UTILIZATION REVIEW PROCESS

DEFINITIONS

The following definitions are incorporated into the UM Program:

Adverse Determination is a determination that a requested admission, extension of stay or other health care service, based on the information provided, is not medically necessary or is experimental and/or investigational.

Concurrent Review is the monitoring of Medical Necessity of an episode of care during a course of treatment. These reviews are conducted by telephone or facsimile follow-up to ensure that discharge and treatment milestones are reached. Concurrent review is performed for inpatient as well as outpatient care.

Concurrent/Extension of Care is the determination of Medical Necessity, or appropriateness of care involving continued or extended health care services, or certification of additional services for an individual undergoing a course of continued treatment when no additional visits are available at the time of the requests.

Discharge Planning is the process of identifying patients who require continuing care after release from the hospital and ensuring that patients receive necessary care.

Emergency Condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the life or health of the person afflicted with such condition in serious jeopardy; or, in the case of a behavioral condition, placing the life or health of such person or others in serious jeopardy;
- Serious impairment of such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Medical Necessity (as defined by the AMA) means health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

Physician Reviewer is a physician who possesses a current and valid non-restricted license to practice medicine. A Physician Reviewer may also be a health care professional other than a licensed physician who, where applicable, possess a current and valid non-restricted license, certification or registration, or where no provision for a license, certificate or registration exists,

is credentialed by the national accrediting body appropriate to the profession and is in the same or similar profession/specialty as the health care provider who typically manages the medical condition.

Prospective Review/Prior Authorization is a request for services which are anticipated and have not yet been received or a request for additional outpatient services when approved visits are available at the time of the request and where the timing of decision will not affect access to care.

Reconsideration Review is the review of an Adverse Determination by offering the attending physician an opportunity to request and receive reconsideration of an adverse determination by providing additional clinical information or by discussing the case with a Physician Reviewer.

Retrospective Review is the detailed analysis of an episode of care after the care has been rendered. Retrospective review can encompass both inpatient and outpatient services.

Total Process Time is total turn-around time allotted to process a review. This timeframe is inclusive of the time of receipt through communication of the final determination.

Utilization Review is the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient are medically necessary or experimental/investigational. None of the following shall be considered utilization review:

- Health plan denials based on failure to obtain health care services from a designated or approved health care provider as required under a member's contract;
- The review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedures;
- Any issues related to the determination of the amount or extent of payment other than determinations to deny payment based on Adverse Determinations;
- Any determination of any coverage issues other than whether health care services are or were medically necessary or experimental/investigational.

CLINICAL REVIEW CRITERIA (CRITERIA)

Medical Necessity Determinations

American Health conducts Medical Necessity reviews during the Prospective Review process, as well as for concurrent and Retrospective Reviews. These determinations are performed to ensure that the services requested are provided in the most appropriate, safe and cost-effective setting for the diagnosis and treatment of patients' condition.

Clinical criteria are used in the process of the Medical Necessity review process.

Utilization Management staff, in consultation with the Medical Director and/or Physician Reviewer, will establish whether care was medically necessary. The decision may be based in part on a review of medical records. Medical opinions received will also be evaluated. This

could include the medical opinion of a professional society, peer review committee, or other groups of physicians.

In determining if a service is medically necessary, the following may also be considered:

- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations, that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending Professional Providers, which have credence but do not overrule contrary opinions; and
- Any other relevant information provided.

Services will be deemed medically necessary only if:

- They are appropriate and consistent with the diagnosis and treatment of the medical condition;
- They are required for the direct care and treatment or management of that condition;
- The patient's condition would be adversely affected if they are not provided;
- They are provided in accordance with community standards of good medical practice;
- They are not primarily for the convenience of the patient, patient's family, the professional provider or another provider;
- They are delivered in a timely manner and is the most economical level of care which can safely be provided to the patient; and
- During an inpatient stay, the medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided in any other setting (e.g., outpatient physician office or at home).

Service or care must be an approved standard treatment. Except as otherwise required by law, no service or care rendered will be considered medically necessary unless American Health staff determines, in its sole judgment, the service or care is consistent with the diagnosis and treatment of the medical condition; generally accepted by the medical profession as an approved standard treatment for the medical condition; and considered therapeutic or rehabilitative.

Clinical Information/Case Documentation

To make an informed clinical decision, the Utilization Management staff may request copies of portions of the medical records from all sources involved in the patient's care. Only the minimum necessary documentation will be requested. The medical documentation may be requested from the patient's primary care physician, the specialist involved in the patient's care, or any institutional or ancillary providers. If documentation is insufficient or needs clarification, the Medical Director(s), Physician Reviewer(s), or Utilization Management staff may telephone the provider requesting the service, to discuss the case. This clinical information is reviewed

against established criteria, standards, guidelines; policies and procedures; and state and federal law and regulations.

Criteria Selection and Application

American Health utilizes MCG® criteria (formerly Milliman Care Guidelines), Aetna Clinical Policy Bulletins and/or American Society of Addiction Medicine (ASAM) criteria whenever applicable. These guidelines include evidence-based criteria, care pathways, and other care management tools.

In addition, certain state-mandated or client-specific criteria may be used as required.

UM PROGRAM ACTIVITIES

The scope of the UM Program includes activities that are designed to assist providers in efficiently caring for patients.

Prospective Review/Prior Authorization

When the Health Plan contract covering a member contains a pre-certification requirement, the Utilization Management staff shall assess all services that are subject to the requirement, using an established Prospective Review process and approved criteria.

The patient, their authorized representative (including family members), physician, or facility/provider rendering a service may request a Prospective Review (pre-certification) by telephone, fax, or written request. The Utilization Management staff evaluates Medical Necessity of proposed health care services. Prospective review facilitates care coordination and provides an opportunity to educate patients and providers.

If a case does not meet the criteria requirements to establish Medical Necessity for Prospective Review (pre-certification), the case is forwarded to the Medical Director who may refer the case to another physician advisor or like specialist. For any Adverse Determination, attending physicians have 24/7, 365 access to the Medical Director's office to leave supporting clinical information and/or arrange a telephone conversation

Notifications of review results are provided in accordance with state and federal regulations and according to American Health policies and procedures. All notices of an Adverse Determination include the reason and clinical rationale for the Adverse Determination, instructions on how the Adverse Determination may be appealed, the availability of the right to external appeal of final Adverse Determinations, details on how to request and receive, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the member's request and also any internal rule, guideline, protocol or similar criterion that was relied upon in making the Adverse Determination and when applicable, the availability to speak with the reviewing Medical Director.

Concurrent Review

Concurrent review monitors the Medical Necessity of an episode of care during a course of treatment. These reviews are conducted through telephonic/fax care management. Concurrent review is performed for inpatient as well as outpatient care.

Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other Physician Reviewer for determination. If the reviewer denies the case, the determination is subject to appeal.

Retrospective Review

Retrospective review is the detailed analysis of an episode of care after the care has been rendered. Retrospective review can encompass both inpatient and outpatient services. The purpose of the Retrospective Review process is to:

- Determine the Medical Necessity of the services applying criteria;
- Determine appropriateness of the level of service and provider of service;
- Screen for cases appropriate for referral to Case Management; and
- Identify and refer potential quality of care issues.

APPEALS OF ADVERSE DETERMINATIONS

There are consistent policies and procedures for responding to requests for appeals of Adverse Determinations by a patient, the patient's authorized representative or a provider. The appeals process meets or exceeds all state, federal and accreditation requirements and assures that all parties are treated fairly.