VERDA HEALTHCARE's UTILIZATION MANAGEMENT PROGRAM AND CRITERIA

Purpose and Scope

Verda Healthcare's (Verda) 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 processes 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 Verda Health Plan Chief Medical Officer, the IPA UM Committee, or the IPA Clinical Medical Director.
- Services are not over utilized or underutilized.
- 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 specific contracted member populations, (e.g. Commercial, and Medicare).
- 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.

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 Texas 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.
- Collaborate and cooperate 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 Verda Health Plan are based only on the appropriateness of care and service. Verda does not compensate the physician or the nurse reviewers who conduct utilization reviews for any denials of coverage or service. There are no financial incentives in the organizations that that deny service.

2. All medically necessary decision determinations are based on established medical necessity criteria. The criteria applied are based on industry-recognized hierarchy of importance, with the following order:

- CMS local and national determinations
- Verda peer-reviewed guidelines, if applicable (none currently)
- InterQual ® evidence-based decision support tool
- If applicable, other nationally recognized professional society endorsed guidelines (eg. National Comprehensive Cancer Network ® guidelines) or other evidence-based guidelines

3. The Verda Chief Medical Officer, a senior physician with substantial involvement in the implementation of the UM Program, will oversee the appropriate use of criteria along with the Utilization Management Committee. Participating IPA practitioners outside the Utilization Management Committee are available to assist in the review and/or acceptance of criteria, as necessary.

4. 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 nonphysician 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

5. 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.

6. 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.

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

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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/herself

15. Provider and member appeals will be effectively processed according to the IPA/health plan appeals policy.

16. 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.

17. 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.

18. 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.

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