as physical, occupational and speech therapies)
7. Pharmaceuticals
8. Medical Equipment and/or Supplies

As well as services that do NOT require pre-service determinations but may enter request for tracking purposes and care coordination, such as:

1. Emergency Services,
2. Family Planning
3. Sensitive Services and confidential service treatment
4. Preventive Services, (including immunizations)
5. Basic Prenatal Care (in-network),
6. Services related to Sexual Assault or Sexually Transmitted Disease (applies to Minor Consent Services)
7. HIV Testing/Counseling;
8. OB and GYN services in network
9. Language Assistance Program/Interpretation services;
10. Health Education.
11. Hospice/End of Life
12. Behavioral Health (includes Mental Health Counseling/treatment, Drug & Alcohol Abuse (as delegated and at risk)
13. Carve Out Programs such as MLTSS, IHSS, CBAS
14. Out of Area Renal Dialysis Services (as Delegated/at risk)
15. Urgent Care Services
16. Tobacco Cessation (APL-16-014)

HPN and its affiliate' providers are not restricted in advocating on behalf of a member or advising a member on medical care. This includes, but is not limited to:

1. Risks, benefits, and consequences of treatment or non-treatment;
2. Member's right to refuse medical treatment and to self-determination in treatment plans.

PROGRAM OVERSIGHT

Governing Body

The Executive Committee (Governing Body) shall have ultimate authority and responsibility for the Utilization Management Program. It shall establish and maintain an effective and efficient UM program.

The Executive Committee will ensure that each of its affiliates receives and complies with all

aspects of the UM Program.

The Executive Committee will review, evaluate and make any necessary revisions to the UM Program at least annually.

The structure and responsibilities of the Executive Committee are outlined in the Executive Committee Charter and made available to its committee members.

Utilization Management Committee

The Utilization Management Committee (UMC) and any ad-hoc committees or subcommittees of the UMC will report to the Executive Committee via the UMC. The UMC reports to the Executive Committee at least biannually.

The Utilization Management Committee will meet at least quarterly to review, evaluate and provide the Executive Committee with recommendations for revisions to the UM Program. For urgent issues that require immediate updating, these will be addressed separately by the designated ad-hoc committee meeting (either virtual or in person) utilizing appropriate practitioners (3 physicians) and/or subcommittee

Minutes and records are kept of all UM Committee activities for which the UM Committee is responsible. Such materials are considered confidential and are maintained in locked quarters; therefore, are only available to the appropriate staff, as well as contracted full services health plan directors, auditors or designees for annual review or follow up.

Each attendee, including guests, at each Committee meeting will sign confidentiality and a conflict of interest statement.

The composition of the UM Committee shall include but is not limited to:

1. Executive Vice President of Clinical Affairs/ Plan Medical Director
2. Medical Directors of each Primary Medical Group
3. Vice President of Clinical Services
4. Director of Clinical Services
5. Director Clinical Operations
6. Other clinical staff as appropriate, i.e. Behavioral Health Specialist
7. All HPN affiliate's UM VP and/or Directors and/or other UM physicians and staff as appropriate
8. Additional personnel and technical experts as requested by the UMC or Executive Committee
9. Health Plans Representatives may participate within areas that apply to individual health plans, upon invitation, at the individual group level.

The UM Committee responsibilities shall include:

1. Evaluation of the its affiliates capacity to perform UM activities
2. Review and approval of the UM Program annually
3. Review regular reports from its affiliates.
4. Evaluate the affiliate activities to ensure they are being conducted in accordance with HPN's expectations and regulatory standards

5. Ensuring all Member information is confidential and protected from unauthorized dissemination

Designated Physician

HPN's affiliates shall employ or designate a Medical Director who holds an unrestricted license to practice medicine in the State of California issued pursuant to Section 2050 of the Business and Professional Code or pursuant to Osteopathic Act. H&SC 1367.01 (c);

1. The Medical Director or designee has responsibility/authority for implementation and oversight of the UM Program
2. The Medical Director shall ensure that the process by which the Delegate reviews and approves, modifies or denies, based in whole or in part on medical necessity, and benefit coverage, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to members, complies with the requirements of Health & Safety Code 1367.01.

The Medical Director (a senior physician within each of the HPN affiliate groups) is fully credentialed by HPN and is the designated physician who is involved in the UM Program development, evaluation, and facilitates all UM activities, supports the various committees, appropriate staff, resources, and makes recommendations based on various analyzed clinical care and administrative data.

Designated Behavioral Health Care Practitioner

The HPN affiliates may contract with a vendor or provider, but not delegate UM responsibilities to their respective Behavioral Health (BH) Care Provider Organization. The Medical Director of the affiliate's contracted Behavioral Health Care Organization shall be a behavioral healthcare physician or a doctoral level behavioral healthcare practitioner. The Heritage BH Medical Director is the designated physician who is involved in the behavioral aspects of the UM program development and evaluation.

The Heritage BH Medical Director shall be available for assistance with member behavioral health UM procedures and processes, complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health UM statistical data, follow-up on identified issues, and attend the UM Committee Meeting at least once every 12 months.

HPN'S Affiliate UM Departments

The HPN affiliates may employ clinical and non-clinical persons in their UM Departments to process requests for medical services for their respective members. The affiliates shall employ or designate a Medical Director who holds a California unrestricted license to practice medicine to provide primary oversight of their UM Department.

The UM staff may consist of licensed physician reviewers, licensed nurse reviewers and non-clinical support staff.

Each affiliate will maintain a current department Organizational Chart identifying all key UM positions, decision makers and department/staff oversight.

PROGRAM SCOPE AND PURPOSE

Utilization Review Program Responsibilities

HPN will provide each affiliate with policies and procedures that are needed to support UM decisions. Reviews and approves UM policies and procedures at least annually, and as needed for regulatory updates. HPN policies and procedures meet all California Health and Safety codes and regulations.

All HPN affiliates' Medical Directors will ensure that these policies and procedures are reviewed and adopted by their respective UM Committees and that all clinical and non-clinical staff responsible for UM activities are educated on the most current policies and procedures. Medical decisions are to be made by credentialed, qualified medical providers, unhindered by fiscal and administrative management using objective criteria based on medical evidence.

Consistent with HPN approved policies and procedures and utilizing evidence of coverage and benefit limitations as well as approved clinical criterion, medical review guidelines and policies and in accordance with all state and federal regulations:

1. Senior licensed physician will supervise all UM staff responsible for making UM determinations.
2. Licensed physician reviewers may approve, modify, delay and/or deny any services based on in whole or in part on medical necessity and benefit coverage.
3. Licensed nurse reviewers may approve any services, deny benefit driven services and provide recommendations to physician reviewers for medical necessity denials.
4. Non-clinical staff may verify benefit coverage, retrieve information necessary for clinical review, approve limited services as assigned and deny benefit driven services as assigned.
5. The affiliate Medical Director will be responsible for all final decisions to deny any and all services based on medical necessity.
6. Determinations of coverage and medical necessity for behavioral health services will include involvement of a behavioral health practitioner.

The HPN affiliates' and their staff may utilize contracted health care professionals and specialists to assist with clinical reviews and/or recommendations but may not delegate or sub- delegate UM activities to any other entity.

The clinical information utilized to make UM determinations may include, but is not limited to, the following:

1. Office and hospital records
2. History of the presenting problem
3. Clinical exam
4. Diagnostic testing results
5. Treatment plans and progress notes
6. Patient psychosocial history
7. Information on consultations with the treating practitioner
8. Evaluations from other health care practitioners and providers
9. Photographs

10. Operative and pathological reports
11. Rehabilitation evaluations
12. A printed copy of criteria related to the request
13. Information regarding benefits for services or procedures
14. Information regarding the local delivery system
15. Patient characteristics and information
16. Information from responsible family members

The affiliate may not rescind or modify an approved service authorization after the provider renders the health care service in good faith for any reason, including, but not limited to, subsequent rescissions, cancellations or modification of the member's contract or when the affiliate did not originally make an accurate determination of the member's eligibility.

All UM information must be kept on file for at least 36 months.

Program Goals and Objectives

The UM Program will be implemented by all HPN affiliates as directed by the HPN Utilization Management Committee. The goal of the Utilization Management Program is to ensure that HPN practitioners provide quality care in the most cost-effective manner.

Objectives

1. To evaluate the utilization of services, member benefits and resources related to the provision of care by reviewing requests for services prior to authorization, conducting concurrent review, discharge planning, retrospective review, and case management.
2. To ensure that all members receiving inpatient and skilled nursing facility care will have a completed continuity-of-care plan developed prior to discharge to a lower level of care.
3. To encourage effective, efficient use of services and resources through communication and education of employees, providers, patients, and their families.
4. To ensure all practitioners and UM reviewers have access to and are utilizing the most current criteria, guidelines and policies as approved by the HPN UM Committee.
5. To develop systems to ensure that criteria and physician/non physician reviewer decisions are applied consistently and that services delivered are medically necessary and consistent with the patient's diagnosis and level of care required.
6. To monitor and improve the coordination of medical and behavioral health care.
7. To target and case manage patients with complex health care needs across the continuum of community and facility-based services to assure that the goals of health promotion, risk reduction, and the prevention of illness complications are met.
8. To communicate and interact effectively with the primary care physicians, specialists and other contracted services through committee meetings, newsletters, verbally, correspondence, and education forums.
9. To work in conjunction with the Quality Improvement Council in referring those issues which require a quality interface/review.
10. To develop Corrective Action Plans, if found necessary, to improve practice or system issues.
11. To work with contracted health plans in disseminating information related to their Language Assistance Programs (LAP) for Limited English Proficient

(LEP) Enrollees, when and where appropriate.

12. To identify utilization issues and problems in the Utilization Management process and to use the Continuous Quality Improvement process to develop interventions to continuously improve the Utilization Management process.
13. To ensure a process by which members and practitioners are informed of their rights and the process to appeal a determination.

UM Program achievements will be measured by the UM Committee through the evaluation of UM work plans, annual program evaluation and other utilization activity reports.

The HPN UM Committee will routinely review and monitor the-services that are provided by the affiliates including, but not limited to:

1. **Prospective Hospitalizations Review**
    a. Necessity of admission determined according to review criteria.
    b. Appropriateness of workup on all elective cases - Medical Director or designee.
    c. Assigns a specific number of days - Case Manager or designee using proprietary review software as a guideline.
    d. Completes written authorization process.
    e. Automatic authorizations are approved according to the Policy and Procedure Manual.
    f. Prospective review is accomplished daily by the Medical Director or designee.
    g. Prospective review of psychiatric and substance abuse admissions are conducted daily by the Medical Director and/or designee with involvement of behavioral health professional(s).
    h. Referral to Psychiatric Assessment Team (PAT) team/disease management, where available, when appropriate.

2. **Concurrent Hospital Review**
    a. Performed daily by Case Managers in the acute hospital.
    b. Concurrent review of psychiatric and substance abuse admissions are conducted daily by Case Managers and/or designee with involvement of behavioral health professional(s).
    c. Case Managers, Social Services Designee, Discharge Planner, Inpatient Physicians, and Medical Director will review daily to determine medical necessity of continued stay, level of care, intensity of service, diagnostic studies, treatment plans, identifying barriers to discharge, and the quality of care being rendered.
    d. Referral to outpatient case management, or disease management, when appropriate.
    e. Documentation of review will be maintained in the Case Management office.
    f. For affiliates that perform onsite reviews, there is a written policy or procedure in place within each setting, which guides identification of onsite provider group's staff, scheduling of onsite visits, and awareness of facility rules.
    g. Care shall not be discontinued until the Member's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

3. **Retrospective Review - Hospitalizations**
   Review of Inpatient admissions for:
   a. Appropriateness of admission and disposition
   b. Severity of illness and Intensity of service
   c. Patient outcome
   d. Proper documentation
   e. Complications of patient care
   f. Appropriateness of the length of stay
   g. Delays of service

4. **Emergency Room/Ambulance Service**
   Services necessary to screen, stabilize and transport members do not require preauthorization of emergency services in cases where a prudent layperson, acting reasonably would have believed that an emergency medical condition exists will be covered.

   Retrospective claims, primarily consisting of emergency room and ambulance services, are reviewed only in an effort to track utilization criteria for improved patient care and/or PCP availability to patient population. The delegated personnel consisting of claims reviewer/auditor with involvement of clinical staff as needed at affiliate will do review on this level.

5. **Post Stabilization Transfer**
   Prior authorization is required for post stabilization services. No person needing emergency services and care may be transferred for any non-medical reason unless certain conditions are met, including, but not limited to a provision that the person is examined and evaluated by a physician and/or surgeon prior to transfer. A patient is considered stabilized when, in the opinion of the treating provider, the patient's medical condition is such that within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient.

6. **Prospective and Retrospective Review - Outpatient Services**
   All prospective and retrospective referrals will be reviewed by the Medical Director or designee for:
   a. Medical indication for referral.
   b. Specific number of visits or services specified on the form.
   c. Sufficient clinical information is documented so that the consulting provider has all known significant information relating to the requested services.
   d. Correct coding - level of care
   e. Contractual Arrangements

7. **Out of Network *I* Non-Contracted Provider Referrals**
   Contracted providers will be utilized whenever possible. If a contracted provider is not available, then a referral for an out of network or non-contracted provider will be reviewed for medical necessity by the Medical Director or designee. For services determined to be medically necessary and not available in network, a Letter of Agreement will be generated

prior to the patient's visit by the affiliate's designated staff.

All out of network or non-contracted provider referrals will be reviewed by the Medical Director or designee.

8. Home Health Agency Care

When a patient is referred to a Home Health agency, the attending physician must order the referral for evaluation and then approve the treatment plan submitted by the Home Health agency. The treatment plan must then be approved by the Utilization Management Department or designee. If there are any questions regarding approval, the Medical Director will be consulted. Continued home health care must be concurrently approved by the Utilization Management Department, Case Manager or designee.

9. Urgent Care Review

When a member uses an Urgent Care, the Urgent Care encounter forms will be submitted to the Claims or Finance Department(s). The respective department(s) will routinely collate and analyze the urgent care services, e.g., Volume and Peer Review of Urgent Care records. This information will be sent, as appropriate, to either the Utilization Management Committee or Medical Quality Management Committee.

10. Behavioral Health Care Review

The affiliate will contract with Behavioral Health Care Provider Organizations to provide behavioral health services for their members.

HPN requires that:

a. Only licensed practitioners make decisions that require clinical judgment.
b. Staffs that make clinical decisions are supervised by a minimum of a licensed master's level practitioner with five years of post-master's clinical experience.
c. A licensed psychiatrist or a licensed doctoral-level clinical psychologist will oversee triage and referral decisions.
d. Protocols for behavioral healthcare triage and referral address all relevant mental health and substance abuse situations. Protocols also address the level of urgency, and appropriate setting. The protocols should be reviewed at least annually and PRN.
e. The designated HPN, or HPN contracted vendor behavioral healthcare practitioner will:
    i. Be involved in the implementation of the behavioral healthcare aspects of the UM program and policy development;
    ii. Participate UM Committee meetings; and
    iii. Review behavioral health UM cases as needed.

11. Second Opinions

Member's request for a second opinion from a qualified health care professional in the health plan or affiliate PMG network will be covered at no cost (with the exception of standard copays and deductibles, and as delegated at risk) to the Member, this includes

second opinion from a qualified health professional for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy, etc.);

a. The affiliates will not deny a Member's request for a second opinion with a contracted, qualified health professional.
b. Requests for second opinions by a non-contracted provider will be referred to health plan for consideration.
c. If the second physician differs regarding the need for surgery (or other major procedure) from the first opinion, a third opinion may also be covered, within the PPG contracted network.
d. Second and third opinions may be covered even through the surgery or other procedure, if performed, is determined not covered.

12. Over and Under-Utilization Review of Services

The affiliate UM Committee will regularly monitor utilization data of high volume care (i.e., specialists, outpatient services, inpatient hospital care and skilled nursing facility care) to detect potential adverse utilization patterns (practice-specific and /or provider-specific) and/or other barriers to the authorization process.

Corrective action and/or other appropriate intervention will be implemented based on Committee's findings. The Committee will allow sufficient time to elapse prior to evaluating effectiveness of the corrective action(s). Comparisons will be made with the previous findings.

13. Reporting Requirements

a. Annual Initial Work Plans - HPN and each affiliate will complete and submit an annual initial work plan to the UMC by 15 January of each New Year. The annual work plan is to include:
    i. Utilization Management goals and objectives, program scope, areas of program focus and the specific utilization related activities and studies that are to occur.
    ii. Planned monitoring of Utilization data, including tracking statistics over time.
    iii. Planned annual evaluation of the Utilization Management program.
    iv. Action steps include target date for completion and responsible party.

b. Quarterly Work Plan Evaluations - The affiliate will update and submit a quarterly work plan to the UMC. Based on regulatory and plan contracting requirements quarterly work plan evaluations are due to the UMC by 15 April, 15 July and 15 October unless otherwise noted. Quarterly work plan updates must include:
    i. Utilization management activities completed
    ii. The organization's performance in Utilization Management should be trended.
    iii. An analysis of whether there have been any demonstrated improvements in the utilization management program

iv. A description of how these improvements were meaningful to the organization's population should be included.

c. Monthly/Quarterly/Semiannual/Annual UM Reports – Based on regulatory and plan contracting requirements all UM reports due to HPN by the 10th of each month (e.g. NOMNC, Part C Reporting, CCS Log, ESRD Log, etc.)

d. Final Work Plan Evaluation: - HPN and each affiliate will complete and submit a final work plan evaluation to the UMC by 15 January of each New Year.

The final assessment will include a full review and analysis of each component as listed on the UM Work Plan and an overall evaluation summary in each section as to the affiliate's attainment to written goals and any additional strategies, clarifications as necessary.

UM 2: CLINICAL CRITERIA FOR UM DECISIONS

The Utilization Management review process uses a wide range of criteria, guidelines, and reference tools to assist in determinations of benefit coverage, behavioral health needs and medical appropriateness. Supporting clinical and benefit information, relevant to each particular case will be reviewed when making medical necessity coverage determinations. HPN and PMG's will maintain a list of National evidence based guidelines adopted by the organization from Health Plans and evidence based literature searches and other evidence based sources, all sites will be sited.

HPN and its affiliates maintain written policies addressing the application of objective and evidence-based criteria in making UM determinations while taking into account the local delivery system, individual circumstances and the member's needs such as age, comorbidities, and complications, progress of treatment, psychosocial situation and home environment, when applicable.

Review materials include, but are not limited to:

1. Plan Eligibility and Coverage (benefit plan package)
2. CMS Criteria
    a. National Coverage Determination (NCD)
    b. Local Coverage Determination (LCD) used only for the area specified in the LCD
    c. Local Coverage Medical Policy Article
    d. Medicare Benefit Policy Manual
3. Health Plan criteria (e.g. Coverage Summary, Medical Policy)
4. Evidence based criteria such as MCG and InterQual, latest version
5. Other evidence-based resources available in HPN Policy UM-007: Medical Necessity in Absence Published Criteria, a list of specialty resources (not meant to be the exclusive).

The approved and adopted clinical guidelines, criteria or medical policies will be applied as follows:

Commercial Members

1. Health Plan Eligibility and Evidence of Coverage (benefit plan package)
2. State Specific and Federal Guidelines and Mandates
3. Specific Health Plan Benefit Coverage, Medical Policy or Clinical Guidelines
4. National/Specialty Guidelines (e.g., McKesson InterQual, USPSTF, AHA/ACC, American Imaging Management, Milliman, EviCore, etc.)
5. Health Plan "APPROVED" Group Adopted evidence based guidelines
6. Other Evidenced-based Criteria (see HPN Policy UM-007: Medical Necessity in Absence Published Criteria)

Medicaid (CA: Medi-Cal) Members

1. Health Plan Eligibility and Evidence of Coverage (benefit plan package)
2. State Specific and Federal Guidelines and Mandates, such as, MEDICAID (NY & AZ; National Medicaid, CA: Medi-Cal/DHCS) Guideline
3. Specific Health Plans' Medical Policy or Clinical Guidelines
4. National/Specialty Guidelines (e.g., McKesson InterQual, USPSTF, AHA/ACC, American Imaging Management, Milliman, EviCore, etc.)
5. Health Plan "APPROVED" Group Adopted evidence based guidelines.
6. Other Evidenced-based Criteria (see HPN Policy UM-007: Medical Necessity in Absence Published Criteria)

Medicare Advantage Members

1. Health Plan Eligibility and Evidence of Coverage (benefit plan package)
2. State Specific and Federal Guidelines and Mandates
3. Specific Health Plans' Benefit Coverage, Medicare Policy - NCD > groups own locality's LCD (§1862(a) (1) (A) of the Social Security Act) **CMS Chapter 13; 13.5 LCD MUST BE only within organizations (local) jurisdiction.
4. Specific Health Plans' Medical Policy or Clinical Guidelines
5. National/Specialty Guidelines (as above in Commercial)
6. Health Plan "APPROVED" Group Adopted evidence based guidelines
7. Other Evidenced-based Criteria (see HPN Policy UM-007: Medical Necessity in Absence Published Criteria)

DUALS/SNP (CA: CalMediConnect) Members

1. Health Plan Eligibility and Evidence of Coverage (benefit plan package)
2. State Specific and Federal Guidelines and Mandates
3. Medicare Prime (Follow Medicare Advantage)
4. Medi-Cal Secondary (Follow Medicaid, CA: Medi-Cal)
5. National/Specialty Guidelines (as above in commercial)
6. Other Evidenced-based Criteria (see HPN Policy UM-007: Medical Necessity in Absence Published Criteria)

The affiliates will utilize reports and Case Management services to ensure that practitioners assist with a member's transition to other care, if necessary, when medical necessity is not met or benefits end: while a member still needs care,

Delegate shall offer to educate the member (or the member's designated representative) about alternatives for continuing care, how to obtain care and/or access to community resources as appropriate.

Annual Review of Criterion

1. Materials are reviewed, approved, and/or updated/modified as needed but not less than annually.
2. Only appropriate clinical and behavioral health practitioners with relevant experience are involved in the development, adoption and reviewing of the criteria.
3. Criterion complies with Medicare local and national coverage determinations and relevant Medicaid requirements.
4. Upon final approval, all materials are made available to UM staff and practitioners in writing either by mail, fax or e-mail or on the affiliate website according to affiliate standard communication/dissemination processes.

Availability of Criteria, Guidelines, Policies

Upon request, HPN and its affiliates will make available all criteria, clinical review guidelines and medical review polices utilized for decision making to members and practitioners. With each determination made by the affiliate, members and providers are notified in writing of the process for requesting a free copy of the criteria guideline or policy used to make the determination.

HPN and its affiliated medical groups disseminate to the members and make available to the public, upon request, criteria or guidelines for specific procedures or conditions.

Additionally, all criteria, guidelines, policies utilized will be maintained and made available onsite at each affiliate for review at all times.

Consistency in Applying Criteria, Guidelines, Policies

To ensure case review consistency and uniformity in decision making among the physician and non-physician reviewers, Inter-Rater Reliability audits will be conducted at least annually by the affiliate.

Utilizing the "8/30" methodology, randomly selected authorization requests shall be reviewed by a same level staff (physician, nurse, non-clinical) who was not responsible for the initial decision.

At a minimum, the inter-reviewer reliability survey shall contain the following elements:

Outpatient Services

1. The case was completed within the line of business Standard Timelines
2. The reason for the referral delay was clearly documented, if applicable.
3. There was sufficient clinical documentation to support the decision.

4. The files were correctly categorized.
5. The appropriate UM Criteria or Benefit provision was applied.
6. There was appropriate referral to the Medical Director *I* Physician Advisor.
7. Medical necessity Denials included MD signatures.

Inpatient Services

1. Documentation supports the medical necessity for admission and continued stay.
2. There was sufficient clinical documentation to support the decision.
3. The appropriate UM Criteria or Benefit provision was applied.
4. Disposition of patient is documented on worksheet.
5. There was appropriate referral to the Medical Director *I* Physician Advisor.
6. Continuity of care and discharge planning initiated and family involved, when applicable

Physician Reviews

Randomly selected denials shall be reviewed by a Medical Director not responsible for the initial decision, and all selected denials shall be reviewed by an independent physician to ensure determinations are made based on adopted clinical guidelines against the following criteria:

1. The case was approved with appropriate UM Criteria applied.
2. The case was pended, if applicable, and determination was made within required Timelines.
3. The case was denied using appropriate UM Criteria and process
4. There was sufficient clinical documentation to support the decision.
5. Physician review was clearly documented.

Results of Reviews

These results must be presented to the affiliate UMC for review and discussion within their organization. The affiliate will act on opportunities to improve consistency in applying criteria, as applicable.

Corrective action shall be implemented for any reviewer not meeting the established benchmark of 80% in either category

Results of such surveys shall be documented by the affiliate on the work plan and will subsequently be reviewed by the HPN UM and QI Committees. The findings and any corrective action/performance improvement recommendations will also be reported to the HPN Executive Committee.

Opportunities for improvement will be monitored by the HPN UM and QI Committees, as applicable.

UM 3: COMMUNICATION SERVICES

HPN will ensure that the affiliate provides access to staff for members and practitioners, seeking information about the UM process and the authorization of care. Inbound and outbound communications may include communication with practitioners and members in person, in writing

by mail or fax, by telephone, or by electronic communications (e.g. sending e-mail messages or leaving voicemail messages.) Communication requirements shall include:

1. Staff available at least 8 hours a day during normal business days for inbound calls regarding UM issues.
2. Ability of staff to receive inbound member and provider communication after normal business hours regarding UM issues.
3. Out bound calls regarding inquiries about UM during normal business hours, unless otherwise agreed upon.
4. Staff identifies themselves by name, title and organization name when initiating or returning calls regarding UM issues.
5. A toll-free number or a staff who accepts collect calls regarding UM issues.
6. Access to staff for callers with questions about UM process.
7. TDD/TTY services for deaf, hard of hearing or speech-impaired members.
8. Language assistance for members to discuss UM issues.

Communication services and availability will also be posted on each affiliate's website.

HPN and its affiliates will maintain written policies and procedures regarding the above communication requirements and standards. Additionally, Provider Manuals will include, at minimum:

1. The business hours during which staff are available.
2. Instructions for obtaining specific information about a request.
3. Instructions for faxing or leaving a voicemail message outside of business hours that prompt members and practitioners to provide contact information for responses by the UM staff on the next business day.
4. Instructions on how out-of-area callers can obtain information

In accordance with HPN privacy and information security policies as well as all state and federal regulations regarding use and disclosure of PHI, providers, practitioners, and all HPN staff with access to patient information, must maintain the confidentiality of member information and records in the course of any written, verbal or electronic communications.

UM 4: APPROPRIATE PROFESSIONALS:

HPN requires that only qualified licensed health professionals:

1. Assess the clinical information used to support UM decisions;
2. Supervise all medical necessity decisions; and
3. Review denials of care based on medical necessity.

The health care professionals who provide medical necessity review will have the education, training or professional experience in medical or clinical practice, including knowledge of Medicare coverage criteria, as well as, other evidence based criteria, and shall be required to have a current, unrestricted license to practice in the state of California without restriction, and all medical directors and physician reviewers or consultants who make UM decisions for pre-service, concurrent, post-service and retrospective claims have been credentialed by HPN (Section 42 CFR € 422.204 (b)(2): Manual Chapter 6 – Section 60.3).

1. A licensed physician with a current, unrestricted license to practice in the state of

California will review any clinical, non-behavioral health denial based on medical necessity for covered services such as:

a. Decisions about covered medical benefits defined by the organization, including hospitalization and emergency services in the Certificate of Coverage or Summary of Benefits.
b. Decisions about pre-existing conditions when the member has creditable coverage and the organization has a policy to deny pre-existing care or services.
c. Decisions about care or services that could be considered either covered or not covered, depending on the circumstances, including decisions on requests for care that the organization may consider experimental.
d. Decisions about dental procedures that are covered under the member's medical benefits. If dental and medical benefits are not differentiated in the organization's benefits plan, the organization must identify the services or care as if there is differentiation. This means identifying only care or services associated with medically necessary medical or surgical procedures that occur within or adjacent to the oral cavity or sinuses.
e. Decisions about medical necessity for "experimental" or "investigational" services. Decisions about pharmacy-related requests regarding step-therapy or prior authorization cases.

2. A behavioral health practitioner or medical physician reviewer will review any behavioral healthcare denial of medical stabilizing care based on medical necessity.

3. Board certified physician consultants may be used, as needed, to assist in making medical necessity determinations, such as:
    a. Pharmacists: Pharmaceutical denials.
    b. Dentists: Dental denials.
    c. Chiropractors: Chiropractic denials.
    d. Physical therapists: Physical therapy denials

4. Staff members who are not qualified health care professionals may collect data for preauthorization and concurrent review for medical necessity determinations under the supervision of appropriately licensed health professionals. They may also have the authority to approve (but not to deny) services based on medical necessity for which there are explicit criteria. Staff members who are not qualified health care professionals may approve or deny coverage determinations such as:
    a. A benefit determination that is a 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 (e.g., in vitro fertilization). Benefit determinations include the following.
    b. Decisions about services that are limited by number, duration or frequency in the member's benefit plan.
    c. Denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan.
    d. Decisions about care that do not depend on any circumstances, such as the member's medical need or a practitioner's order.

e. Request for personal care services

Decisions on personal care services, such as transportation, cleaning and assistance with other activities of daily living (ADL), are considered benefit determinations and are not subject to UM file review. However, these benefit decisions may be appealed and are included in the scope of appeal file review.UM Staff at each affiliate will be supervised by a licensed practitioner with appropriate clinical experience (e.g., physician, RN, NP or other appropriately licensed UM staff). Licensed doctoral-level clinical psychologists may oversee behavioral healthcare UM decisions.

All staff who provides UM determinations will have a current job description on file at t h e assigned affiliate. The job description will include the qualifications that are required, including but not limited to:

1. Education level (Masters, Doctoral)
2. Training or professional experience in medical or clinical practice.
3. A current license to practice without restriction.

The UM staff or behavioral health care professional responsible for making a determination for approval, benefit or administrative denial or medical necessity denial must be clearly documented by use of initials, unique electronic identifier, signature or notation in the electronic record.

Compensation for individuals who review service requests will not contain incentives, direct or indirect Practitioners, providers and staff who make utilization related decisions and those who supervise them must annually affirm the following:

1. Medical decisions, including those by sub-delegated entities and rendering providers, are not unduly influenced by fiscal and administrative management.
2. UM decision making is based only on appropriateness of care and service and existence of coverage.
3. The organization does not specifically reward practitioners or other individual's for issuing denials of coverage.
4. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
5. HPN annually distribute a statement to all practitioners, providers and employees who make UM decisions affirming the above information.

To encourage appropriate utilization, discourage underutilization and clearly, indicate that the affiliate does not use incentives to encourage barriers to care and service, these affirmative statements will be distributed by the affiliates annually to all members, staff, providers, and practitioners involved with UM determinations

Distribution may include but not limited to:

1. Mailings
2. Newsletters

3. Email
4. Published on the Intranet
5. Included in provider/member handbooks

UM 5: TIMELINESS OF UM DECISIONS

In accordance with HPN policy, affiliates will provide medical and behavioral health determinations and notifications for approvals and denials according to the following timeliness standards:

COMMERCIAL TIMELINES
This includes inpatient, outpatient, skilled nursing facility, residential, and ambulatory care.

1. Emergent: Physician available 24 hours a day, 2 hour maximum.
2. Urgent Pre-Service: Within 72 hours of receipt of request.
3. Urgent Concurrent Review: within 24 working hours of receipt of the request
4. Non-urgent Pre-service: Within 5 business days of receipt of request
5. Post-Service (Retrospective): Within 30 calendar days of receipt of request.

All UM determinations for Commercial members will be compliant with the timeliness standards outlined in the UM Timeliness Standard policy.

MEDICARE TIMELINES (CMS)
This includes inpatient, outpatient, skilled nursing facility, residential, and ambulatory care.

1. Emergent: Physician available 24 hours a day, 2 hour maximum
2. Expedited Initial Determinations: Within 72 hours of receipt of request (includes weekends and holidays)
3. Standard Pre-Service: As soon as medically indicated, within a maximum of 14 calendar days after receipt of request)
4. Post-Service (retrospective) - Within 14 calendar days of receipt of request only in instances where the claim has not been received.

All UM determinations for Medicare Advantage members will be compliant with the timeliness standards outlined in the UM Timeliness Standard policy.

MEDICAID TIMELINES (Medi-Cal)
This includes inpatient, outpatient, skilled nursing facility, residential and ambulatory care.

1. Expedited Pre-Service: Within seventy-two (72) hours of receipt of the request
2. Urgent Concurrent: Within twenty-four (24) hours of the receipt of the request
3. Non-Urgent Concurrent: Within five (5) working days or less
4. Non-Urgent Pre Service: Within five (5) working days of receipt of the request
5. Post Service (Retrospective): Within thirty (30) calendar days from receipt of request
6. Hospice: Within twenty-four (24) hours of the receipt of the request

All UM determinations for Medi-Cal Managed Care members will be compliant with the timeliness standards outlined in the UM Timeliness Standard policy.

For the purpose of determining timeliness standards, "Urgent" shall mean a condition or situation that:

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

Members and Member Representatives may request an expedited review verbally or in writing. For urgent care decisions, the affiliate will allow a health care practitioner with knowledge of the member's medical condition (e.g. a treating practitioner) to act as the member's authorized representative. Physicians who request or support a member's request for expedited review will not encounter punitive or other disciplinary actions.

Notification for Approvals, Denials, Delays, Modifications, or Termination of Referral Requests:

1. HPN and its Affiliates will provide required notification to members and/or their representatives in accordance with the timeframes set forth in Title 22, CCR, Sections and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request for Medi-Cal and 30 days for Healthy Kids, if delegated for the specific line of business by the health plan.

UM 6: CLINICAL INFORMATION

When the affiliate receives a request from a Practitioner, member or member representative for health or behavioral health care services, the affiliate will obtain relevant clinical information and consult with the member's treating practitioner in order to make a determination of medical necessity.

In the event, the reviewer believes additional information may be needed to support medical necessity and that by obtaining the necessary medical information, a request for service may be approved, the reviewer or the reviewer designee may delay or defer the request in order to obtain the necessary information.

An authorization request may only be deferred one time. If sufficient information is not available to render a decision following one deferral, the Medical Director or designee is to contact the requesting provider directly. Documentation of this verbal communication will be added to the referral package and a decision will be rendered.

UM 7: DENIAL NOTICES

Denial of medical health services will be managed by the affiliates as follows:

1. Only a current unrestricted California licensed physician reviewer from the appropriate education, training, professional expertise or specialty may initiate a denial for medical necessity.

2. Written notification is sent to both patient and requesting provider.

3. Regulatory (Federal, State), plan specific or best practice (Industry Collaboration Effort)approved pre-service denial, delay, modification notification forms/letters and all pertinent inserts and attachments will be utilized to communicate determinations to members and requesting providers.

4. Communications regarding decisions to approve or deny a providers request to provide health or behavioral health care services, must specify the services that were approved or denied; and

5. Communications regarding decisions to deny, delay or modify a provider's treatment request must be communicated to the affected member and requesting provider in writing although initial communications can be made by telephone, facsimile, or online notification.

   These communications must include:
   a. A clear and concise explanation of the reasons for the denial decision that is specific to the member's diagnosis, condition or situation in easy to understand language, so that the member can understand the-reason for denying the service;
   b. A description of the benefit provision, criteria or guidelines used as a basis for the decision;
   c. Other clinical information used as a basis for a decision regarding medical necessity;
   d. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
   e. Information as to how the enrollee may file a grievance with the plan pursuant to Section 1368; and for Medi-Cal enrollees, an explanation of how to request an administrative hearing and paid pending under Sections 51041.1 and 51042.2 of Title 22 of the California Code of Regulations;
   f. A description of the member's appeal rights, including the right to submit written comments, documents or other information relevant to the appeal. An explanation of the appeal process, including the right to member representation and appeal time frames.
   g. A description of the expedited appeal process for urgent preservice or urgent concurrent denials.
   h. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
   i. Information will be included, where applicable, of the member's right to file a complaint with the Department of Managed Health Care.

6. Provider notification will include the name and direct telephone number of the physician who reviewed the referral if the provider wishes to discuss the case.

7. Alternative plan of care will be identified in the case of medical need issues.

8. Only reasonably, necessary, adequate and appropriate information will be gathered and considered to make initial denial determination.

9. A tracking system for status of authorizations, denials and appeals will be maintained electronically by appropriate authorization department.

10. If the affiliate delays a determination because it cannot make a decision regarding a treatment request within the required timeframe because the affiliate has not received all of the information reasonably necessary and requested, or the affiliate requires consultation by an expert reviewer, or the affiliate has asked that an additional examination or test be performed upon the member, the affiliate will, immediately upon the expiration of the specified timeframe, or as soon as the affiliate becomes aware that it will not meet the time frame, whichever occurs first, the provider and the member will be notified in writing that a determination cannot be made within the required timeframe. The notification will indicate the information needed, the expert consultation to be obtained, or the test or examination required, as well as the anticipated date on which a determination will be made.

11. The affiliate may reopen a case only in the event of a clerical/data entry error. Members, practitioners and/or health plans may request a case be reopened or reconsidered (this is an appeal) either verbally or in writing. The request for any appeal will be forwarded to the appropriate health plan.

12. In the event the affiliate decides to terminate approved service coverage (such as Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice Or Comprehensive Outpatient Rehab Facility (CORF), the affiliate shall provide the Member with a Notice of Medicare Non-Coverage (NOMNC) no later than two days before the proposed end of the services. The NOMNC shall include:
    a. the date of the enrollee's financial liability for continued services begins;
    b. a description of the enrollee's right to a fast-track appeal via the Quality Improvement Organization (QIO);
    c. information about how to contact the QIO;
    d. the enrollee's right to submit evidence to the QIO; and
    e. alternative appeal mechanisms if the enrollee fails to meet the deadline for a fast-track appeal

13. Should the member appeal the affiliate' s decision to terminate services, the affiliate must provide the Detailed Explanation of Non-Coverage (DENC) (CMS-10095-B), an explanation as to why the provider services are no longer reasonable or necessary or are no longer covered. The DENC shall include:
    a. applicable CMS rules, instruction, or policy including citations, and
    b. how the enrollee may obtain copies of such documents; and

c. other member specific facts or information relevant to the non-coverage decision in easy to understand language

14. If the QIO reverses the affiliate's decision to terminate services, the affiliate shall notify the Member with a new notice consistent with the QIO determination.

15. Upon notification that a Member has been advised that inpatient care is no longer necessary and the Member has requested an immediate review of the determination, the affiliate or contracted Hospital shall provide the Member with a Detailed Notice of Discharge (DND) as soon as possible but no later than noon of the day after the notification. During the review process, the affiliate shall ensure that all information the QIO needs to make its determination is provided, either directly (with hospital cooperation) or by delegation, no later than noon of the day after the QIO notifies the Delegate that a request for an immediate review has been received from the enrollee. The DND shall include:
    a. A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered in an inpatient hospital setting;
    b. A description of any applicable CMS coverage rule, instruction, or other CMS policy used in this determination, including information about how the Member may obtain a copy of the CMS policy; any applicable organization policy, contract provision, or rationale upon which the discharge determination was based; and
    c. Facts specific to the enrollee and relevant to the coverage determination sufficient to advise the enrollee of the applicability of the coverage rule or policy to the Member's case.

UM 8: POLICIES FOR APPEALS

The HPN affiliates maintain an established, impartial process for resolving members' disputes and responding to member requests to reconsider a medical decision they find unacceptable regarding their care and service as outlined in HPN UM Appeal policies.

Concurrent with denial notification, all members and/or providers are given a description of the internal and external appeal rights and the opportunity to submit a verbal or written appeal, including an expedited appeal, if applicable, to the full service Health Plan. The full service Health Plan will notify the member and the delegated affiliate of the outcome

Members will be informed in the denial notification that they have at least 180 days to appeal an adverse organization decision.

When applicable, the member will be provided information regarding their right to continued coverage under their medical benefit pending the outcome of an internal appeal.

UM 9: APPROPRIATE HANDLING OF APPEALS

The HPN affiliates have a full and fair process for resolving member disputes and responding to members' requests to reconsider a medical or behavioral health decision they find unacceptable

regarding their care and service as outlined in HPN UM Appeal policies. The PMGs will:

1. coordinate all appeals with the full service Health Plan and will document, investigate and (when appropriate) respond to each appeal;
2. provides no subordinate reviewers who were not involved in the previous determination and same-or-similar-specialist review, as appropriate;
3. resolve preservice, post service and expedited appeals within the specified time frames:
    a. preservice appeals within 30 calendar days of receipt of the request
    b. post service appeals within 60 calendar days of receipt of the request
    c. expedited appeals within 72 hours of receipt of the request

The internal appeal notification will include:

1. Specific reasons for the appeal decision, in easily understandable language.
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.
4. Notification that the member is entitled to receive reasonable access to and copies of all documents, upon request.
5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
6. Signature of appeal reviewer.
7. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.

In the event of an external Independent Review Officer (IRO) review resulting in a decision to overturn the initial determination, the affiliate will implement the IRO decisions in all cases reviewed.

UM 10: EVALUATION OF NEW TECHNOLOGY

The Medical Director or designee may initiate a review of new technologies or new uses for existing technologies which may be requested by a Health Plan, Provider or Member. The UM Committee or Committee member designee will review all recommendations for new technologies or changes to existing technologies. Review will include at least a review of Government Standards, medical literature or other sources, and is reviewed by the appropriate specialty physicians, and health plan. All necessary parties will be notified at least 24 hours prior to implementation of new technologies.

New technologies may include, but is not limited to:

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

UM 11: EXPERIENCE WITH THE UM PROCESS

The affiliate will assess the Member and Provider satisfaction with the UM process by utilizing surveys designed to document positive and negative experiences of members and providers.

The surveys will include indicators to measure satisfaction with the Utilization Management Program. Opportunities for improvement will be identified and correction action(s) will be taken at that time.
Results of patient satisfaction and physician satisfaction UM surveys performed by the contracted provider groups will be analyzed at least annually by the affiliate Utilization Management Committee.

UM 12: EMERGENCY SERVICES

Emergency services are available to members 24 hours a day, 365 days a year. Emergency services shall consist of:

Emergency service providers, acting as an authorized representative on behalf of the affiliate, shall:

1. authorize the provision of emergency services
2. screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
3. It is PPG's standard procedure to approve all ED visits unless clearly evident that the member has a history of abusing ED prudent layperson rights by using the ED for routine/non emergent services during hours when their Primary Care Physician is available via office visit or phone call.

The PMGs may deny emergency ancillary services based on medical necessity, retrospectively, after medical review by PPG physician reviewer. Claims for non-emergent care may be denied retrospectively but the member will not be billed for these services

PMGs will sign annual attestations confirming non-denial of emergency services as appropriate.

UM 13: PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

The HPN affiliates' policies and procedures for pharmaceutical management promote t h e clinically appropriate use of pharmaceuticals as determined by a licensed physician and/or pharmacist and based on sound clinical practice.

1. Using a list of pharmaceuticals recommended by the affiliate' s Pharmacist or by a contracted pharmacy benefits management (PBM) vendor, generally known as an open formulary
2. Using a list of pharmaceuticals for which the organization requires prior authorization.
3. Limiting the number of refills, doses or prescriptions available to members based onmedical necessity and benefit coverage.
4. Using generic substitution, therapeutic interchange or step-therapy protocols.

The affiliate will maintain an expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.

The affiliate will notify members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification.

Development, review and adoption of pharmacy policies will follow the standard HPN process for all other HPN policy, guideline, and criteria. The HPN Pharmacy policies will include, but are not limited to, processes for:

1. Making an exception request based on medical necessity.
2. Obtaining medical necessity information from prescribing practitioners.
3. Using appropriate pharmacists and practitioners to consider exception requests.
4. Timely request handling.
5. Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.

Annually and after updates, the affiliate communicates to members and prescribing practitioners:

1. A list of pharmaceuticals, including restrictions and preferences.
2. How to use the pharmaceutical management procedures.
3. An explanation of limits or quotas.
4. How prescribing practitioners must provide information to support an exception request.
5. The process for generic substitution, therapeutic interchange and step-therapy protocols.

UM 14: TRIAGE AND REFERRAL FOR BEHAVIORAL HEALTHCARE

Triage and referral (T&R) functions for behavioral healthcare services are provided via direct access to the affiliate contracted behavioral health (BH) care group practice organization (treatment source) and/or via the affiliate Member Service Department staff who provide information about the BH practitioners but do not make judgments regarding the needed level of care or type of practitioner the member should see. Protocols maintained by the affiliate's behavioral health (BH) care group practice organizations (treatment source) address all relevant mental health and substance abuse situations, the level of urgency and the appropriate care setting and treatment. Affiliates require all behavioral health (BH) care group practice organizations protocols to be reviewed and/or revised a minimum of every two years.

A licensed psychiatrist or a licensed doctoral-level clinical psychologist will oversee triage and referral decisions.

The affiliates may utilize a contracted behavioral health (BH) care group practice organizations to perform T&R and oversee behavioral health review but will not delegate or sub-delegate an UM responsibilities or activities.

UM 15: DELEGATION OF UM

HPN fully owns and operates its affiliate. HPN develops all operational programs, work plans and policies, including but not limited to:

1. Adopting criteria.
2. Monitoring the quality and timeliness of decisions.
3. Preservice decisions, by service.
4. Urgent concurrent review and decisions.
5. Post service review and decisions, by service.
6. Approvals and denials.
7. Appeals.
8. Assessing member and practitioner satisfaction of UM
9. Establishing, applying and maintaining pharmaceutical management procedures.
10. Evaluating new technology.
11. Communicating with members about the UM process and authorization of care
12. Managing triage and referral of behavioral healthcare.

HPN monitors and evaluates the following UM activities performed by each of its affiliates:

1. Number of UM cases handled by type (Preservice, urgent concurrent or post service) and by service (inpatient or outpatient).
2. Number of denials issued.
3. Number of denials appealed.
4. Uses and disclosure of protected health information as outlined in HPN privacy and information security policies.

HPN does delegate the UM responsibilities to its affiliates but does not allow the HPN affiliates to sub-delegate ANY UM responsibilities without prior written approval of the HPN Executive body.