Community Care Alliance of Illinois

UTILIZATION MANAGEMENT PROGRAM

2016
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I. INTRODUCTION

Community Care Alliance of Illinois (CCAI) is a Managed Care Community Network specializing in the care of adults and seniors with disabilities. Operating under the Biopsychosocial theoretical framework, our model of care encompasses the medical, functional, environmental, financial, social and behavioral health aspects of care surrounding the individual. CCAI is committed to ensuring that our Members receive the right care, at the right time in the right setting, while achieving the best health outcomes.

The purpose of the Utilization Management (UM) Program at Community Care Alliance of Illinois is to systematically monitor and evaluate services provided to our Members across the healthcare continuum, while identifying opportunities for quality improvement, developing data- and evidence-based initiatives that target over- and underutilization of healthcare services. This is a continuous process that involves internal UM staff, clinical practitioners, network providers, external business associates and contracted vendors all operating under the auspices of the CCAI senior-level Medical Director. The ultimate goal of the UM Program is to ensure the provision of medically necessary care that produces optimal quality outcomes, cost efficiency and coordination of care in compliance with accrediting bodies and all State and Federal regulations.

II. UM PROGRAM GOALS AND OBJECTIVES

CCAI’s UM Program has several important goals. These goals are applicable to both medical and behavioral health aspects of care across all lines of business:

a. To determine areas of over- and under-utilization and inefficient utilization of healthcare resources;
b. To determine whether services are withheld or delayed;
c. To determine appropriateness, availability and efficiency of healthcare services including home and community based services;
d. To ensure that utilization of healthcare services meet standards of good practice;
e. To enhance provider and Member satisfaction with the UM Program; and
f. To ensure that providers comply with CCAI UM policies and procedures.

To attain these goals, the following objectives have been established for the UM program:

a. Provide an effective structure and processes for assessing quality of healthcare services;
b. Identify barriers to care and implement initiatives to improve and promote equitable healthcare access;
c. Support coordination of care efforts at all levels of the healthcare delivery system;
d. Coordinate communication among practitioners that fosters quality improvement, reduces waste and improves healthcare outcomes;
e. Collect, analyze and report service utilization data to identify practice patterns, healthcare trends and healthcare outcomes along with quality improvement initiatives;
f. Facilitate the provision of appropriate healthcare services across the healthcare continuum; and
g. Provide UM oversight through the QI/UM Committee.

III. UM PROGRAM SCOPE

CCAI’s UM program’s scope includes all Members living in its service area and their authorized representative. Under the direction of the CCAI Medical Director, the UM program’s scope includes the integration of timely evaluation and authorization of medical and behavioral healthcare services across the continuum with a focus on transitions of care, quality improvement, cost efficiency and continual evaluation of program initiatives. Included within the scope of the UM Program are:

a. Inpatient Medical Services: Pre-service, concurrent and post-service review; discharge planning; transition of care; coordination with behavioral healthcare
   i. Acute care (medical, surgical, long term acute care, and rehabilitation admissions)
   ii. Post-acute care (sub-acute, custodial and home care services)
b. Outpatient Medical Services: Pre-service and post-service review
c. Inpatient Behavioral Health Services: Pre-service, concurrent and post-service review; discharge planning; transition of care; coordination with nonbehavioral healthcare
   i. Acute care
   ii. Post-acute care
d. Outpatient Behavioral Health Services: Pre-service and post-service review
e. Referrals to Care Coordination
f. Denials
g. Member and provider satisfaction with the UM Program
h. Medical necessity criteria

The UM program’s scope also incorporates elements defining:
i. Processes surrounding UM decision-making criteria that is objective and based on clinical practice guidelines, how the criteria and UM staff are made available to practitioners and Members, and the process for inter-rater reliability;

j. The types of licensed professionals supervising all medical necessity decisions, including overviews of job descriptions;

k. The roles of CCAI’s Medical Director, Board-certified consultants, physicians or other healthcare professionals in reviewing nonbehavioral and behavioral healthcare denials;

l. Identify opportunities for improvement in terms of under- and over-utilization of medical and behavioral healthcare services;

m. How CCAI ensures that UM decision-making is based solely on appropriateness of care and existence of coverage without financial or other reward or incentive for UM decision-makers for issuing denials;

n. Processes for timely UM decision-making for both nonbehavioral and behavioral service requests;

o. How relevant clinical information is gathered to support UM decision-making for both nonbehavioral and behavioral service requests;

p. Denial, appeal and external review practices for both nonbehavioral and behavioral services;

q. Evaluation policies for new technology;

r. Assessment of member and practitioner experience with the UM program;

s. Coverage of emergency services;

t. Triage and referral processes for behavioral healthcare; and

u. CCAI oversight for any delegated UM activities.

IV. UM PROGRAM STRUCTURE

Oversight of CCAI’s UM program begins with the QI/UM Committee which is chaired by CCAI’s Medical Director. The Medical Director, an executive staff member who works in collaboration with our Vice President of Healthcare, is responsible for setting UM policy, implementing the UM program, supervising UM operations, reviewing UM cases, chairing the QI/UM Committee and evaluating the overall effectiveness of the UM program. CCAI has partnered with a behavioral healthcare provider to oversee the behavioral health aspects of the UM Program. This delegated partner works in collaboration with the Medical Director to address behavioral healthcare aspects of the UM Program.

As the Chair of the QI/UM Committee, the Medical Director is responsible for the strategic leadership and direction of the UM program and for reporting all UM activities, plans and initiatives to the Quality Improvement committee. Final and ultimate responsibility for CCAI’s UM program lies with CCAI’s Board of Directors.
The QI/UM Committee is composed of the CCAI Medical Director, the CCAI Behavioral Health Medical Director (a physician contractor of CCAI), CCAI primary care providers, specialty care practitioners representative of the Member population, and internal CCAI staff. The QI/UM Committee performs the following functions:

a. Annual UM Program review and approval
b. UM policy and procedure approval quarterly as needed
c. Annual UM criteria approval
d. Annual data analysis on Member and provider satisfaction and experience with the UM process and recommendations for improvement
e. Quarterly review and analysis of UM statistics with recommendations for improvement quarterly, including admissions/1000 Member months, average length of stay, emergency room utilization, readmission rates, turnaround timeframes, denial and appeal rates and Inter-rater reliability
f. Data review and analysis related to over- and under-utilization with development of corrective action quarterly as indicated
g. Benefit determinations/Review of new technology quarterly as indicated
h. Quarterly delegated UM reporting and data analysis, including behavioral health UM data

Once approved by the QI/UM Committee, the UM Program is then sent to CCAI’s Board of Directors and the Plan President for final and ultimate approval. Once final approval has been obtained, the program is signed by the Vice President of Healthcare Management, the Medical Director and the Board of Directors’ designee.

CCAI’s Behavioral Health Medical Director, in collaboration with the Medical Director, provides oversight of the UM Program as it relates to behavioral health. CCAI delegates UM decision-making and care coordination services for behavioral health to its delegate Health Integrated, an NCQA accredited organization. While Health Integrated is charged with behavioral health UM decision-making, CCAI’s behavioral health program development and execution is led by CCAI’s Behavioral Health Medical Director. The Behavioral Health Medical Director is a board-certified psychiatrist who provides oversight of Health Integrated in behavioral healthcare delivery by:

a. Approving Health Integrated’s behavioral health program on an annual basis
b. Continually monitoring UM data as it relate to behavioral healthcare service delivery
c. Implementing and evaluating any needed performance improvement initiatives related to behavioral health service delivery
d. Participating in weekly UM rounds to discuss any behavioral health aspects relating to medically complex Members
The Medical Director is also responsible for monitoring any delegated UM activities. These functions are completed in close collaboration with the Vice President of Healthcare Management and CCAI’s designated behavioral healthcare practitioner. CCAI’s designated behavioral healthcare practitioner works jointly with the Medical Director on aspects of the UM program relating to behavioral health and substance abuse in several key ways:

a. Collaboration on policies and procedures specific to mental health and substance abuse;

b. Collaboration on any policies and procedures which jointly address or are relevant to both the medical and the behavioral health aspects of care;

c. Denial and appeal management relating to behavioral health service requests;

d. Implementation, oversight and evaluation of behavioral health aspects of the UM program;

e. Oversight of any delegated behavioral healthcare providers; and

f. Analysis of behavioral health utilization data.

V. Evidence-Based Criteria

Medical Criteria

As selected and approved by the Board of Directors, CCAI uses McKesson’s Interqual Criteria Set, an evidence-based criteria set used to support medical UM decision-making activities to ensure that care delivery is built on a scientifically valid and objective foundation and to improve both healthcare quality and efficiency. CCAI’s UM nurses apply criteria to all service requests in order to approve the request, including inpatient and outpatient service requests. The UM criteria are reviewed annually by the Medical Director and the Vice President of Healthcare Management and are presented annually to the QI/UM Committee for final approval as part of the annual UM Program evaluation.

Behavioral Health Criteria

CCAI’s behavioral health UM delegate, Health Integrated, has designed a proprietary system and process for evaluating and managing behavioral health services. Proprietary, clinical criteria sets designed by Health Integrated determine medical necessity and quality of care, as applied to each level of care available to each patient. While criteria sets are used as guidelines for making medical necessity determinations, each reviewer shall consider any unique or special circumstances of a member/patient before rendering a determination on the requested level of care.

Behavioral Health Clinical Criteria Sets are designed by a Health Integrated team headed by their Chief Medical Officer, a board-certified psychiatrist. The criteria are
developed for use with adult, senior, and children/adolescent populations. Following the initial design and development of the criteria sets, they are sent to an independent panel with representation across the United States consisting of four board-certified psychiatrists and two general medical physicians for their feedback, input and suggestions. The Health Integrated team and the independent panel use established, nationally recognized standards of diagnosing and treating behavioral conditions as the basis for developing the criteria sets. This includes the American Psychiatric Association guidelines, National Guideline Clearing House, DSM-5 and American Psychological Association as well as other evidenced-based resources. Once a consensus is reached by both Health Integrated and the independent panel, Health Integrated’s QI/UM Committee reviews and adopts the criteria for use and release to Health Integrated network providers and clients. Health Integrated’s QI/UM Committee consists of their CMO, six board-certified psychiatrists, as well as Health Integrated physician representation. The CMO chairs the committee meetings. To ensure adherence to current standards of diagnosis and treatment, Health Integrated reviews its clinical criteria sets, at minimum, on an annual basis.

VI. UTILIZATION MANAGEMENT PROGRAM ROLE IN QUALITY IMPROVEMENT

CCAI considers all UM initiatives as opportunities for quality improvement. UM is often the means by which CCAI’s Quality Improvement department becomes aware of potential quality issues in healthcare delivery, allowing for investigation and monitoring of trends in a manner that improves service delivery. UM data, including but not limited to, average length of stay, admissions per 1000, sentinel events identification and tracking, mortality reporting, emergency room utilization, pharmacy utilization and readmission rates are all indicators of healthcare quality and cost efficiency which facilitates UM data-driven quality improvement activities. Through its annual review and approval of the UM Program, the UM/QI Committee provides oversight of all UM activities and provides the foundation by which the UM program is actualized.

VII. UTILIZATION MANAGEMENT ACTIVITIES

Roles and Responsibilities

CCAI UM staff consists of registered nurses and licensed practical nurses who report to the Director of UM and Transition of Care in carrying out the day-to-day clinical activities of the UM Program, including service request review (prospective, concurrent and retrospective), application of clinical criteria, management of adverse determinations, discharge planning, referral initiation to behavioral healthcare practitioners and care coordination, identification of potential quality of care issues, and post-hospitalization follow up calls to Members. New hires into CCAI’s UM department receive a comprehensive orientation that provides for education on all aspects of the CCAI UM
program, policies and procedures, return demonstration of tasks and mentored oversight by an experienced UM staff member in the performance of work duties until completion of the orientation period.

All UM activities, including UM decision-making for service requests not meeting medical necessity criteria, are overseen by the Medical Director. CCAI UM nurses are required to hold an unrestricted nursing license in Illinois as a condition of employment with the organization. The Director of UM and Transition of Care, also a licensed registered nurse, reports to the Vice President of Healthcare Management. Non-clinical, non-nursing staff provides administrative support to the nurses and the department by performing intake and other non-clinical duties. Non-clinical staff functions solely in an administrative support role under the supervision of The Director of UM and Transition of Care and are not involved in UM decision-making.

Medical Director - The CCAI Medical Director is a physician licensed in the state of Illinois who is responsible for the development, implementation, administration and evaluation of the UM Program. This role works cooperatively with CCAI network providers, internal departments and senior-level executive staff in overseeing the development of UM standards to assure the delivery of quality health care service in a cost effective manner, and takes a leadership role in efforts to improve access to care, reduce excessive utilization, evaluate for under-utilization and chairs the QI/UM Committee. The Medical Director also reviews all healthcare requests that do not meet medical necessity criteria and is the only individual who may issue an adverse determination for a request.

Vice President of Healthcare Management – The Vice President of Healthcare Management is senior-level leader who works in collaboration with the Medical Director and other senior-level management in overseeing all UM Program activities. This role is an integral component in providing leadership and direction for the UM department in strategic planning as it relates to the UM program.

Independent Review Organization – The Independent Review Organization (IRO) provides a panel of board-certified physicians who are available to review requested healthcare services based upon specialty. Cases are referred to the IRO by the Medical Director for review for additional clinical support when needed and for second level appeal review.

Director of UM and Transition of Care - The Director of UM and Transition of Care is a registered nurse licensed to practice in the state of Illinois. The Director of UM and Transition of Care reports to the Vice President of Healthcare Management and is responsible for the leadership and daily operations of the UM and Transition of Care department, including the activities carried out under the UM Program. This position is
responsible for ensuring that the UM Program is compliant with State and federal regulations and accrediting bodies. Facilitating cost effective and quality transitions of care through the appropriate utilization of resources also falls under the purview of this position, which reports to the Vice President of Healthcare Management.

Transition of Care Coordinators (TOCCs) – As part of the interdisciplinary healthcare team, the Transition of Care Coordinator either licensed practical or registered nurse licensed in the State of Illinois who is responsible for coordinating all transition of care activities. Focusing on hospitalizations and Members in facilities for discharge planning and transitions to appropriate levels of care, TOCCs work in collaboration with the Member or the Member’s authorized representative, the primary care provider, hospital discharge planning staff, specialty care providers, ancillary care providers and internal CCAI departments such as Care Coordination, Member Services and Network Management to move Members safely and efficiently through the healthcare continuum in order to ensure that medically necessary care is provided at the most appropriate level to promote quality healthcare outcomes. TOCCs report to the Director of UM and Transition of Care Coordination.

UM Specialists – CCAI UM Specialists are licensed practical or registered nurses whose role is to provide UM review of outpatient healthcare services. These requests include, but are not limited to, durable medical equipment, physical and occupational therapy, imaging, ambulatory surgery, outpatient infusions and dialysis. UM nurses work closely with primary care and ancillary providers to ensure timely provision of outpatient healthcare services. UM Specialists report to the Director of UM and Transition of Care Coordination.

Referral Coordinators – Referral coordinators are nonclinical staff responsible for distributing service requests requiring clinical review to the nurses for timely management. They perform initial data entry of , and provide administrative support to clinical staff. Administrative support includes generating UM letters, performing initial event entry into CCAI’s care management system and triaging calls that come into the CCAI UM toll free phone number. Referral Coordinators report to the Director of UM and Transition of Care Coordination.

UM Operations

Use of Criteria

CCAI Referral Coordinators are nonclinical staff responsible for triaging healthcare service requests and distributing requests that require clinical review as they are received to the nurses for clinical review. If criteria is met, the request is approved by the clinical staff. In the event that the request does not meet medical necessity based upon the criteria, the request is forwarded to the Vice President of Healthcare
Management or Director of UM and Transition of Care as part of the second level review process. If the Vice President of Healthcare Management or Director of UM and Transition of Care agrees that the request does not meet criteria for approval, the case is forwarded to the Medical Director for review and final determination. Based upon his review, the Medical Director may request additional information on the request or issue a denial for lack of medical necessity. CCAI’s Medical Director is the only individual authorized to issue a medical necessity denial. Once the Medical Director issues a denial for lack of medical necessity, a written communication is sent to the requesting provider and member notifying them of the decision, appeal instructions, and that the UM criteria used to support the decision is available in writing via fax, email or mail for their review upon request. Requests for supporting criteria received from Members and providers are noted in CCAI’s care management system for reporting purposes. The criteria application of Interqual and notification of the outcome follow turnaround standards defined by CCAI UM policies and procedures. The policies and procedures are compliant with requirements of the State of Illinois Department of Health and Family Services, Centers for Medicare and Medicaid Services and accrediting organizations. The UM review and decision-making process is documented by the UM nurses, the Vice President of Healthcare Management, the Director of UM and Transition of Care, the Medical Director and CCAI’s Appeal Unit in CCAI’s care management system from beginning to end, including, but not limited to, requested services, dates received, decision dates, notification dates, responsible parties, final determinations and any reconsideration or appeal process if requested by the Member or provider.

All clinical criteria specific to the request in question are available to Members and practitioners via fax or email upon their request. When requests are received, they are forwarded to the Director of UM and Transition of Care along with all information related to the request. In collaboration with the Medical Director, the Director of UM and Transition of Care or designee will forward the specific criteria used to make the UM determination within 2 (two) business days of receipt of the request, and also enters the request and all relevant information into CCAI’s care management system.

Admission and Concurrent Review

Inpatient Review

TOCCs conduct second level review for inpatient level of care appropriateness, continued stay appropriateness as part of the concurrent review process, and retrospective review as part of the post-service review process. Evidence-based clinical criteria are used to determine medical appropriateness. Those cases not meeting criteria are referred by the TOCC for review by the Vice President of Healthcare Services or the Director of UM and Transition of Care as part of the second level review.
process. If the services cannot be approved on secondary review, the case is sent to the CCAI Medical Director for final determination.

Discharge Planning

Discharge planning is the process by which TOCCs work with the interdisciplinary team that includes the Member, the Member's family, the primary care practitioner, facility staff, CCAI Care Coordinators and ancillary providers to plan for lower levels of care across the healthcare continuum. The discharge planning process begins at the time of pre-admission certification and/or at admission to the facility and continues throughout the confinement. CCAI’s UM Department works to initiate timely discharge planning activities to facilitate safe and timely transitions to lower levels of care and promote quality outcomes. CCAI UM staff take the following considerations in account during the discharge planning process:

a. The Member's age
b. The Member's medical condition
c. The Member's home setting and support systems
d. Awareness and ability of the Member and/or family to participate in the discharge plan
e. Community resources
f. Plan benefits

The discharge planning process begins with an assessment of the Member’s clinical status, treatment plan, home setting and caregiver situation. CCAI staff works with the facility discharge planner/case manager to facilitate timely implementation of the discharge plan. Medically necessary services are coordinated and on-going communication occurs with the Member and the interdisciplinary care team to monitor goals and to determine possible need for revision or modification in the discharge plan.

Referral to Care Coordination

Referrals to Care Coordination are made to facilitate a Member’s transition to the community or to custodial care setting from higher levels of care. As UM staff assess and manage Members’ healthcare service requests, referrals are made to Care Coordination within CCAI’s care management system. Examples of circumstances which may lead to a Care Coordination referral include, but are not limited to:

- Members in a facility with complex discharge planning issues and barriers
- Members transitioning to hospice or custodial care in a facility
- Members requiring solid organ or stem cell transplants
- Members with high utilization, including frequent emergency room visits and hospital admissions
- Members with certain medical conditions such as hemophilia, malignancies, immunological insufficiencies or hematological diagnosis
- Members with high risk pregnancy
- Members with catastrophic trauma or burns
- Members with chronic conditions and inadequate support systems

UM staff works closely with Care Coordination to provide a holistic approach that promotes quality outcomes based on the Member’s needs.

Transition of Care and Continuity of Care

CCAI works to identify and coordinate care for Members who need transition secondary to insolvency or unexpected closure of a provider site or primary care provider site for any reason. When these transitions occur, interventions are implemented to facilitate a medically safe and effective transition that addresses the Member’s medical and behavioral healthcare needs.

Inter-Rater Reliability

CCAI has licensed McKesson’s inter-rater reliability (IRR) tool to ensure consistency in criteria application across its nursing staff and its Medical Director. IRR for all nursing staff and the Medical Director is assessed at minimum on a quarterly basis according to policy and procedure (HCM011). Any potential opportunities for improvement are evaluated and acted upon, including, but not limited to, department-wide training and refresher education and individual coaching. Results of IRR assessments, initiatives to improve consistency of criteria application and evaluation of those initiatives are reported to the QI/UM Committee as part of the UM program’s annual evaluation.

Processes Used To Make UM Decisions

Nonbehavioral healthcare service requests come in to the UM department through varied means, including but not limited to, faxes from provider offices and hospitals and phone calls into CCAI Member Services or directly to the UM department. As the requests are received into the UM department, UM Referral Coordinators enter the requests into CCAI's care management system, perform first level review, approve any requests not requiring clinical review, and forwards requests requiring clinical review and all supporting clinical documentation to the clinical nursing staff for review. As part of the second level review, nursing staff review the clinical information attached to the request and apply criteria. Requests not meeting criteria are forwarded for review by the Director of UM and Transition of Care or the Vice President of Healthcare Management as part of the secondary review process. If the case is unable to be approved upon completion of a secondary review, it is referred to the Medical Director for final determination. Once a final determination is reached, a notification letter that specifies
the types of services requested and the final determination is sent to the provider and to the Member per contract requirements, and the case is closed in the UM system. In the event of an adverse determination, the notification letter also includes the rationale for the adverse determination and instructions for filing an appeal. Established turnaround timeframes are observed per approved policies and procedures throughout the review process.

Benefit Coverage, Benefit Limitations and Medical Necessity Determinations

CCAI maintains lists of covered services for both the Medicare and the Medicaid lines of business for inpatient and outpatient services based upon CCAI’s contract with the State of Illinois and CMS. The lists include information on covered services, any limitations on covered services, and those services requiring prior authorization by UM. The lists are available electronically on the company-shared CCAI computer drive and on the CCAI website, as well as in the Member handbook. In addition, hardcopies are available at designated locations throughout CCAI offices and also are provided and reviewed with UM staff during orientation. UM staff are educated to refer to the Member handbook and covered services lists as resources for any questions regarding benefit coverage. Other resources UM staff use as resources for benefit coverage include, but are not limited to, CCAI’s contract with the State of Illinois and CMS guidelines.

UM decision-making at CCAI is based solely on appropriateness of care and service and existence of coverage. CCAI does not reward UM staff, practitioners, or other individuals for issuing denials of coverage. Any financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Medical necessity determinations are made by UM staff based upon application of standardized criteria under the direction of the Medical Director. In the event a request does not meet medical necessity criteria, or in the event a provider or practitioner fails to provide clinical information needed to issue a medical necessity decision, the case is referred to the Medical Director for final determination. CCAI considers a provider’s or practitioner’s failure to provide needed clinical information as a medical necessity decision requiring a final determination by CCAI’s Medical Director. Only the CCAI Medical Director can issue medical necessity denials. All steps along the medical necessity review process are conducted and documented in compliance with turnaround timeframes according to CCAI’s UM policies and procedures.

Requests for services beyond the covered services or beyond any limitations in covered services require review by the Medical Director in collaboration with the Vice President of Healthcare Management Services for final determination of coverage.

Description of Data and Information Used to Make Determination
CCAUM uses several key sources of data to make UM determinations. The primary data source is the relevant clinical information to the request submitted from the practitioner making the request. Based upon the type of services requested, the clinical includes many data elements which assist in the UM decision-making process, including, but not limited to:

a. Identifying Member information  
b. Medical, surgical and psychosocial history  
c. Medical or behavioral health co-morbidities  
d. Complications  
e. Current and past medications with response  
f. Diagnosis description or codes  
g. Requested procedure description or codes  
h. Current clinical status  
i. Specific services requested  
j. Requested location of service or level of care  
k. Proposed treatment plan  
l. Anticipated goals of the treatment plan  
m. Estimated length of need  
n. Evaluation of the treatment plan and proposed modifications based on the Member’s response  
o. Anticipated needs upon hospital discharge  
p. Characteristics of the local delivery system available to the Member, such as coverage benefits and availability of skilled nursing facilities, sub-acute facilities, long term care facilities, home care agencies and durable medical equipment providers

Additional data elements used in UM decision-making include, but are not limited to, current clinical standards of care, scope of covered benefits, internal care plan documentation, previous hospital and outpatient services reviewed, claims data, pharmacy data and Member interaction logs. These data elements in total, along with standardized criteria, serve as the foundation for CCAI’s UM process and UM decision-making.

Review Standards and Turnaround Timeframes

UM determinations are issued within the required timeframes based on line of business (Medicaid versus Medicare):

Medicaid

- Routine, nonexpedited requests – ten (10) calendar days
- Expedited requests, pre-service – seventy-two (72) hours
- Expedited requests, concurrent – twenty-four (24) hours
- Post-service requests – thirty (30) calendar days

**Medicare**

- Routine, nonexpedited requests – fourteen (14) calendar days
- Expedited requests, pre-service – seventy-two (72) hours
- Expedited requests, concurrent – twenty-four (24) hours
- Post-service requests – thirty (30) calendar days

Concurrent requests for both Medicaid and Medicare Members hospitalized in an acute care setting are treated as expedited requests.

Requests for healthcare services can be received from practitioners, hospitals and ancillary providers. Providers are educated on how to request healthcare services via the CCAI website, in the CCAI Provider Manual, at onsite meetings by CCAI Network and UM representatives, and during 1 on 1 meetings and discussions. Relevant clinical information supporting the need for the requested services must be submitted with the request.

Based upon clinical circumstances, requests are considered expedited, standard or retrospective based upon urgency of need. Expedited requests must be requested by the requesting party; however, the decision to consider a request as expedited is determined by CCAI clinical staff.

Authorization of healthcare services may be requested on a pre-service, concurrent or post-service basis. Prospective review consists of evaluating requests for services before they have been rendered and can include both inpatient and outpatient services. Concurrent review involves requests made while a Member is receiving an ongoing course of treatment. Retrospective requests are made when the Member has already received the services for which the request is being made.

As part of new hire orientation, UM staff are educated regarding UM determination timeframes and reports are generated on a monthly basis to monitor timeliness and identify possible inefficiencies and opportunities for workflow improvement.

**Emergency Services**

Per CCAI policy (HCM 005 Emergency Department Services), emergency services do not require prior approval and it is CCAI’s policy that automatic payment will be issued for specific services rendered based on a defined list of diagnosis codes and descriptions. All other emergency services are subject to review. CCAI bases its Emergency Department Services policy on the following definition of a healthcare
emergency: any medical or behavioral condition of recent onset and severity, including but not limited to severe pain, that would lead a Member, acting reasonably, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in placing the Member’s life or health in serious jeopardy, cause serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or in the case of a behavioral condition, placing the life or health of the Member or others in serious jeopardy. This definition of emergency medical or behavioral health condition focuses on the Member’s presenting symptoms rather than the final diagnosis when determining whether to pay emergency services claims. Claims for emergency services with diagnosis codes not on the auto-approval list or falling outside of the emergency services definition are subject to the same rigor of review as other service requests and are reviewed by clinical staff and can only be denied by the Medical Director if so warranted.

Adverse Determinations

An adverse determination is issued by CCAI’s Medical Director when actual or proposed services do not meet medical necessity criteria or when insufficient information is available to apply clinical criteria. Only CCAI’s Medical Director may issue a medical necessity denial. Clinical criteria are applied in accordance with individual Member needs and assessment of the local delivery system.

Healthcare service requests not meeting medical necessity criteria are referred by clinical UM staff to the Director or UM and Transition of Care or the Vice President of Healthcare Management for review and recommendation as part of the secondary review process. If he or she believes that there is sufficient clinical justification to approve the request, the request is approved and sent back to the clinical staff for notification of the approval to the provider. If the Director or UM and Transition of Care or the Vice President of Healthcare Management is unable to recommend approval, the request is forwarded to the plan Medical Director for review and final determination. The Director of UM and Transition of Care or the Vice President of Healthcare Management documents their review, findings and actions in the UM computer system.

Cases in which a practitioner is offered an alternative service to that which was originally requested and they agree are not considered denials. These cases and the circumstances surrounding them are documented in CCAI’s care management system and the approval letter includes documentation of the services originally requested, the alternative service offered and the acceptance of the alternative service from the provider.

If the Medical Director’s determination is to approve the request, he or she sends the case back to the clinical UM staff notification of the approval to the provider. If the
Medical Director issues a denial or adverse determination on the request, the provider is given telephonic notification within twenty-four (24) hours after the adverse determination is reached. Written notification of the adverse determination is provided to the Member and provider within one (1) business day of the adverse determination. The Medical Director is available to the requesting provider to discuss adverse determinations during reasonable and normal business hours unless otherwise mutually agreed upon. Notifications of adverse determinations include reference to the criteria subset and rationale for the adverse determination.

Clinical criteria specific to the request in question are available to Members and practitioners via fax or email upon their request. When requests are received, they are forwarded to the Directory of UM and Transition of Care along with all information related to the request. In collaboration with the Medical Director, the Director of UM and Transition of Care or designee will forward the specific criteria used to make the UM determination within 2 (two) business days of receipt of the request, and also enters the request and all relevant information into CCAI’s care management system.

Appeals for Medical Necessity Adverse Determinations

Members and their authorized representative have the right to request an appeal for any medical necessity adverse determination. CCAI’s Appeals Unit manages all requests for medical necessity appeals and external review according to CCAI policies and procedures that describe how Members and their authorized representatives may request an appeal of an adverse determination. These policies and procedures are applicable to both inpatient and outpatient healthcare service requests. They are also specific to each line of business and are compliant with CCAI’s contract with the State of Illinois and applicable Federal and Illinois laws and requirements of accrediting bodies relating to process and turnaround timeframes. The Appeals Unit manages the appeal from intake to completion, including sending acknowledgement letters and requests for additional information that includes the provision and process for having an authorized representative and submission of additional information, review of any additional medical documentation submitted, preparing the appeal for review by a different physician from the one who made the initial adverse determination, obtaining the outcome, providing verbal and written notification to the Member or authorized representative, and documentation of the progress of the appeal in CCAI’s care management system. Explanation of the appeal process and instructions for filing an appeal are included in all notifications of adverse determination communications, including the address the written request and materials must be submitted to.

Appeal turnaround timeframes are based upon line of business:
<table>
<thead>
<tr>
<th>Level</th>
<th>CCAI (Medicaid-ICP)</th>
<th>CCAI-NFP (Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>“Appeal”</td>
<td>“Reconsideration”</td>
</tr>
<tr>
<td></td>
<td>Filing – within 60 days</td>
<td>Filing – within 60 days of Organization Determination</td>
</tr>
<tr>
<td></td>
<td>Standard – 15 business days</td>
<td>Standard – 30 days</td>
</tr>
<tr>
<td></td>
<td>Expedited – 48 hours</td>
<td>Expedited – 72 hours</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>“External Review” (service only)</td>
<td>“Independent Review Entity”</td>
</tr>
<tr>
<td></td>
<td>Filing – within 30 days (option for either Ext. Review or State Fair Hearing or both)</td>
<td>Filing – Automatic on denial of Level 1.</td>
</tr>
<tr>
<td></td>
<td>Standard – 15 business days</td>
<td>Standard – 30 days</td>
</tr>
<tr>
<td></td>
<td>Expedited – 2 business days</td>
<td>Expedited – 72 hrs.</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td>“State Fair Hearing” (can also be level 2)</td>
<td>“Administrative Law Judge”</td>
</tr>
<tr>
<td></td>
<td>Filing – within 30 days</td>
<td>Filing – within 60 days</td>
</tr>
<tr>
<td></td>
<td>Decision – set by State</td>
<td>Decision – set by court</td>
</tr>
<tr>
<td><strong>Level 4</strong></td>
<td>Hearing Officer decision final</td>
<td>“Medicare Appeals Council”</td>
</tr>
<tr>
<td></td>
<td>(Circuit Court appeal only)</td>
<td>Filing – within 60 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decision – set by court</td>
</tr>
<tr>
<td><strong>Level 5</strong></td>
<td></td>
<td>“Federal District Court”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filing – within 60 days</td>
</tr>
</tbody>
</table>

In managing the appeal, the Appeals Coordinator conducts a full investigation of the request and documents the nature of the appeal and any actions taken in the care management system as well as determines which practitioner made the initial denial. The Member or their authorized representative is provided the opportunity to submit written comments, documents or other relevant information. The Appeals Coordinator refers the appeal to a board-certified practitioner of the same or similar specialty related to the request and who is different from the practitioner who made the initial denial determination. CCAI uses an external independent review organization to provide a pool of board-certified physicians for first level appeals review. Appeal determination notification letters are provided in a culturally and linguistically appropriate manner to the Member or their authorized representative and include:

a. Instruction for filing further appeal in the event the original adverse determination is upheld;
b. The specific benefit provision, guideline protocol or other similar criteria on which the appeal decision is based; and
c. The list of titles and qualifications, including specialties, of the appeal reviewer and those participating in the appeal review.

Upon their request, Members or their authorized representative are allowed reasonable access to copies of all documents relevant to the appeal at no financial charge to them.
Members are also allowed to continue to receive coverage while the outcome of the appeal is pending.

Availability of UM Staff

CCAI’s UM staff and Medical Director are available eight (8) hours a day during normal business hours for inbound calls regarding UM issues via a toll free phone number. Normal business hours are 8:30am to 5:00pm CST Monday through Friday. UM-related calls are routed to the UM Department by Member Services. The toll free number can be found on the Member’s identification card, on the CCAI website, and in the Member and provider handbooks. Outside of normal business hours (5:00pm to 8:30am CST, and on weekends and holidays), CCAI’s UM toll free number is answered by a business partner delegated to perform specific UM functions for CCAI, including afterhours management and triage of inbound phone calls. In addition, CCAI’s delegated UM partner manages incoming electronic faxes afterhours as well. Callers with urgent UM issues are assisted at the time of the call; requests of a less urgent nature are forwarded for follow up by CCAI UM staff during normal business hours. Calls are responded to immediately during working hours but no later than one (1) business day after receipt of a message.

In initiating or returning calls regarding UM issues, CCAI UM staff are trained to identify themselves by name, title and organization name. TDD/TTY services and language assistance is utilized to discuss UM issues when needed.

VIII. BEHAVIORAL HEALTHCARE SERVICES

CCAI has an open access Behavioral Health Program. Members may self-refer to a mental health or substance abuse provider by calling the CCAI Member Services Department for assistance or the behavioral health toll free number on the back of their card. The initial consult with a behavioral health or substance abuse practitioner does not require referral from the Member’s primary care practitioner or authorization from CCAI. In the case of an emergency, members are encouraged to call 911 or consult with their current behavioral health provider. This information is available in the Member handbook and the phone numbers are located on the back of the Member’s CCAI identification card. CCAI’s behavioral health program development and execution is led by the CCAI Behavioral Health Medical Director. CCAI delegates BH Um functions to Health Integrated, a NCQA certified behavioral health entity. CCAI also contracts with PsycHealth, Ltd. for its behavioral health provider network. PsycHealth, Ltd. is a healthcare organization that manages a behavioral healthcare provider network that offers a full range of behavioral health and substance abuse services by licensed behavioral healthcare psychologists, physicians and therapists.

Evaluation
Evaluation of behavioral healthcare services UM falls under the purview of the QI/UM Committee’s responsibility. Data from behavioral health UM statistics, Member and practitioner satisfaction surveys, data related to over- and under-utilization of behavioral healthcare services, turnaround timeframes are all used to evaluate the UM process as it relates to behavioral healthcare.

IX. EVALUATION OF NEW TECHNOLOGY

‘New technology’ refers to new technological developments in the healthcare industry related to medical treatment, behavioral health treatment, pharmaceutical treatment or medical devices and the application of existing technology in new medical and behavioral health treatment modalities. CCAI evaluates requests for new technology and new applications of existing technology to help ensure that Members have equitable access to technological advances in medicine and behavioral health. This process includes evaluation for inclusion of new technology and the new application of existing technology in a Member’s benefit plan.

Requests from practitioners for approval of inclusion of new technology or the new application of existing technology are reviewed on an individual basis and as appropriate with the Member’s benefit plan and contract requirements.

The initial request is reviewed by CCAI’s Medical Director in collaboration with the Vice President of Healthcare Management.

The Medical Director reviews information surrounding the request and obtains information from appropriate government regulatory bodies, peer-reviewed literature, published scientific evidence, professional societies and input from experts in the relevant field of specialty. If the requesting practitioner provided information on the technology, that information is also included in the evaluation of the information.

The Medical Director in collaboration with the Vice President of Healthcare Management renders a recommendation on the request based on the review findings.

Behavioral healthcare professionals provide input and feedback in the decision-making process for new technology related to behavioral healthcare services.

Requests are forwarded to QI/UM Committee members on ad hoc basis and to the QI/UM Committee at large during Committee meetings for additional review, feedback and final recommendations for new inclusions and new changes in technology application. Decisions on the request are made by the physicians on the QI/UM Committee.
The requesting practitioner is notified of the approval or denial of the request, along with the clinical criteria and scientific evidence used to render the decision. The notification also includes instructions on Member appeal rights as needed.

QI/UM Committee recommendations are reported the Board of Directors for final approval.

Once final approval is obtained, policies, procedures and workflows are developed for adoption into daily UM practice.

Determinations are made in a timeframe consistent with the Member’s clinical condition as warranted.

Requests for the evaluation of new technology are recorded by the Director of UM and Transition of Care or designee in a log that supports the tracking of practice trends.

X. OVER- AND UNDER-UTILIZATION

Over-utilization is the utilization of services that is repetitive or deemed medically unnecessary or that are performed in a higher setting than is medically appropriate. Under-utilization is the lack of utilization of services that are deemed medically necessary or services that are performed in a lower setting than is considered medically appropriate. In order to ensure appropriate quality and medically necessary Member care in the most appropriate setting and that all CCAI Members receive the covered benefits that they are entitled to, CCAI utilizes available sources to detect potential over- and under-utilization. The CCAI QI/UM Committee reviews data related to over- and under-utilization and develops corrective action plans as necessary. CCAI monitors utilization of services for over- and under-utilization on a quarterly basis as needed, evaluating such data sources as encounters, QI study results, Member service calls and complaints, inpatient utilization data analysis, emergency department utilization, reports of Members not receiving services, Member satisfaction surveys, review of committee meeting minutes of delegated UM entities for behavioral health, and referral tracking.

XI. PRIVACY

All CCAI employees, business partners and delegated entities regard Member information as confidential and available only to authorized users who have a need to know the information in order to carry out CCAI business. Discussions which include Member-specific information are conducted discreetly and involve only appropriate staff members and providers directly involved in the Member’s care. Routine staff training regarding protected health information (PHI) is provided to CCAI staff, including information on password protection, appropriate use of PHI, appropriate disposal of PHI and computer safeguards against breaches in Member confidentiality. Breeches in
confidentiality may result in disciplinary action. Confidentiality policies and procedures are communicated to Members, practitioners, providers and others as needed.

XII. MEMBER AND PRACTITIONER COMMUNICATION

Members

CCAI communicates with and outreaches to our Members in a variety of ways to ensure that they are receiving appropriate services in a timely manner. The CCAI UM Department hours of operation are Monday through Friday 8:00am to 5:00pm and staff are available during these hours for Members and their families calling to discuss certification decisions, clinical criteria or any other UM-related issue or concern. CCAI also has a health information line that Members can call 24/7 for to speak with a nurse for advice on how to use healthcare resources like the emergency department appropriately. Both of these are available by a toll-free phone number. Language and interpretation assistance is available when needed, as well as access to TDD/TTY services for Members with hearing or speech impairment. Members are educated about these avenues via CCAI’s Member handbook, during 1 on 1 discussion and via the Member mailings. In addition, CCAI maintains a website that includes information about the UM Program and accessing services.

Practitioners and Providers

CCAI also communicates with providers and practitioners in several ways, including the provider handbook, provider newsletters and via the CCAI website. CCAI UM staff and the Medical Director are available to discuss UM issues and clinical criteria Monday through Friday 8:00am to 5:00pm. CCAI also contracts with a partner who provides afterhours availability for reporting hospital admissions and has an efax process by which practitioners can submit requests for healthcare services. Finally, CCAI conducts 1 on 1 meetings with practitioners and providers where UM practices and procedures are reviewed.

XIII. MEMBER AND PRACTITIONER SATISFACTION WITH THE UM PROGRAM

Members

Member satisfaction with the UM program is assessed through evaluation of Member survey results and Member complaint data. Member satisfaction surveys are conducted annually and the results are used for continuous quality improvement of key service indicators as well as overall levels of satisfaction with the UM Program. Surveys are conducted annually and are designed to assess Member satisfaction with CCAI UM staff interactions, policies and services. Survey results are summarized and presented
to the QI/UM Committee for review to identify opportunities for improvement and corrective action planning as necessary.

Providers

Provider satisfaction surveys are distributed to participating practitioners and are conducted annually to assess their satisfaction and perception of CCAI UM Program, policies, staff interaction and services. These survey results are also summarized and presented to the QI/UM Committee for review to identify opportunities for improvement and corrective action planning as necessary.

XIV. DELEGATION OF UM

The Director of UM and Transition of Care in collaboration with the Medical Director are charged with completing pre-delegation audits and monitoring all UM activities delegated to any business partner to ensure compliance with requirements of regulatory agencies and accrediting bodies except for pharmacy UM which is overseen by CCAI’s Pharmacy Department. CCAI’s Behavioral Health Medical Director collaborates in oversight of any delegated behavioral health UM functions. The contractual agreement between CCAI and the business partner is mutually agreed upon and specifies the responsibilities of both parties, including the delegated activities, reporting frequency, performance evaluation process and potential de-delegation of responsibilities. Prior to any delegation of UM activities, the Director of UM and Transition of Care evaluates the capability of the organization to perform the delegated activities according to CCAI expectations. Delegated entities are monitored according to specified reporting timeframes whereby regular reports are received and reviewed; annual comprehensive evaluation performance audits are also conducted. If, during the course of oversight activities, opportunities for improvement are identified, the Director of UM and Transition of Care works with the business partner to develop a customized corrective action plan (CAP) to address the specific area to be resolved. Compliance with the CAP is monitored by the Director of UM and Transition of Care in collaboration with the Medical Director and the Behavioral Health Medical Director as appropriate. Activity related to UM delegation oversight and monitoring, including any CAP, is reported at the QI/UM Committee meetings for recommendations for performance improvement opportunities.

CCAI’s current delegated entities:

<table>
<thead>
<tr>
<th>Delegate</th>
<th>Delegated Preservice Function</th>
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<tbody>
<tr>
<td>Health Integrated</td>
<td>1) Outpatient services: PT/OT overflow, Testing/Imaging,</td>
</tr>
<tr>
<td>*An NCQA-Accredited Entity</td>
<td>2) Behavioral health admissions</td>
</tr>
<tr>
<td></td>
<td>3) Outpatient behavioral health services</td>
</tr>
<tr>
<td></td>
<td>4) Behavioral health care coordination</td>
</tr>
<tr>
<td>Company</td>
<td>UM Activities</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CVS/Caremark</td>
<td>1) Delegation of all pharmacy-related UM activities</td>
</tr>
<tr>
<td></td>
<td>2) Pharmacy &amp; Therapeutics Committee functions</td>
</tr>
<tr>
<td></td>
<td>3) Pharmacy prior authorization process</td>
</tr>
<tr>
<td></td>
<td>4) Formulary management</td>
</tr>
<tr>
<td>EyeQuest</td>
<td>Delegation of UM functions in administering mandated vision care benefits</td>
</tr>
<tr>
<td>DentaQuest</td>
<td>Delegation of UM functions in administering mandated dental care benefits.</td>
</tr>
</tbody>
</table>