Section Three – CHP Utilization Management Policies & Procedures

The Utilization Management (UM) Policies described in this section pertain only to services managed or paid directly by CHP. These policies relating to UM are not applicable to all CHP contracted plans:

- UM is not applicable to providers treating CAM Plus members.
- UM is not applicable to some leased network contracts. UM Policies specific to such plans are provided separately.

UM Program Overview

0.01 Mission, Goals and Objectives

The mission of The CHP Group (CHP) Utilization Management (UM) Program is to ensure the quality and medical necessity of health care services provided to members of contracted plans. The UM Program has three primary goals:

- Validate the medical necessity of services rendered.
- Confirm the health care services are provided at the appropriate level of care.
- Substantiate the health care services meet local community standards for quality of care.

In support of these goals, the UM Program has the following objectives:

- Have clearly a defined structure aligned with explicit policies and procedures for utilization management functions.
- Make utilization management decisions that are fair, impartial, consistent and in compliance with established policy and law.
- Use the best available evidence-based criteria for assessing quality, appropriateness, and necessity of service.
- Provide useful information to providers and members about the UM criteria and processes.
- Use only qualified licensed health professionals to assess clinical information to support UM decisions.
- Make and communicate utilization management decisions in a timely manner.
- Obtain all relevant clinical information and appropriate consults to support UM decision making.
- Clearly document and communicate to affected providers the reasons for any denial of services or payment.
- Maintain explicit policies and procedures for thorough, appropriate, and timely resolution of appeals of UM decisions.
- Resolve appeals in a thorough, appropriate, and timely manner.
- Evaluate new technology and new application of existing technology for coverage by the contracted health plans.
- Monitor utilization to detect and correct unexplainable variation, under-use, and over-use of services.

0.02 Effectiveness of UM Program

The effectiveness of the UM Program is measured by the extent to which medically necessary services are delivered, medically unnecessary services are constrained, and underutilization of medically necessary services is avoided.

0.03 Scope of Program

The scope of the UM Program is comprehensive and addresses the demographic and epidemiological factors of the member population served as well as the needs of individual members, i.e., where, who, and how care and service are provided.

0.04 Environments and Service Area

Credentialed providers are located throughout the States of Oregon, Washington, Idaho, Utah, Montana, Alaska, and Colorado. CHP's network is comprised of both sole provider offices and offices with multiple providers.

0.05 Delivery System

The network is distributed to provide optimum access for members enrolled in contracted health plans with over 2400 providers in the service area. All providers have met initial credentialing standards and participate in timely re-credentialing in compliance with NCQA standards.

0.06 Access

Care is provided to members within provider offices. The majority of provider offices are open four to five days per week with standard office hours (ranging from 7 a.m. to 7 p.m.). Offices are instructed to have either an answering machine or answering service to direct members appropriately after-hours. Surveys of office wait times reveal the majority of providers begin treatment 5 to 10 minutes after the member's arrival at their office and offer urgent appointments within 24 hours. Access is monitored annually to encourage offices to meet ADA requirements.

0.07 Members Served

Any member has the right to access a provider; there are no limitations on age, sex, race or national origin, gender, or sexual orientation. Members may receive treatment at any age (birth to death).

0.08 Important Aspects of Care and Services

Important aspects of care and service relating to acute and chronic conditions are evaluated and monitored. The focus is on those functions having the greatest impact on the quality of care and service ultimately received by the member. When appropriate, the following topics/activities are coordinated with Quality Management and Credentialing Programs. Information from each of these areas is kept in the provider's quality file.

The following list contains the topics and activities reviewed on an ongoing basis by CHP:

- Patient Satisfaction Surveys related to the quality of care.
- Complaint/grievance monitoring related to the quality of care.
- Provider Satisfaction surveys related to CHP's claims and UM process.
- Review of contracted services.
- Review of UM Interventions.
- Clinical record evaluations.
- Health promotion.
- Monitoring of clinical pathways.
- Continuity and coordination of care.
- Under- and over-utilization.
- Provider performance.
- Participation in studies mandated by health plans, regulatory and accreditation agencies.

0.09 Urgent Requests

There are mechanisms in place to expedite reviews or treatment extension requests when a member or provider believes an urgent condition exists. Please Refer to Section 5.00.

0.10 Appropriateness of Clinical Services

Appropriateness of clinical services is evaluated in light of evidence-based standards of practice. Evidence from consensus of expert opinion and review of scientific clinical literature are combined to develop criteria used for determination of medical necessity. Evidence is summarized in clinical pathways, which are posted on the website and are available to every network provider. This evidence drives policy development, which in turn guides CHP's Medical Directors in determining appropriateness and necessity. Criteria are reviewed by the CHP Medical Director's and the Combined Medical Directors (CMD) Committee annually, or as new evidence becomes available.

Review criteria and procedures are more thoroughly described in Section 2.00. UM decisions are reviewed by using an internal audit process for consistency with professional standards and CHP criteria.

Clinical policy is developed through the collaborative efforts of the Clinical Management Committee (CMC) and the Combined Medical Directors Committee (CMD). In the development process the following sources may be utilized:

- Health care literature data bases such as Medline and PubMed, Index to Chiropractic literature, CINHAL, MANTIS.
- Systematic reviews such as the Cochrane Collaboration
- Government agencies such as the Agency for Healthcare Research and Quality, National Center for Complementary and Integrative Health.
- Clinical guidelines resources such as ECRI Institute.
- Professional sources such as the Society for Acupuncture Research, American Chiropractic Association.
- Current authoritative sources such as textbooks, professional journals.
- Online point-of-care evidence-based clinical resources such as UpToDate, DynaMed.
- Provider advisors.
- Provider surveys.

0.11 Consideration of Non-Covered Services

The scope of services offered by CHP providers is limited by the contracts defined by health plans. All services used to provide treatment and/or evaluate CHP members in provider offices must be recognized by CHP and be appropriate to the type and level of benefit.

If a provider requests a non-covered service be provided to a member, the provider will work with the Chief Clinical Officer or appropriate designee to determine where the most appropriate delivery of the recommended service would occur. In most cases, it is appropriate to refer the member to the Primary Care Physician or referring clinician of the contracted health plan. If a non-covered service is deemed appropriate and effective for use by the provider, CHP's Chief Clinical Officer or appropriate designee will review and determine payment. This will be done on a case-by-case basis.

Consultation will most usually occur between the CHP Chief Clinical Officer or appropriate designee, the health plan representative, the provider and, in some cases, the member.

1.00 Utilization Management Structure and Function

1.01 Role of the CHP Board of Directors (CHP BOD)

The CHP BOD is ultimately responsible for the UM Program. As with other management functions, the BOD delegates responsibility for the UM Program to the Chief Executive Officer.

1.02 Role of the Chief Executive Officer (CEO)

The CEO is accountable to the CHP BOD for the overall performance and results of the UM Program. The CEO maintains authority to allocate resources and staff for utilization management activities. The CEO is responsible for:

- Ensuring identified UM deficits are corrected.
- Monitoring UM reports to detect trends in the ongoing delivery of healthcare.
- Ensuring the Clinical Management Committee is performing diligent oversight of the UM Program.
- Providing an Annual Utilization and Quality Management Summary report to the CHP BOD.

The CEO delegates responsibility for coordinating and implementing the UM Program to the Chief Clinical Officer; oversight of the UM Program to the Clinical Management Committee; and performance of UM activities to the Combined Medical Directors (CMD) Committee.

1.03 Clinical Management Committee (CMC)

The CEO grants oversight responsibility of the UM Program to the Clinical Management Committee, which includes non-staff network providers. The responsibilities of the Clinical Management Committee to the UM Program are:

- Oversee that CHP's strategic goals relating to the UM Program are met.
- Review quarterly and annual reports from the Chief Clinical Officer pertaining to the UM Program.
- Oversee the clinical activities of the Combined Medical Directors Committee.
- Approve all clinical policies and procedures recommended by CHP administration and the clinician committees.
- Monitor provider utilization management outlier behavior is corrected in accordance with policies.
- Monitor policies for oversight of the CHP's UM Program.

1.04 The Combined Medical Directors Committee (CMD)

Members of the Combined Medical Directors Committee are the Chief Clinical Officer, Regional Medical Director(s) and Associate Medical Directors representing each of CHP's disciplines, all of which hold voting authority. The responsibilities of the Combined Medical Directors Committee to the UM Program are:

- Oversee the effectiveness of monitoring, evaluating, and improvement of UM systems and providers.
- Coordinate UM clinical and quality activities with related activities to improve quality of care and service.
- Analyze UM findings to make clinical recommendations based on results and assess improvements.
- Monitor compliance with regulatory requirements, including health plan delegation and claims processing.
- Provide reports to Clinical Management Committee regarding UM clinical program performance.
- Develop and review the UM Policies and Procedures annually.

1.05 Ad Hoc Advisory Committees

Ad Hoc Advisory Committees may be called periodically. These Committees serve in a clinical advisory capacity to the CEO, the Chief Clinical Officer, the Regional Medical Directors(s), and the Clinical Management Committee regarding discipline specific issues. Membership of each Advisory Committee includes the Chief Clinical Officer, an Associate Medical Director for the respective discipline, the Clinical Services Supervisor, and network providers of the respective discipline.

1.06 Role of the Regional Medical Director

The Regional Medical Director acts at the direction of the Chief Clinical Officer and supports the CHP Clinical Services Department to accomplish the goals and objectives of the Clinical Quality Management (QM), Credentialing and UM Programs. This also includes QM, Credentialing and UM policy and program support, maintenance, development, and implementation. The Regional Medical Director provides direction and participates with internal and external staff to ensure the goals and objectives of the programs are achieved as well as develops and implements strategies to improve the quality, safety and efficiency of services provided by contracted providers. The Regional Medical Director serves as the chair of the Credentialing Committee as well as provides support to the Associate Medical Director functions as necessary. The Regional Medical Director must be a licensed practitioner; provide proof of current, unrestricted licensure; and have been in active practice for a minimum of 5 years.

1.07 Role of the Chief Clinical Officer

CHP's Chief Clinical Officer is accountable to the CEO and leads the organization in the establishment and accomplishment of goals and objectives of the QM, Credentialing and UM Programs, The Chief Clinical Officer's responsibilities also include the following: collaborate with the Regional Medical Director(s) for effective coordination and integration of the QM, Credentialing, and UM programs, timely reporting to appropriate entities relating to UM activities; providing CMD ,CMC and Credentialing Committee support; overseeing CHP's Clinical Services Department to manage timely completion of all UM and QM activities, collaborate with internal and external staff in aligning CHP Policies and Procedures with NCQA standards, provide support to the Associate Medical Director function as necessary, and facilitating and preparing for external delegated audits. The Chief Clinical Officer must be a licensed practitioner; provide proof of

current, unrestricted licensure; and have a minimum of 5 years' experience in the health care insurance industry.

1.08 Role of the Associate Medical Director(s)

Associate Medical Director(s) (AMD) perform medical necessity and clinical record reviews, initial credential, and re-credential file reviews, and are actively involved in setting UM policy. All AMD's must meet CHP's participation criteria which include proper education and training and a current, active license. Additional qualifications of an AMD include in active practice in the representative discipline for a minimum of 3 years and an unrestricted license. Training is provided by the Chief Clinical Officer and Regional Medical Directors(s) who are the direct reports for the AMD personnel. The AMDs participate on the Combined Medical Directors Committee as well as participate in multi-disciplinary problem solving, as needed.

1.09 Role of the CHP Staff

The UM staff collects data and has authority to authorize services based on CHP policy. The UM staff functions as the administrative interface between the Claims and UM departments, collecting and disseminating information for claims determinations of all UM claim reviews under the supervision of CHP's Chief Clinical Officer. The UM staff is responsible for maintaining accurate documentation of all UM activities to include internal and external audits, claims review tracking, file documentation, and correspondence to members and providers regarding UM decisions to include ensuring documentation of appropriate professional review via signature or the UM staff signature attributing the specific professional reviewing the case.

The UM staff is not authorized to approve or deny claims relating to a medical necessity determination. Decisions requiring clinical judgment are referred to the Chief Clinical Officer, Regional Medical Director, Associate Medical Directors, or other qualified professional. Any denial of medical necessity or appropriateness is a result of review by a fully licensed professional practicing with an unrestricted license and in the same discipline as the provider in question. The UM staff may deny a claim for reasons other than medical necessity and appropriateness only in accordance with established UM policies as documented in CHP's Billing Manual and the Professional Services Agreement.

1.10 Provider Participation

Providers are expected to make themselves available for service within the UM Program. Additionally, each provider's signed Professional Services Agreement states the agreement to participate in and comply with all peer review, utilization review and quality assurance activities, and with dispute resolution processes.

1.11 Appeals

The CHP UM Appeal process is designed to handle appeals expeditiously and equitably. The timeliness of responses and the appeal process shall follow the timeframes and procedures specified in the UM Appeals Policy, Section 8.00.

1.12 Annual Program Evaluation and Update

The UM-QM Program is evaluated annually for effectiveness and consistency with program objectives by the Chief Clinical Officer, with support from the Regional Medical Director(s) and Associate Medical Director (s). CHP's written Year End Summary Report includes the completed UM-QM activities, evaluation of improvements in care, evaluation of effectiveness of UM-QM activities, and trending of clinical and service indicators.

CHP updates the UM and QM programs and develops quality improvement initiatives based on the annual assessment of the UM-QM activities performed in the previous year, or earlier, if necessary. The Clinical Management section of Year End Summary Report is presented to the CMD Committee; reviewed and approved by the CMC; and reported to the CEO and the Board of Directors.

The annual update involves review and revisions as appropriate of the UM Policies and Procedures which are posted on the CHP website. Providers are notified of updated UM policies and procedures via written notification of such with the availability to obtain a written copy upon request.

The primary goal of UM is the delivery of medically necessary services. Effectiveness of UM is measured by the extent to which medically necessary services are delivered, medically unnecessary services are constrained, and the underutilization of medically necessary services is avoided.

Direct measures of UM effectiveness are derived from claims data for individually reviewed claims, samplings achieved during provider-specific interventions and clinical pathway reviews. Evaluation of practice variation is conducted quarterly by CHP UM Staff. At least annually, all CHP Chiropractic physicians, Naturopathic physicians and providers of acupuncture services receive a Provider Trend Analysis report. Provider Trend Analysis reports are distributed to the outlier and high-volume providers on a quarterly basis and are utilized in monitoring these providers as evidence of practice quality assessment and improvement.

Indirect measurement of UM Program effectiveness occurs through the analysis of patient complaints and satisfaction regarding access to care and the adequacy of that care. Provider complaints regarding UM also measure the impact of the UM Program on the provider's perception of their ability to render quality care. Annual provider satisfaction surveys inquire about provider and provider office staff experiences with CHP's UM Program.

Evaluation of the UM Program includes a formal evaluation of the AMD's. This evaluation includes assessing the consistency of UM decisions across reviewers on a routine basis, completion of duties as described in this document and review of the Associate Medical Director job descriptions. Program evaluation and revisions are reviewed and approved by the Clinical Management Committee at least annually.

2.00 Clinical Criteria for Utilization Management

2.01 Medical Necessity

"Medical Necessity" or "Medically Necessary" shall mean health care services that a provider, who is exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms. Medically necessary care is intended to help the member achieve maximum therapeutic benefit. Medically necessary care is:

- in accordance with generally accepted standards of medical practice,
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the member or the health care provider.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature, generally recognized by the relevant medical community.

"Maximum therapeutic benefit" has been achieved when the member's health status has returned to a pre-clinical/pre-illness condition, or the member's condition no longer shows progressive improvement toward a return to a pre-clinical/pre-illness condition. Health care services rendered beyond the point of maximum therapeutic benefit are not medically necessary.

"Medically necessary supportive care" is treatment of a member's condition that has achieved maximum therapeutic benefit, but when periodic trials of withdrawal of care fail to sustain previous objective and subjective improvement. In addition to passive therapies, appropriate supportive care includes education, active care, lifestyle modification, exercise programs, and other self-care techniques.

"Elective treatment" is defined as care provided for a stable condition that will remain stable without further care; care that is discretionary and at the option of the member; care that is intended to promote optimum function, wellness or maintenance. Elective treatment is not medically necessary.

2.02 Criteria for Medical Necessity and Clinical Appropriateness Determinations

The CHP Group (CHP) has an obligation to review the services provided to members for medical necessity and clinical appropriateness verification. Determination of medical necessity and clinical appropriateness includes assessment of the following parameters within the information outlined in Section 6.01:

- Appropriateness:
    - Is treatment recognized as appropriate for the condition?
    - Has there been consideration of patient age, co-morbidities, risk factors, and psychosocial factors?
    - Is there evidence of exacerbation or complications?
    - Is care appropriate for the clinical stage of the condition?
- Consistency:

    - Is the diagnosis consistent with the subjective and objective data?
    - Is the treatment consistent with the diagnosis?
- Community standards:
    - Is the treatment consistent with professional consensus and expressed in documents such as treatment guidelines, textbooks, and professional literature?
    - Does the care provided correlate with standards of quality care?
- Member Progress:
    - Are there signs of progress in the subjective or objective information?
    - Are there functional indicators or outcome assessments indicating improvement?
    - Is there documentation of a change in therapeutic approach in response to lack of progress?
    - Is there indication of an active care component to the treatment regimen?

2.03 Medical Necessity and Clinical Appropriateness Determinations

The term "medical necessity" refers to what is medically necessary and clinically appropriate for a particular member, and hence medical necessity and clinical appropriateness determinations entail an individual assessment rather than a general determination of what works in the ordinary case. If there is sufficient evidence to show that a treatment is not medically necessary and clinically appropriate in the usual case, it is up to the member and their provider to show the individual member is different from the usual in ways that make the treatment medically necessary and clinically appropriate for that member.

Medical necessity and clinical appropriateness determinations are made by a clinician with training and practical experience in the same discipline as the provider submitting the claim in question. Determinations are based on the reviewer's clinical experience, the clinical pathways, CHP clinical policy and available current evidence. Generally, if the clinical records show evidence of the presence of a covered condition and documentation of sustained improvement through outcome measures, a positive change in subjective complaints, or indication of objective improvement, then the care is considered to be medically necessary and clinically appropriate.

2.04 Evidence-Based Criteria

Appropriateness of clinical services is evaluated in light of evidence-based standards of practice. Evidence from consensus of expert opinion and review of scientific clinical literature are combined to develop criteria used for determination of medical necessity and clinical appropriateness. Evidence is summarized in clinical pathways, which are provided to every network provider via CHP's website with written notification of such and availability of copies upon request. This evidence also drives policy development, which in turn guides clinical staff in determining appropriateness and necessity.

Clinical pathways are suggested clinical approaches and not rigid protocols. CHP expects there will be members whose needs vary from the clinical pathways. In those instances, the provider is expected to maintain a clinical record that clearly outlines subjective and objective information documenting the variation in clinical presentation and giving a clear indication of the assessment and treatment plan.

2.05 Consistency in applying UM Criteria

CHP evaluates consistency in applying UM Criteria on an ongoing basis via audits performed to evaluate the consistency of the UM decisions. Such audits evaluate all CHP UM decisions against professional standards and CHP UM criteria. Written reports are provided to the Chief Clinical Officer and Combined Medical Directors Committee for review and appropriate action upon identification of any opportunity for improvements as necessitated.

2.06 Review Criteria Development

UM review criteria are developed through collaborative efforts of the Medical Director's, the Combined Medical Directors Committee, and the Clinical Management Committee.
In the development process the review of the following relevant sources may be utilized:

- Health care literature data bases such as Medline and PubMed, Index to Chiropractic Literature, CINHAL, MANTIS.
- Systematic reviews such as the Cochrane Collaboration.
- Government agencies such as the Agency for Healthcare Research and Quality, National Center for Complementary and Integrative Health.
- Clinical guidelines resources such as ECRI Institute.
- Professional sources such as the Society for Acupuncture Research, American Chiropractic Association.
- Current authoritative sources such as textbooks, professional journals.
- Online point-of-care evidence-based clinical resources such as UpToDate, DynaMed.
- Provider advisors.
- Provider surveys.

2.07 Annual Review of UM Criteria

UM Criteria for medical necessity and clinical appropriateness is reviewed annually by the Associate Medical Directors at the Combined Medical Directors Committee, or as new evidence becomes available. The CHP Chief Clinical Officer routinely monitors updates from evidence-based clinical resources such as those listed in Section 2.06, e.g., PubMed, Cochrane Collaboration, Agency for Healthcare Research and Quality, National Center for Complementary and Integrative Healthcare, ECRI Institute, professional journals, online point-of-care resources.

The UM Policies, containing the UM Criteria, are updated at least annually at which time providers are notified in writing of the availability of the policies on CHP's website. The opportunity is provided for providers to obtain a copy upon request.

Availability of Clinical Criteria

The clinical criteria are distributed via the CHP Provider Operations Manual to newly participating providers. Revisions of the Provider Operations Manual are communicated to participating providers in writing, with the opportunity to obtain a copy upon request. The clinical criteria are within the Utilization Management Policies and Procedures which are posted separately from the Provider Operations Manual on the CHP website.

3.00 Communication Services

3.01 Availability of Staff
Providers and members with questions about UM issues will have access to UM staff during normal business hours, between 8:00 am and 5:00 pm Monday through Friday.

3.02 Contact Outside Normal Business Hours
Contact outside of normal business hours is available via CHP's dedicated UM fax or will be accommodated by special arrangement with affected parties.

3.03 Outbound Communication
UM decisions will be communicated to the affected parties during normal business hours between 8:00 am and 5:00 pm, Monday through Friday, excluding holidays and office closures.

3.04 Staff Identification
CHP policies and procedures state when UM staff initiate, receive, or return calls to members or practitioners regarding UM issues, they identify themselves by name, title, and The CHP Group.

3.05 Toll free Number
CHP maintains a toll-free number, 800-449-9479, for out-of-area members and providers to access UM staff. There is also a CHP UM dedicated toll-free fax, 877-252-8452. This fax number is available 24/7 and accepts all non-urgent request outside of business hours but is not monitored during non-business hours. Receipt of requests will be documented on the next business day. For TDD (telecommunication device for the deaf) or TTY (telephone typewriter, or teletypewriter) assistance, members may call 711 Relay Services. For members not able to use the 711 number, they may use 1-800-735-2900 as an alternate number. For language interpretation services, Kaiser Permanente members may call 800-324-8010.

3.06 Access to Staff for Callers with Questions
The Provider Operations Manual and the Billing Manual provide instruction regarding contact with CHP's UM department. Any correspondence related to UM is sent to providers or members includes contact information such as CHP's toll-free telephone and toll-free fax numbers, including information about requesting an interpreter when one is needed. CHP uses Language Line Personal Interpreter Services on an as needed basis for members or providers requesting language assistance in discussing UM concerns.

General UM inquiries may be addressed by customer service or the Clinical Services staff. Specific UM inquiries will be forwarded to the UM staff, the Chief Clinical Officer or appropriate designee who are responsible for describing or explaining UM processes, criteria, or decisions.

4.00 UM Reviews Performed by Appropriate Professionals

4.01 Appropriate Licensed Professionals (Clinician Reviewers)
Qualified licensed professionals include CHP's Chief Clinical Officer, Regional Medical Director and the Associate Medical Director's (AMD's) representing the following disciplines: Chiropractic and Naturopathic Physicians, Acupuncture, Massage Therapy.

4.02 Authority for UM Decision Making
CHP's Clinician Reviewers, i.e., Chief Clinical Officer, Regional Medical Director and the Associate Medical Directors are the only individuals in the organization who may make claims denials pertaining to medical necessity.
CHP staff review claims identified by claim system edits and approve claims payment consistent with established UM and Clinical Review policy. Staff may not deny claim payments regarding medical necessity.

4.03 Qualifications for Reviewers
Refer to Section 1.06, 1.07 and 1.08 for qualifications for reviewers. CHP also has written job descriptions that define qualifications for reviewers.

4.04 Reviewer Responsibilities
The Clinician Reviewers are responsible for reviewing all available material to ascertain whether there is sufficient information in order to make a determination on medical necessity of either covered or non-covered health care services. Upon determination, the Reviewer provides the decision and rationale for the decision to CHP's UM Department in accordance with CHP policy.

4.05 Documentation of Reviews
Thorough documentation of all reviews is the responsibility of UM staff. In addition, items listed in 8.06, UM staff assures the following on all UM case reviews:

- The date of receipt of each request
- The date of resolution
- Documentation of appropriate professional review on the CHP review form by:
    - Completion of the applicable CHP review form containing any of the following:
        - Handwritten signature or initials of the reviewer.
        - The reviewer's unique electronic signature or identifier.
        - UM staff signature or initials attributing the review to the specific reviewer of the case.

5.00 Timeliness of UM Decisions

5.01 Timely UM Decisions
The CHP Group makes UM decisions in a timely fashion as prescribed by the type of request and in accordance with applicable NCQA Standards, contracted health plans, and state law in order to minimize any disruption in the provision of health care. The UM staff, under the oversight of the Chief Clinical Officer, is responsible for accurate tracking and timeliness of all UM activities which is

routinely monitored and reported as part of CHP's UM Program. Elements to be tracked are clearly outlined in Section 8.06.

5.02 Definition of Nonurgent and Urgent

Definitions used when classifying UM requests:

- Nonurgent:
    - In accordance with NCQA Standards, non-urgent is defined as, "A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain."
    - The inclusion of a more restrictive state law definition of "nonurgent" or "standard" will be applied where applicable, e.g., Washington state, "'Standard prior authorization request' means a request by a provider or facility for approval of a service where the request is made in advance of the enrollee obtaining a service that is not required to be expedited.
- Urgent:
    - In accordance with NCQA Standards, urgent is defined as, "A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:
        - 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 judgement, or
        - Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
        - In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request."
    - The inclusion of a more restrictive state law definition of "urgent" or "expedited" will be applied where applicable, e.g. Washington State: "'Expedited prior authorization request' means any request by a provider or facility for approval of a service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the service that is the subject of the request."

CHP allows a provider with knowledge of the member's medical condition to act as the member's authorized representative and to indicate "urgent" or "expedited" on CHP's review form.

5.03 Receipt of Requests

CHP documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the CHP, even if it is not received by the UM department, regardless of whether all information necessary to make the decision at the time of the request and as follows:

- Non-urgent:
  - The next business day is the time of receipt for requests received outside normal business hours, as prescribed in Section 3.02, via fax machine. This is communicated to providers via this policy contained in the Provider Operations Manual. If received by mail, the date of receipt is the day CHP receives the mailed document.
- Urgent:
  - The receipt for urgent requests is the exact time received via fax machine, regardless of outside normal business hours. If received by mail, the date of receipt is the day CHP receives the mailed document.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. CHP documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

5.04 Pre-Service Decisions

Treatment Extension Requests (TER) are considered pre-service requests as interpreted by CHP's contracted health plans. Certain benefit plan designs require a treatment plan review prior to additional services being rendered and are conducted during a course of care at specified intervals. For example, individual member-focused reviews occur at specific intervals during a course of care as indicated by the number of visits, such as beyond 12 visits. These reviews are intended to assess medical necessity and detect potential excessive utilization and potential compromises of quality care.

Certain health plan contracts require Treatment Extension Requests (TER) by performing specified threshold reviews as described above. The resulting UM decisions are communicated to the requesting provider within the timeframes prescribed below in accordance with the most restrictive of applicable NCQA Standards, contracted health plans or applicable state laws. The decision is communicated to the member in cases of denial or partial denial of services.

These pre-service request or prior authorization request requirements are applied in accordance with applicable NCQA standards, contracted health plan or applicable state laws, e.g. Washington state law for public employees, a health carrier may not require prior authorization for an evaluation and management visit or an initial treatment visit in a new episode of chiropractic care where a "new episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider with in the previous 90 days and is not currently undergoing any active treatment. For additional details please refer to CHP's Billing Manual Section 3.2 Kaiser Permanente For Southwest Washington and Washington regulations RCW 41.05.074 and RCW 48.43.016 6157-S.SL.

Non-Urgent Pre-Service Decisions: (*Includes "Standard prior authorization requests" in Washington state)*

Standard Timeframe

The final decision is communicated in writing to the provider and in the case of a denial also to the member. This must occur in accordance with the most restrictive of applicable NCQA standards (within 14 calendar days for Medicaid and Medicare and within 15 calendar days of the request for others), contracted health plans or applicable state law, e.g., within 5 calendar days from the receipt of such requests, as per the more restrictive policy required by Washington State law. CHP UM staff documents the time and date of the verbal notification as well as who spoke with the provider. A voicemail is not an acceptable form of oral notification. Where there is a denial and notification is by telephone, CHP UM staff also documents notification of physician reviewer availability.

In the event a pre-service request from a provider is not accompanied by necessary information, CHP UM Staff will contact the provider via telephone, unless otherwise requested, within 5 calendar days of receipt to advise of the proper protocol and deadline for submission. CHP UM staff documents the time and date of the verbal notification as well as who spoke with the provider.

Extending Timeframes

If CHP is unable to make a decision due to circumstances beyond control or lack of necessary information, the decision timeframe may be extended by the most restrictive of applicable NCQA standards (up to 15 calendar days) or applicable state law (e.g., Washington state law, up to 14 days) if the following exists:

- The provider is notified of the specific information required within the decision timeframe for the pre-service request.
- The provider is given the most restrictive of applicable NCQA standards (at least 45 calendar days) or applicable state law (e.g., WA state law, within 5 calendar days) to provide the specific information requested.
- The provider is notified of the expected decision date upon receipt of requested information.

A decision must be made within the most restrictive of applicable NCQA standards (up to 15 calendar days) or applicable state law (e.g., WA state law, within 4 calendar days) which begins on either of the following:

- The date the provider's response is received by CHP, regardless if all requested information is received, or
- The end of the deadline given to the provider to supply the additional information if no response is received.

CHP may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Urgent Pre-Service Decisions: (*Includes "Expedited prior authorization requests" in Washington state)*

Standard Timeframe

Decisions must be made in accordance with the most restrictive of applicable NCQA standards (within 72 hours of the request), contracted health plan or applicable state law, e.g., within 2 calendar days of receipt as per the more restrictive policy of the Washington state law. Verbal notification is acceptable as long as electronic or written notification is given no later than 3 calendar

days of the verbal notice. A voicemail is not an acceptable form of oral notification. CHP UM staff documents the time and date of the verbal notification as well as who spoke with the provider.

In the event an urgent pre-service request from a provider is not accompanied by necessary information, CHP UM staff will contact the provider via telephone, unless otherwise requested, within 24 hours of receipt to advise of the proper protocol and a deadline for submission. CHP UM staff documents the time and date of the verbal notification as well as who spoke with the provider.

Extending Timeframes
If CHP is unable to make a decision due to lack of necessary information, the decision timeframe may be extended, once, to the most restrictive of applicable NCQA standards (48 hours or up to 14 days for Medicare and Medicaid with member request) or applicable state law if different (e.g., WA state law is 2 calendar days). The notification to the provider of the need for such extension within 1 calendar day must include the following:

- The provider is notified of the specific information required to make a decision on the urgent pre-service request.
- The provider is given the most restrictive of applicable NCQA standards (48 hours) or applicable state law if different (e.g., WA state law is 2 calendar days) to provide the specific information requested.
- The provider is notified of the expected decision date upon receipt of requested information.

A decision must be made within the most restrictive of applicable NCQA standards (48 hours) or applicable state law if different (e.g., WA state law is 2 calendar days) which begins on either of the following:

- The date the provider's response is received by CHP, regardless if all requested information is received, or
- The end of the deadline given to the provider to supply the additional information if no response is received.

5.05 Concurrent Decisions

Concurrent requests are defined, as per NCQA Standards, "A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care." For example, if a TER was approved for a time period through a specified date and more visits are needed during that time period, the provider may submit a concurrent request for additional care.

- Nonurgent:
  - The timeframes for non-urgent concurrent decisions are the same as noted above in 5.04 Pre-Service Decisions.
- Urgent:
  - The timeframes for urgent concurrent decisions are made in accordance with the most restrictive of NCQA standards (24 hours of receipt for commercial and Marketplace and 72 hours of receipt for Medicare and Medicaid) or applicable state law (e.g., WA state law, as soon as possible, taking into account the medical exigencies, and no later than 24

hours provided the request is made at least 24 hours prior to the expiration of previously approved period of time or number of treatments). Per NCQA, if the request was not made prior to 24 hours before the expiration of the prescribed period of time or number of treatments, the request may be treated as urgent preservice and make a decision within the most restrictive of NCQA standards (within 72 hours) or applicable state law (e.g., WA state law, within 48 hours). The time frames and criteria for extending decisions specifically for Medicare and Medicaid are the same as for urgent pre-service decisions.

5.06 Post-Service Reviews

Post-service (retrospective) reviews are conducted for UM purposes to detect potential under- and over-utilization or quality deficits. The organization may deny a post service request without conducting a medical necessity review, even if a medical necessity review is required, if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures but must provide the reason for the denial.

Reclassification of nonbehavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or post service if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by CHP. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or post service).

5.07 Reclassification of Request – Not Meeting Urgent Care Definition

If a request to extent a course of treatment beyond the previously approved time period or number of treatments previously approved by the organization does not meet the definition of "urgent care", the request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., pre-service or post-service).

5.08 Filing Procedures

CHP may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures, e.g., provider files a request over the phone or outside specific time frames.

5.09 Daily Claims Reviews – CHP Reimbursement Policies

Daily claims reviews are processed by the UM staff responsible for timely distribution to the appropriate Clinician Reviewer within 2 weeks of receipt by CHP. The Clinician Reviewer will review and communicate the claims decision to CHP UM staff within two weeks of their receipt to enable CHP to process the claim within 30 days of CHP claim receipt date. Please refer to 1.09 Role of CHP Staff for further information.

6.00 Clinical Information for UM Decisions

6.01 Relevant Clinical Information
Clinician Reviewers assure all relevant clinical information needed to make a determination of medical necessity has been collected and documented.

Information used to support medical necessity decision-making includes documentation supplied by the treating provider of the health care services such as CMS-1500, examination and treatment notes, member self-reports, reports of consultations, and diagnosis codes.

Clinician Reviewers may request additional information from the treating provider when available documentation does not support medical necessity.

6.02 Contacting the Treating Provider
Clinician Reviewers may contact the treating provider directly in the event written documentation does not demonstrate medical necessity of the service under review.

7.00 Denial Notices

Denial notices to the provider and member contain sufficient information regarding the rationale of the UM decision for such parties to determine the need to appeal a medical necessity denial or partial denial. A denial is defined as denial of all requested services or a partial denial of some of the requested services. In situations when the reviewer approves an alternative service and the provider and member agree to the alternative services, the provider has essentially withdrawn the initial request, and this would not be considered a denial. In the event a denial notice is issued due to a lack of necessary information and a phone call, or the required information is received not as a result of the denial notice, the reviewer who issued the initial denial may review the case with the new information and reverse the decision. In this scenario, the case should be classified as a denial because the denial notice was issued.

7.01 Discussing a Denial with a Nonbehavioral Healthcare Reviewer
The denial notice to the provider will contain a name and telephone number for CHP's UM department to facilitate contact with the Clinician Reviewer providing the opportunity to discuss the denial decision.

7.02 Specific Reasons for Denial
The Clinician Reviewers will clearly document the rationale for denial of service due to lack of medical necessity which will be communicated in writing directly to the treating provider and member. The explanation for the denial will be provided in easily understandable language and will not include insufficient language such as treatment is determined not to be medically necessary or not a covered benefit.

7.03 Criterion for Decision
The explanation to both the provider and member will contain a reference to the benefit provision, guideline, protocol or other criteria, or an excerpt specific to the denial criteria on which the denial

decision is based and instructions to obtain a copy of the actual benefit provision guideline protocols and other criteria, or an excerpt specific of the denial criteria upon which the denial was based.

7.04 Elements of Member Notification

Electronic or written notification to the member will include:

- The date of the decision.
- Documentation of the name of the individual who notified the practitioner.
- If a voice mail is left, the denial file must include who left the message and the date and time.
- The decision in easy, understandable language.
- The decision in a culturally and linguistically appropriate manner
- The specific reasons for the decision, in easy understandable language.
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the decision was based. The member is advised a copy of such reference may be requested.
- Notification the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to an appeal.
- Notification the member has the right to have a representative act on their behalf.
- A list of the titles, qualifications, and specialty of each individual participating in the review. Names of such individuals do not need to be included unless the member requests this information.
- The written notification of the medical necessity denial will include the following in reference to the right to appeal the denial decision:
    - A description of appeal rights, including the right to submit written comments, documents, or other relevant information.
    - An explanation of the appeals process, including the description of the expedited appeals process, if an urgent pre-service or urgent concurrent request.
    - Notification the member has the right to have a representative act on their behalf at all levels of appeal.
    - A Right to Appeal brochure provided by the contracted health plan, as applicable, to include:
        - An explanation of the appeals process, and
        - In applicable cases pertaining to urgent services, a description of an expedited appeal process.

7.05 Reconsideration Reviews

Reconsideration is defined as providing new information not previously reviewed in the original decision. CHP will grant a reconsideration review upon submission of additional information by the CHP provider. The UM staff will send an acknowledgement of a reconsideration request to the provider within 5 business days of receipt, to include the expected timeframe for a decision. The final decision will be communicated in writing to the provider within 30 calendar days of receipt.

7.06 File Documentation

UM staff will document UM cases denied as outlined in Section 4.05.

7.07 System Controls for Denial Notification Dates

Authorized UM staff will document and maintain information specific to UM prior authorization requests and decisions, including receipt dates/times, denial notification dates, and modification of dates.

Date of Receipt

Upon receipt of a prior authorization request, UM staff are responsible for verifying the receipt date/time and manually entering the date/time into a custom field in a secure electronic data system.

When the regulatory timeframe for processing a case is calculated and the request is received after business hours or on a weekend/holiday, the actual receipt date is recorded as the first business day after receipt to accurately reflect regulatory timeliness rules.

When a prior authorization denial decision is received from a clinician reviewer, written denial notices are issued to the member and the member's provider within regulatory timeframes. If the member's provider is notified of the denial decision verbally, the date and time, the authorized UM staff member who placed the call, and the person the UM staff member spoke to are documented. Verbal notification is followed by written notification within regulatory timeframes. The date/time of notifications are manually entered by authorized UM staff into a secure electronic data system, which is passphrase protected, requiring an authorized UM staff member's unique ID and passphrase in order to gain access. Hard copies of UM information are locked in filing cabinets with access limited to authorized UM staff.

Authorization to Modify Dates

Only authorized UM staff members are able to enter and modify dates/times in the secure electronic data system. UM staff authorized to access paper and/or electronic UM information is limited to the Chief Clinical Officer, Regional Medical Director, Clinical Services Supervisor, Clinical Services Coordinator, and Medical Directors involved in conducting or overseeing UM reviews via role-based authorization at the direction of the Chief Clinical Officer. All authorized users are trained on NCQA and CHP UM Policy and Procedures to protect the accuracy of information gathered and accessed. When modifications are made to a receipt and/or notification date/time, the secure electronic data system automatically creates an audit trail that documents the date/time the modification was made and the individual who made the modification. The reason a date is modified is documented within the applicable member's file. UM staff authorized to modify dates, which may occur due to a data entry error, will track/document the modification in the secure electronic data system and includes, at a minimum:

a. What modification was made.
b. When the date was modified.
c. Why the date was modified.
d. Staff who made the modification.
e. Scanned supporting images when appropriate.

At least annually, the organization demonstrates that it monitors compliance with its UM denial controls. This is done by identifying all modifications to receipt and decision notification dates and analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.

Securing System Data
All personal computers are automatically set to lock after 5 minutes of inactivity. Additionally, all staff are required to ensure their computers are locked when leaving their workstations. All staff use strong passphrases, do not write down or share their passphrases, and use unique logins for different accounts. Passphrases are changed on a regular basis. CHP servers are located behind secure access doors and are regularly backed up. The IT and HR departments are involved when a passphrase needs to be disabled in the event of an employee's departure or other reasons. Only authorized UM staff have access to UM information within the secure electronic data system. There are steps in limiting physical access to the operating environment that houses utilization management data, including, but not limited to, the organization's computer servers, hardware, and physical records and files. "Physical access" does not refer to the organization's building or office location.

UM Process Audit
All modifications are audited in real time by the Clinical Services Supervisor and/or the Chief Clinical Officer to ensure appropriateness and accuracy of the information recorded in the secure electronic data system. At least semi-annually, all denial files are audited by the delegating authority. The results of the Denial Audit are reported to the Clinical Services Supervisor and Chief Clinical Officer, who is responsible for the oversite of the audit process, UM staff, and the Clinical Services Department.

7.08 UM Denial System Controls Oversight

At least annually, the organization demonstrates that it monitors compliance with its UM denial controls:

1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.
2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.
3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.

CHP determines when modification is appropriate.

8.00 UM Appeals

The CHP Group (CHP) has an appeals process in place to handle provider appeals, on the member's behalf. This element applies to all medical necessity and benefit decision appeals. Where CHP is delegated to handle member appeals or deal with continued or rescission of coverage during an appeals process, regardless of whether the denial resulted from medical necessity review; this will

be performed in accordance with the more restrictive of applicable NCQA standards, contracted health plans and state law. Members of contracted health plans are provided written instructions at the time of a medical necessity denial advising them of their appeal rights and are referred directly to their health plan carrier, as outlined in Section 7.04. An appeal is defined as any request to reverse a decision.

8.01 Full and Fair Investigation Process

The CHP UM Appeal process is designed to handle provider appeals thoroughly, promptly and fairly. This includes a full investigation of the substance of the appeal, including any aspects of clinical care involved. Relevant documentation is collected, as outlined in Section 6.00. Reference to a denial is precluded by sanitizing all references to the initial denial decision and the initial reviewer(s).

Utilization Management decision-making is based only on appropriateness of care and service and the existence of coverage. No compensation is given to the Clinician Reviewers for conducting utilization review for denials of coverage or service as described completely in Section 12.00.

8.02 Member's Appeal Time Frame

As stated within the right to appeal brochure enclosed with CHP's denial or partial denial letter, a member's request for an appeal must be received by their health plan carrier within 180 days or the more restrictive of applicable NCQA standards (e.g., 60 calendar days for Medicare and Medicaid), contracted health plans, and state law, of the notification of an adverse decision. The member is advised if the appeal involves urgently needed future or continuing care services. A decision will be expedited to meet the clinical urgency of the situation as outlined in the health plan's member brochure accompanying the denial notice.

8.03 Opportunity for Member Input

The member is notified within the right to appeal brochure, enclosed with CHP's denial or partial denial letter, of the right to submit written comments, documents, records and other information relevant to the member's appeal directly to their health plan carrier.

8.04 Member or Representative Appeal

The member is notified within the right to appeal brochure enclosed with CHP's denial or partial denial letter, of the right, or the member's representative's right, to appeal any adverse decision directly impacting the member directly to the health plan carrier.

8.05 Provider Appeal

CHP providers, acting on behalf of the member, may appeal a UM decision for which the member is not held financially responsible. Upon receipt, CHP UM staff will follow the process outlined below.

8.06 CHP Process for Provider Appeals:

The UM staff will perform the following procedure below in handling provider appeals:

- Gather and track all relevant documentation to include the substance of the appeal/ original decision, any action taken, and documentation provided with the appeal.
- Determine if CHP is delegated to handle the appeal or forward to appropriate contracted health plan.
    - ***If not delegated***, the UM staff will forward the appeal to the appropriate contracted health plan within 1 business day of receipt of the appeal and notify the member and provider of such within this same timeframe.
    - ***If delegated***, the UM staff will send the provider (acting on behalf of a member) an acknowledgement of receipt within 5 business days of receipt, to include the applicable timeframe, as outlined in Section 8.07 for the final decision. The UM staff will follow the process below.
- Forward all relevant documentation to the appropriate clinician reviewer for a determination. The clinician reviewer will not have been involved in the initial decision and will not be a subordinate of the individual making the initial decision.
- Upon receipt of decision, notify the member and provider of the appeal decision as outlined below in Section 8.09.

The UM staff is responsible for document management, accurate tracking, and appropriate reporting of the following, which also applies to all UM decisions:

- Date received
- Type of Appeal or review
- Member name
- Provider name
- Date(s) of service
- Type(s) of service
- Date forwarded to Clinician Reviewer
- Date decision received from Reviewer, if no Reviewer signature the UM staff may initial or sign attributing the decision to the Reviewer.
- Decision documented
- Date provider and member notified
- Percentage rate calculations for timeliness adherence for UM decision making and notifications using at least 6 months of data

Recording dates in UM systems

Upon receipt of an appeal, UM staff are responsible for verifying the receipt date/time and manually entering the date/time into a custom field in a secure electronic data system. All appeal information is recorded in a secure electronic data system which is passphrase protected, requiring an authorized UM staff person's unique ID and passphrase in order to log on and gain access to UM information. Hard copies of UM information are locked in filing cabinets with access limited to authorized UM staff members.

Authorization to Modify Dates

Staff authorized to access paper or electronic UM information is limited to the Chief Clinical Officer, Regional Medical Director, Clinical Services Supervisor, Clinical Services Coordinator, and Medical Directors involved in conducting or overseeing UM reviews via role-based authorization at the direction of the Chief Clinical Officer. All authorized users are trained on NCQA and CHP UM Policy and Procedures to protect the accuracy of information gathered and accessed. When modifications are made to a receipt and/or notification date/time, the secure electronic data system automatically creates an audit trail that documents the date/time the modification was made and the individual who made the modification. The reason a date is modified is documented within the applicable member's file. UM staff authorized to modify dates, which may occur due to a data entry error, will track/document the modification in the secure electronic data system with and includes, at a minimum:

a. What modification to date was made.
b. When the date was modified.
c. Why the date was modified.
d. The staff who made the modification.
e. Scanned supporting images when appropriate.

Securing System Data

All personal computers are automatically set to lock after 5 minutes of inactivity. Additionally, all staff are required to ensure their computers are locked when leaving their workstations. All staff use strong passphrases, do not write down or share their passphrases, have user ID's and passphrases unique to each other, and use unique logins for different accounts. Passphrases are changed on a regular basis. Appropriate staff who oversee computer security which may include HR and/or IT Departments are alerted when a passphrase needs to be disabled or removed in the event of an employee's departure or for other reasons. CHP servers are located behind secure access doors and are regularly backed up. Only authorized UM staff have access to UM information within the secure electronic data system.

UM Process Audit

All appeal modifications are audited in real time by the Clinical Services Supervisor and/or the Chief Clinical Officer to ensure appropriateness and accuracy of the information recorded in the secure electronic data system. At least semi-annually, all denial files are audited by the delegating authority. The results of the Denial Audit are reported to the Clinical Services Supervisor and Chief Clinical Officer, who is responsible for the oversite of the audit process, UM staff, and the Clinical Services Department. CHP's policies and procedures must include a description of the monitoring process outlined above, regardless of system functionality.

8.07 CHP's Provider Appeal Timeframes

The following timeframes, depending on the type of appeal, apply upon receipt of a provider's appeal:

- ***Pre-Service Appeals***: Some contracted health plans require a pre-service authorization in the form of a Treatment Extension Requests (TERs). Upon receipt of a TER pre-service appeal, CHP will notify the provider in writing of such decision within 14 days of receipt. In the event an extension is necessary, a decision delay will be communicated, but not longer than

30 days. For other pre-service appeals, notification to the provider and resolution will be provided in accordance with the more restrictive of applicable NCQA standards, contracted health plans and applicable State law.

- ***Expedited Appeals***: The resolution to an expedited appeal will be made within 1 business day to meet the clinical urgency of the request but not to exceed 72 hours (including weekends and holidays), regardless of whether or not all necessary information is received. Any request for an expedited appeal for services already rendered will be denied and treated as a standard appeal. An oral initial notification may be provided within 72 hours with the requirement that written notification is issued not later than 3 calendar days after the initial oral notification.
- ***Post-Service Member Appeals***: Where CHP is delegated to perform appeals for services already provided to members, notification to the provider and resolution of post-service appeals will be provided in accordance with the more restrictive of applicable NCQA standards (e.g., Medicaid and Medicare within 30 days, others within 60 days), contracted health plans and applicable state law, e.g., within 14 days of receipt of the appeal per the more restrictive policy of Washington State law
- ***Member Appeals***: Where CHP is delegated for member appeals, CHP will follow the more restrictive of applicable NCQA standards, contracted health plans and applicable state laws in providing an external independent review.
- ***Member Appeal Allowable Extensions***:
    - CHP may extend the appeal time frames to obtain additional information when the member agrees to extend the appeal time frame, or where Federal program regulations allow CHP to request additional information from the member.
    - Allowable extensions for Medicare and Medicaid product line only:
        - For Medicare and Medicaid CHP may allow a 14-day extension if the member requests the extension or CHP demonstrates that more information is needed and the delay is in the member's interest.
        - For Medicaid, oral notification is appropriate for nonurgent preservice, post service and expedited appeals, but CHP will notify members of any delay and resolve appeals as expeditiously as the member's health requires.
    - Any extensions are documented in the appeal file and CHP may deny the appeal and notify the member if it does not receive the information within the time frames.
    - For Medicare appeals, CHP will notify the member that an upheld denial was sent to MAXIMUS.

8.08 Same or Similar Specialist Review

Medical Necessity-Same Reviewer: A licensed clinician of the same discipline as the provider providing the disputed service will review appeals related to medical necessity determinations. That clinician will not have had involvement in the initial decision and will not be a subordinate of the clinician making the initial decision.

Medical Necessity-Similar Specialist Reviewer: A similar provider who has experience treating the same problems as those in question of the appeal may review appeals related to medical necessity.

Non-Medical Necessity: Appeals of UM determinations not related to medical necessity will be reviewed by the Chief Clinical Officer or appropriate designee; that individual will not have had involvement in the initial decision.

8.09 Elements of Provider and Member Notification

Appeal policies and procedures specify that CHP informs the member, or the member's authorized representative, with written notification to both parties and will include:

- The date of the appeal decision.
- The decision and specific reasons in easy, understandable language.
- A reference to the benefit provision, guideline, protocol or other similar criterion, or an excerpt of the criterion on which the appeal decision was based specific to the member's condition or the requested service with the opportunity to obtain in writing.
- Notification the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal, free of charge. Information indicating specific criteria, or an excerpt of the criterion used in reaching the determination, in easily understandable language.
- Notification the member has the right to have a representative act on their behalf at all levels of appeal.
- A list of the titles, qualifications, and specialty of each individual participating in the review. Names of such individuals do not need to be included unless the provider or member requests this information.
- The written notification of the medical necessity denial will provide the following in reference to the right to appeal the denial decision:
    - A description of appeal rights, including the right to submit written comments, documents or other relevant information.
    - An explanation of the appeals process, including the description of the expedited appeals process, if an urgent pre-service or urgent concurrent request.
    - Notification the member has the right to have a representative act on their behalf at all levels of appeal.
    - Notification of how the member may receive, upon request, their notification in a culturally and linguistically appropriate manner.
    - A Right to Appeal brochure provided by the contracted health plan, as applicable, to include: an explanation of the appeals process, and in applicable cases pertaining to urgent services, a description of an expedited appeal process.
    - A description of the next level of appeal, either within the organization or to an independent review organization, as applicable, along with any relevant written procedures.
    - Where the next level of appeal is an independent external review, the notification includes a statement that members are not required to bear costs of the IRO, including any filing fees, unless state law mandates that members pay an IRO filing fee.

8.10 Expedited Appeals

A denial of an urgent care request is not common and would rarely be seen at CHP as explained in the UM Program Overview Section. However, CHP has a mechanism in place to expedite denials for treatment extension requests when a member believes an emergency condition exists due to the presence of severe pain or other symptoms, whether or not it is clinically considered an emergent or urgent situation.

The expedited claims appeal process is stated in Section 8.07 above and is available to member's by CHP when permitted by the contracted health plan, their representative or provider's acting on behalf of the member. An expedited appeal includes pre-service issues felt to possibly jeopardize the member's life, health, or ability to regain maximum function, based upon a prudent layperson's judgment. An expedited appeal, in the opinion of a provider 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.

9.00 Technology Assessment

9.01 Relevant Professional Expertise

The CHP Chief Clinical Officer is responsible for ensuring new medical technologies and new application of existing technologies are evaluated as necessary for inclusion in benefit plans. The purpose of this written evaluation is to remain current with new technology. This includes modalities, therapeutic procedures, and diagnostic devices and procedures. The Chief Clinical Officer, Regional Medical Director, and Associate Medical Directors are responsible for identifying new technology or new applications of existing technology that are appropriate for assessment. CHP will also respond to requests from network clinicians for technology assessment.

9.02 Review of Information

A written technology assessment will be based on:

- Thorough review of the relevant scientific and clinical literature.
- Review of information from appropriate government agencies.
- Information from relevant specialists and professionals who have expertise in the technology.

9.03 Decision Variables

Consideration for inclusion of a new technology will be based on:

- Evidence of efficacy.
- Assessment of risk.
- Evidence that the new technology produces better outcomes than existing technology.

9.04 Decision and Implementation

The written assessment of new technology will be presented to and reviewed by the Combined Medical Directors Committee, with final approval by the Clinical Management Committee. The final decision(s) may be either of the following:

- A policy determination to include a new technology as a covered benefit in the future, or
- A case-based decision whether or not to cover a specifically requested service.

If the new technology is deemed appropriate and effective for use by providers with covered members, the Chief Clinical Officer will contact their counterparts with contracted health plans and ask for their review and approval before CHP endorsement is made public to the providers.

10.00 Experience with UM Process

10.01 Member Experience with UM Program

CHP is not delegated to assess member satisfaction with the UM Program. Service denials do not generally impact members adversely in that there is generally no financial responsibility on the member's part. CHP elects to conduct annual member satisfaction surveys for the purpose of opportunities for improvement.

10.02 Provider Experience with UM Program

The CHP Group (CHP) conducts annual provider satisfaction surveys to inquire about satisfaction with the UM Program and various other aspects of CHP business performance to identify improvement opportunities.

10.03 Opportunities for Improvement

The Quality Management (QM) Program is structured to identify any opportunities for quality improvement in the UM Program with appropriate action if necessitated.

11.00 Appropriate Utilization

11.01 Monitoring Potential Under- and Over-Utilization of Services

The Chief Clinical Officer, Regional Medical Directors, and Associate Medical Directors regularly review utilization reports to identify unexplainable variation which may indicate potential under or over-utilization. At least annually, all chiropractic, naturopathic physicians and providers rendering acupuncture services receive information about their own utilization in relation to explicit utilization targets. High volume and outlier providers may receive such reports on a quarterly basis. Providers identified as having significant deviation from expected utilization which cannot be explained will result in a corrective intervention.

11.02 Established Thresholds

Performance indicators are well-defined, objective measurements of provider performance assessing important aspects of care and service. The process analyzes available demographic and health data in order to identify areas for study and determine priorities. Clinical indicators are based on clinically valid, current knowledge and experience and direct attention to potential problems or opportunities to improve care. Variation in clinical practice in the use of services is widely documented.

The distribution analysis of provider performance identifies statistical outliers, both above and below the mean. Statistical variation serves to identify practice patterns and individual providers of interest for further analysis. Investigation may reveal explainable variation such as certain uncontrollable factors, including case mix or condition severity, co morbidities and member response. Unexplainable variation may indicate problems with over or under utilization of healthcare services.

- Over-utilization is the provision of healthcare services, which cannot be demonstrated to be medically necessary. It may be revealed by unexplainable statistical variation, which appears in the third (3rd) standard deviation or more above the network mean.
- Under-utilization is failure to provide healthcare services that are medically necessary. Unexplained statistical variation which appears in the negative third (3rd) standard deviation or more below the network mean is underutilization.

Over-utilization is relatively easy to identify. The claims processing system can pick out high volume services, providers, and even high utilizing members, any of which might represent over utilization. It is much more difficult to identify services which should have been rendered but were not.

Under-utilization results from a number of causes. Systemic sources of failure to deliver or receive appropriate healthcare include problems of access whether due to geography, culture, language, member preference, or economics. Health plan characteristics such as benefit design, limitations on coverage, deductibles, co pay levels, referral protocols, to name a few may have a detrimental effect on the delivery of medically appropriate services. Provider-driven under-utilization stems from lack of awareness of clinical protocols, lack of protocols themselves, or inappropriate financial incentives impacting the clinician.
Member preference and expectations also can have an effect on both under- and over-utilization. Inadequate member education, lack of personal motivation, and unrealistic expectations for a healthcare provider encounter can drive underutilization of otherwise appropriate healthcare services.

11.03 Qualitative Analysis Data Not Within Thresholds

The data collected must be analyzed to determine the level of improvement and/or achievement of desired outcomes. Data is analyzed and compared to patient expectations; appropriate standards and guidelines consistent with current literature; clinical pathways and clinical experience; approved policies, procedures, and protocols; and regulatory requirements. Data analysis may include trending and comparison with standards of best practices and outcomes of other organizations.

The evaluation of data is documented in reports, minutes, or similar documents at the committee level. Documentation of analysis indicates the possible cause(s) for the data variance thereby providing the direction for the specific action to be taken.

11.04 Types of Relevant Utilization Data Monitored

The primary screen for medical necessity and appropriateness is embedded in the claims processing system. The system is "loaded" with the edits for allowable procedures determined by peer professionals to be appropriate in the evaluation and treatment of member's and for which services are allowable by health plan contract.

CHP performs pre-service, concurrent and post service reviews. There are some services, allowed under CHP benefits, which require clinical records to be submitted to substantiate complex codes or infrequently utilized codes. There are also a number of opportunities to evaluate medical necessity on an ad-hoc basis as files come up for review during quality management activities. These include reviews of clinical records for clinical record keeping quality improvement program, monthly clinical record audit reviews, pathway reviews, and quality studies. The procedural details related to medical necessity review activities are contained under Section 2.00, Clinical Criteria for Utilization Management.

11.05 Actions to Correct Patterns of Potential or Actual Inappropriate Utilization

The Utilization Management Program consists of two approaches:

- Evaluation of aggregate data, including provider profiles, to identify services that require focused review and/or providers whose practice patterns are inconsistent with local community standards for quality cost efficient care, and
- Identification of specific claims or cases for review using embedded edits, as described in Section 11.04 above, in the claims processing system. These reviews are primarily non-urgent post service, pre-service or concurrent reviews.

The purpose of data collection is to identify trends, patterns, or problems. Data is systematically collected concurrently or retrospectively using established criteria. If sampling is appropriate for high volume aspects of care or service, the sample size and selection are pre-established and statistically valid.

Data may be collected and displayed utilizing one or several quality improvement tools such as cause and effect diagrams, tables, graphs and charts, stratification, Pareto analysis, histograms, and scatter diagrams.

11.06 UM Intervention: Provider Care and Service Review

The effectiveness of UM intervention is measured by the length of time required for an outlier provider to demonstrate practice that is aligned with CHP benchmark performance. Non-compliance of outliers in a corrective action process may result in termination from the network as per the terms of the Professional Services Agreement.

This process was developed to monitor, evaluate, and continuously improve the quality and effectiveness of care and services provided by CHP providers and to detect and investigate potential under- and over- utilization of services and to apply appropriate intervention steps when utilization issues are identified.

Provider Reporting

Computer generated reports and/or dashboards allow for review of claims data for provider profiling information. The following reports and/or dashboards are generated and reviewed on a regular basis:

- ***Provider Distribution Analysis***: Reports 12-month trailing data that gives practice pattern information for each provider. Categories include average cost (per visit and an average per patient per year), patient visit average, number of visits, number of new patients, number of individual patients, and average services per visit. Each category is compared to the network mean. A report with the same information is produced for all contracts combined and for each individual contract and line of business.
- ***Line- Item Profile***: Reports patient specific information in terms of frequency and number of visits, and service types correlated with diagnoses for a 12-month period organized by provider for added detail in terms of practice pattern information.
- ***CPT Utilization Report***: Reports the frequency of CPT code utilization (i.e., CMT, radiographic, laboratory, etc.) for fair distribution of resources.
- ***Radiology Detail Report and Radiology CPT Report***: Reports specific utilization information related to x-rays.
- ***Provider Trend Analysis***: Reports are mailed to providers on a quarterly and/or annual basis that include trends of some of the measures reported on the Provider Distribution Analysis. These measures are reported as the providers' activity against the network norm. The reports give a provider the opportunity to evaluate and/or address any variation before it rises to a level necessitating some level of Medical Director intervention.

The above reports are designed to look at utilization from several different aspects. Significant variation from the norm results in inquiry to determine if it is explainable or unexplainable. Contributing factors may provide explainable variation to include:

- Practice specialization (e.g., sports injuries, complex cases, etc.),
- Low member volume causing skewing of the data,
- Provider being new to the network or to practice location causing increased number of new member services, and
- Geographic or demographic variation in member needs or expectations.

Provider Monitoring

The Provider Distribution Analysis (PDA) reports, reviewed on a quarterly basis, relate to those providers falling in the third (3rd) standard deviation above the mean for any measure. These measures are used as indicators for further exploration of possible over-utilization and/or quality issues and allow for the evaluation of trend, severity, and response to intervention. The provider trends above are analyzed for potential under-utilization and quality issues. Such evaluation may involve any and/or all of the following:

- Checking the database for information on member's seen, number of visits, over what time period, and whether those individuals have sought care anywhere else within our system.
- Compiling existing information from quality studies, patient satisfaction surveys, credentialing file, and quality file.

- Sending files for review (recommended sample includes three files with one visit, two with two to six visits, and one with many visits). The file review assesses the following elements:
    - Quality of treatment plans
    - Possible issues with:
        - Communication skills
        - Clinical competency
        - Personality issues
        - Performing a targeted member survey by telephone or mail using the same patient's whose files were reviewed if possible.

The number of members seen in the twelve-month period under review is an important indicator of statistical validity. Those providers who are new to the network or who are in a geographic area where the number of members with the benefit is low may well have their statistics skewed by low member volume. It is our experience that once the number of members seen in that time period is over 10, the measures become quite reliable.

UM Intervention Process

First Contact with Provider
The appropriate Medical Director contacts any provider who is monitored for either over-utilization or under-utilization if their statistics reflect over the 3rd standard deviation for three consecutive quarters or four of the last six quarters of the 12-month trailing period. The tone of this contact is informational and amounts to inquiry rather than accusation. Utilization management reports will have been reviewed before contact to further clarify any potential utilization or quality issues. Prior to the contact, the UM staff mails the provider a letter advising of a future call from the appropriate Medical Director, a copy of the most recent Provider Trend Analysis report to be discussed in the telephone meeting and a copy of CHP's UM Intervention: Provider Care and Service Review policy.

This contact offers an opportunity to explain the statistical measures and share information with the provider, inquire about possible explanation for the variation, and to offer assistance if appropriate. The provider is generally asked to review his/her practice policies and procedures in addition to an explanation for the practice variation. The goal is to provide the Medical Director with an explanation regarding the provider's marked practice variation from the rest of the network.

A subsequent memo is mailed to the provider documenting the discussion, which provides the provider an opportunity to correct or clarify the memo. A copy of the UM Intervention Policy 11.06 is attached with the memo to clearly outline CHP's expectations. A copy of the memo is placed in the provider's quality file and the intervention is tracked in the UM tracking file.

Second Contact with Provider
A second contact is made by the appropriate Medical Director if unexplainable variation persists after there has been sufficient time for any changes to be reflected in the UM data. This time period will vary with the measure in question and the member volume of the provider. The following feedback is provided by the appropriate Medical Director:

- A telephone call to provide positive feedback if the data indicates the desired trend.
- A telephone call or a face-to-face meeting may be scheduled regarding no change in the measures in question as well as further explanation of the issues involved. Information or help in solving problems is offered.

A subsequent memo is mailed to the provider documenting the discussion, which provides the provider an opportunity to correct or clarify the memo. A copy of the UM Intervention Policy 11.06 is attached with the memo to clearly outline CHP's expectations. A copy of the memo is placed in the provider's quality file and the intervention is tracked in the UM tracking file.

Third Contact with Provider
A third contact is made by the appropriate Medical Director if no substantial improvement is reflected in the UM data. The provider is contacted by telephone and instructed that he/she will be required to develop an action plan addressing the continuing unexplainable variation.

The provider is notified by letter which outlines the issues and the previous contacts attempting to resolve the issue. Specific time frames and targets are provided and the specific steps the provider intends to implement in order to deal with the unexplainable variation is requested. The provider is given two weeks to present an action plan to the Combined Medical Directors. Upon receipt of the action plan, the Combined Medical Directors will review the action plan and vote on a majority approval. The UM staff notifies the provider of approval within 5 business days of decision and continued monitoring by CHP.

Failure to respond to a request for an action plan or failure to complete an action plan will result in termination from the network.

Regression
A provider who had successfully completed the action plan process may become an outlier again. In such cases, the provider will receive a telephone contact from the appropriate Medical Director. Either of the following will occur:

- ***Telephone contact occurs***: A memo is mailed to the provider summarizing the conversation with the Medical Director which gives the provider an opportunity to correct or clarify the memo. A copy of the UM Intervention Policy 11.06 is attached with the memo to clearly outline CHP's expectations. A copy of the memo is placed in the provider's quality file and the intervention is tracked in the UM tracking file. The provider continues to be monitored on a regular basis.
- ***No telephone contact***: If there is no response from the provider, a second action plan is requested in writing and the process under Third Contact above is followed.

12.00 Affirmation Statements

As an employee of The CHP Group, Inc., I affirm that:

- Utilization Management decision-making is based only on the appropriateness of care and service and the existence of coverage,
- The CHP Group, Inc. does not specifically reward providers or other individuals for issuing denials of coverage or care, and
- No compensation or financial incentives are in place to encourage decisions which result in under-utilization.

Reviewing Professional Name (Print): _____

Reviewing Professional Signature: _____

Date: _____