GHC-SCW Utilization Management Program Description

2025

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Group Health Cooperative of South-Central Wisconsin (GHC-SCW) has a structured UM Program that allows for fair, impartial, and consistent utilization decisions affecting the health care of our members.

To keep the UM program current and appropriate, GHC-SCW annually evaluates:

- The program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioners.

GHC-SCW's Directors for Medical and Behavioral Health provide oversight for revising the UM program structure or processes based on the above assessments and evaluations.

Program Structure GHC-SCW's UM Staff consists of the following roles/titles:

a. Behavioral Health Team
    a. Medical Director of Behavioral Health (PsyD)
    b. Director of BH (BS, MBA)
    c. Care Management Manager (RN, BSN, CCM)
    d. Behavioral Health Utilization Management Social Workers
    e. Case Managers – Social Workers
b. Medical Team
    a. Two Associate Medical Directors of Care Management (MD)
    b. Physician Reviewers (MD)
    c. Care Management Manager (RN, BSN, CCM)
    d. Utilization Management RNs
    e. Care Management Associates (CMA's)
    f. Case Managers – RNs and Social Workers

3. Pharmacy Team
    a. Manager of Pharmacy Services
    b. Administrative Pharmacists

UM Staff apply evidence-based criteria to requested services and approve when criteria have been met. In the event criteria is not met, UM Staff prepare case review for presentation at scheduled rounds which are conducted daily for BH rounds and at least three times per week for medical rounds. UM staff presents cases to one of the Associate Medical Directors, or to the Medical Director for Behavioral Health and/or Physician Reviewer for determination of medical necessity. GHC-SCW's Associate Medical Directors are Board-Certified Family Medicine physicians who are responsible for the implementation of clinical utilization management (including behavioral health care aspects) and quality improvement. Scheduled rounds are an opportunity to develop inter-rater reliability amongst UM reviewers and per department policy, all UM reviewers attend all scheduled rounds.

A Medical Cost Trend Analysis meeting held monthly involves the following members of the organization: Chief Medical Officer, Financial Analyst, Decision Support Supervisor, Director of Behavioral Health, Associate Medical Director, Care Management Department Manager, Information Analyst, Controller, and any Ad Hoc members needed to discuss specific areas being reviewed.

Results from these meetings have been used to guide decision making regarding prior authorization requirements for specific services such as outpatient BH individual counselling. Additionally, trends of various providers of equivalent services are compared to look for outliers. Referrals may be made to the Fraud, Waste and Abuse sub-committee if the analysis identifies a need for additional investigation.

The Associate Medical Directors are available by cell phone and/or in the administrative office and will provide for appropriate coverage if unavailable by designating a qualified, licensed senior physician or physician reviewer to act in their absence, as necessary.

The Medical Director for Behavioral Health is a GHC-SCW psychiatrist who is actively seeing patients part-time. GHC-SCW's Chief Medical Officer and Associate medical Directors serve as back-up for Behavioral Health reviews as needed.

Medical and Behavioral Health reviews for determining medical necessity are performed utilizing the following and most current version:

- Member Certificate – Does member have coverage for the requested service/item?
    - Medicaid Badger Care Plus Forward Health Handbook and Updates
- Policy Review
    - Care Management Medical Policies
    - Specialist Consultants
    - Pharmaceutical & Technology Assessment Committee Decisions
- Milliman Care Guidelines (MCG)
- Hayes Technology Reviews (part of recent acquisition by symplr.com)
- Reference to other Health Plan policies comparing accepted standards; GHC-SCW does not deny from these other insurers policies, but our Medical Directors do approve from them.
    - Aetna
    - Quartz
    - Dean Health Plan

Purpose: To conduct a series of coordinated and integrated activities that assist in:

1. Maintaining and improving high quality medical and behavioral health care and services to our members across the full continuum of care.
2. Meeting fiduciary responsibilities.
3. Complying with accreditation and regulatory requirements.

The "**Why"** behind what we do:

- ***Fiduciary Responsibility****:* Members trust us to provide care without scrimping on quality and keep our Cooperative solvent. Care Management allows us to manage and forecast costs but *not* as a deterrent against our members
- ***Health Equity:*** The Quadruple Aim specifically mentions cost of care. If the cost of care is uncontrolled or exceedingly high, it would become inaccessible which is inequitable care
- ***Population Assessment****:* Offers a first line view of what is happening within our member populations
- ***Process Improvement:*** To help improve what we do to meet the members needs
- ***Moral obligation:*** To manage resources since these are not unlimited
- ***Ethical Obligation:*** To protect our members from unproven services (experimental/investigational)
- ***Legal Obligation:*** Benefit Certificates are a contract with our employer groups requiring we cover medically necessary services and do not cover *non-contracted* service items

Goals: To be consistent, impartial, and fair while at the same time achieving the following standards:

1. Promoting, monitoring, and evaluating the delivery of high quality, cost effective, evidence based medical and behavioral health or substance use disorder (SUD) care services for all members
2. Making UM decisions based on medical necessity, appropriateness, and availability of resources and benefits
3. Ensuring confidentiality of personal health information
4. Monitoring and improving practitioner and member satisfaction
5. Connecting members to case management services when appropriate

Objectives:

1. To provide consistency during the UM review and decision-making process
2. To ensure that medical and behavioral health care and SUD services are medically necessary, appropriate, and provided in the most cost-effective setting
3. To facilitate communication and collaboration among members, practitioners, providers, and the organization to support cooperation and appropriate utilization of health care benefits.
4. To provide information to practitioners regarding utilization management updates and activities
5. To identify high utilization of resources for cost containment and implement appropriate case management activities. High Dollar Reports are generated monthly for review and potential Case Management
6. To render timely determinations and issue timely notifications
7. To identify under-utilization and initiate improvement activities to enhance overall quality improvement and compliance with national standards & recommendations for care
8. To assist with discharge planning and transition of care issues

Utilization Management Structure and Accountability

The GHC-SCW Board of Directors grants UM authority to the Chief Medical Officer who entrusts the direct responsibility for general UM activities to the Associate Medical Directors of Care Management. The Associate Medical Director assigns the daily operations of UM to the Care Management Manager. Behavioral Health and SUD UM activities are the co-responsibility of the Medical Director of Behavioral Health and the Director of BH. Pharmacy UM activities are assigned to the Manager of Pharmacy Services. The Chief Medical Officer also has delegated to Prime Rx Management LLC (Prime) and its related entities the responsibility to perform specific utilization management functions for prior authorizations of specialty medical pharmaceuticals on behalf of GHC-SCW to the patients and members of the cooperative. PRIME is NCQA Accredited in Utilization Management.

The Associate Medical Directors of Care Management and the Care Management Manager conduct an annual evaluation of the program structure, processes, and sources used to determine benefit coverage and medical necessity including UM Policies. The outcome of an effective UM Program demonstrates appropriate utilization of medical resources to maximize the effectiveness of care and services provided to the members. The organization evaluates all aspects of the UM Program, including any delegates and if required, their performance, at least annually. Actions taken to address overutilization or underutilization may include:

- Changes in prior authorization requirements
- Creation of shared educational materials
- Presentations to staff model primary care practitioners at scheduled conferences
- Articles to members in our newsletters

UM Responsibilities: The staff actively involved in implementing specific aspects of the UM Program include:

1. Associate Medical Director – responsibilities include, but are not limited to:
    a. General Care Management (CM) Department oversight.
    b. Serves as the liaison between the organization's primary care practitioners and external specialists and the Care Management Department.
    c. Assists in the analysis of utilization data for problem identification and prioritization
    d. Develops and implements action plans along with evaluation of corrective actions.
    e. Acts as the primary physician reviewer and makes determinations regarding:
        i. All Medical Necessity denial determinations.
        ii. All potentially cosmetic/experimental procedures.
        iii. Out-of-network practitioners.

f. Assists in the selection of UM criteria, reviews, and updates medical policies.
g. Chairs the Pharmaceutical and Technology Assessment Committee and participates in reviews.
h. Collaborates with vendors, employer groups, and providers regarding UM issues, and serves as a clinical resource for the Care Management Department.
i. Participates in other meetings as appropriate.
j. Actively involved in implementing GHC-SCW's UM program.
k. Delegates UM decisions to other physician reviewers as needed. Other reviewers include:
    i. GHC-SCW's Chief Medical Officer
    ii. Primary Care Physician Reviewers
    iii. Medical Director of Behavioral Health
    iv. PRIME Rx Management, LLC

2. The Behavioral Health Medical Directors responsibilities include, but are not limited to:
    a. Assists with the development, revisions, and/or implementation of Mental Health UM activities, policies, and procedures.
    b. Reviews and makes determinations regarding:
        i. All Medical Necessity Behavioral Health denial determinations including SUD, transitional & inpatient admissions and continued stay.
        ii. Requests for services with Out-of-Network practitioners
    c. Actively involved in implementing the behavioral healthcare aspects of the UM Program.
    d. Attends meetings of the Behavioral Health Quality Committee and Pharmaceutical & Technology Assessment Committee (PTAC), as appropriate.

3. The Director of BH responsibilities include, but are not limited to:
    a. Making decisions regarding the appropriateness of behavioral health services including the level of care and proper setting based on evidence-based criteria including MCG, Pharmacy & Technology Assessment (PTAC) Policies, or Care Management Medical Policies.
    b. Delegating clinical decision making to a master's level clinician, who has a minimum of five years of experience who can then provide and supervise initial assessments, prioritization of patients for behavioral health treatment via telephone and/or face to face intake (triage). Currently, this position is held by a Licensed Marriage and Family Therapist.
    c. Ensuring all departmental therapists are duly licensed by the State of Wisconsin for their appropriate level licensure in order that they can participate in prioritization of members for behavioral health treatment and referral decision making.
    d. Supports the use of a licensed board-certified psychiatrist for oversight of inpatient utilization services and formal denials of other behavioral health services.
    e. Participates in Pharmaceutical & Technology Assessment Committee (PTAC) as needed.

4. The Care Management Manager's responsibilities include, but are not limited to:
    a. Directs and manages the UM/CM Processes and the Care Management Department,
    b. Collaborates with the Associate Medical Directors on the annual review of the effectiveness of the UM Program.
    c. Ensures that the department is following NCQA Standards and regulatory requirements.
    d. Develops, revises, and implements CM policies.
    e. Coordinates Inter-rater reliability activities and UM Rounds, both medical and mental health (behavioral health and SUD).
    f. Collaborates with internal practitioners, external vendors, employer groups, and providers regarding UM issues.
    g. Supervises staff responsible for making administrative denials.

h. Participates in multi-departmental committees related to appeals, benefits, finance, operations, and technologies.
i. Assists the Associate Medical Directors with technology assessment.
j. Updates and presents UM program description annually to CSQC for approval.

5. Case Management and Utilization Management RNs and Social Worker responsibilities for medical and behavioral health include, but are not limited to:
    a. Perform pre-service, concurrent, and post-service reviews.
    b. Utilization Management RNs can approve UM benefit and medical coverage if medical and or benefit criteria is met. If medical criteria are not met, case must be taken to medical rounds for the Associate Medical Director/Physician Reviewer approval or denial.
    c. Case Managers approve Transition of Care for periods of up to 90 days for new members who meet for continuity of care criteria.
    d. Assuring referral authorizations and administrative denials are made within recommended time frames.
    e. Conduct second claims review.
    f. Collaboration with internal practitioners, external vendors, employer groups, and providers on UM issues.
    g. Participating with inter-disciplinary committees.
    h. Collaborating with patient, providers,' and employer groups to assess, plan, implement, coordinate, monitor and evaluate options and services.
    i. Assist in the management of patient care to ensure optimum outcomes.
    j. Provide education and assistance with available resources to promote quality and cost-effective outcomes.

6. Care Management Associates (CMA) responsibilities include, but are not limited to:
    a. Perform timely data entry of referrals.
    b. Care Management Associates can make benefit approvals on procedures and tests that are listed on the CMA approval list. This list is reviewed as needed and at least annually.
    c. Help the UM staff to ensure timeliness of referral activities, i.e., obtaining On Base scans for UM staff to begin their reviews.
    d. Direct practitioners to appropriate referral resources.
    e. Authorize routine referral services that do not require a Prior Authorization.
    f. Refer all services requiring prior authorization to UM Staff.
    g. Conduct second claims review.
    h. Ensure timely printing and mailing of pre-certification, authorization, and denial letters.

7. Manager of Pharmacy Services responsibilities include, but are not limited to:
    a. Making pharmaceutical determinations based on medical necessity and the implementation of a recommended step-therapy protocol.
    b. Manages administrative pharmacists who make UM approvals and denials.
    c. Monitoring delegated activities associated with pharmaceutical patient safety

8. Manager of Member Services responsibilities include, but are not limited to:
    a. Processing appeals of UM denials.
    b. Managing the day-to-day activities of Member Services staff that are providing members with benefit information and explanation.

9. PRIME Rx Management LLC's responsibilities involve the UM aspects specific to prior authorizations of specialty medical pharmaceuticals. A signed delegation agreement exists between both parties with amendments, as appropriate, when any of the responsibilities of our respective parties' change.

Scope

Care Management develops criteria for UM Staff through the Pharmaceutical & Technology Assessment Committee and/or with input from an appropriate specialist. As new procedures, medications and treatments become available, PTAC reviews related research information from reputable resources such as Hayes Technology and Subject Matter Expert Specialists. The committee meets and discusses the research including the input from specialists to determine whether the technology is appropriate, evidence-based and/or standard of practice. Medical or Behavioral Health criteria may be revised periodically as changes occur and/or annually by the Associate Medical Director or the Committee.

UM staff have policies and workflow processes to assist with determining referral management, medical necessity of outpatient, and inpatient services, along with the appropriate medical and/or behavioral health criteria sets. Each UM staffer is trained in applying the evidence-based criteria and in preparing UM reviews for the Associate Medical Director and/or Physician Reviewer. UM staff audits are also performed biannually to ensure consistency of presentations to the Associate Medical Director, that proper selection and application of evidence-based criteria is taking place, and that any administrative denials are made within scope.

UM staff have written procedures delineating how to document and select the appropriate policy, PTAC, or Milliman Care Guideline to support the clinical decisions they are making. These procedures are contained in CM.ADM.002 Care Management Review Criteria.

The scope of UM activities for Medical and Behavioral Health includes, but are not limited to, the following:

1. Benefit clarification.
2. Referral Management.
3. Pre-service, concurrent, and post-service review and timely determinations.
4. Out-of-area services.
5. Complex Care Coordination, including discharge planning and transition of care.
6. Second review of claims.
7. Technology assessment.
8. Inter-rater reliability.
9. Monitoring adverse effects and sentinel events.
10. Integration with QM Department, Pharmacy, Behavioral Health Department, Marketing, Finance, and Insurance Operations.
11. Interdisciplinary communications.
12. Overutilization: evaluate systematic overuse to implement, monitor, and evaluate the impact of comprehensive cost containment and quality improvement interventions.
13. Underutilization: addressing compliance with national standards and recommendations for care through population health management strategies
14. Review, discussion, and adaptation of UM criteria to NCQA standards and guidelines
15. Develop policies to clarify benefits.
16. Denial and appeal notifications.

Processes for UM activities/functions:

1. Benefit clarification to determine whether member has coverage

    a. UM staff is responsible to know the benefits related to a member's Certificate language when requests are received for a review

    b. UM staff checks eligibility on each UM request received as part of the review process

    c. GHC-SCW must cover all Medicaid HMO services identified within the Forward Health Online Handbook issued by the Wisconsin (WI) Department of Health Services and abide by the max fee schedules. GHC-SCW is required to provide at least the same benefits as those provided under WI-Medicaid Fee for Service Arrangements.

    d. GHC-SCW *does not* manage the formulary or administer the pharmacy benefit for the Medicaid HMO. The WI Department of Health Services Medicaid Program carves out pharmacy services.

    e. GHC-SCW *does not* administer a chiropractic benefit for the Medicaid HMO.

2. Prior Authorization Management

    a. GHC-SCW provides Primary Care services and select specialty services within GHC-SCW owned clinics. Specialty services/care outside of a GHC-SCW owned clinic is subject to requiring prior authorization. The prior authorization list is determined by senior leaders and based upon standards of practice and the financial impact of select services. Primary Care Practitioners (PCP's) initiate outside services with a written order. Specialty office visits (including BH and SUD) unavailable at a GHC owned clinic, and obtained from the appropriate in plan providers, do not require prior authorization.

    b. PCPs submit an order to Care Management Associates, who are responsible for either approving the request or routing it to UM Staff for review.

Type of Review	Decision Timeline	Notification Electronic **or** written	Verbal **May provide oral notification**	Extension
Routine pre-service (non-urgent)	15 calendar days from receipt	15 days		GHC does not use extensions but will deny for lack of information
Routine pre-service (non-urgent) Badger Care Plus*	14 days from calendar receipt*	14 days from calendar receipt*		
Urgent (pre-service)	48-72 hours of receipt of request	Within 72 hours of request	Within 72 hours of request	If insufficient or lack of info and requested by GHC within 24 hours of receipt of request, can allow 1 day up to 48 hours for member/rep to provide additional info
Concurrent Urgent (Active Treatment)	24 hours of receipt	24 hours unless verbal is given first within 24 hours; then have 72 hours to provide written/electronic	Within 24 hours of request	If request to extend is not received with 24 hours of expiration of prescribed period or # of treatments, may extend up to 72 hours and treat as urgent pre-service
Retro (post service)	30 calendar days	30 calendar days		GHC does not use extensions but will deny for lack of information

**Indicates Badgercare HMO (Medicaid) Contract Obligation*

3. Pre-service, concurrent, and post-service review and timely determinations; Over and underutilization of services; Denial and appeal notifications
    a. UM staff follow NCQA guidelines for timely decision making in each respective category:
        i. CM.ADM.007 Pre-Service and Timely Determinations
    b. UM staff utilize evidence-based medicine guidelines which consist of the following:
        i. Member's Certificate language-benefit information
            1. Medicaid Badger Care Plus – Forward Health Online Handbooks and Forward Health Provider Updates
        ii. Care Management Medical Policies, PTAC policies, MCG (edition updated annually), and Hayes
    c. UM staff utilize the policy/guidelines in the UM process and document the appropriate clinical information within Epic to show if the services received do or do not meet the guidelines
        i. Policy CM.ADM.013 Documentation of Clinical Information
    d. UM staff prepares cases for review by MD which fail to meet guidelines/criteria in a timely manner as defined in the NCQA Standards and Guidelines, table above and CM.ADM.003
    e. ER services are not reviewed for medical necessity
    f. Services requested out of plan for HMO members when those same services are available in plan, can be administratively denied by UM staff
    g. Out of area services are reviewed by the Associate Medical Director/Physician Reviewers to determine medical necessity when services are not available within plan providers.

4. Case Management works collaboratively with Utilization Management to provide transition of care (TOC) services and discharge planning.
    a. Case Management processes are listed within the CM.ADM.039 policy
    b. Case Managers assist with TOC following policy CM.ADM.012

5. Second review of claims
    a. "Pended" claims are reviewed by UM staff for services which require but have no prior authorization on file, or do not match codes within a current authorization; (retrospective)
    b. Members who do not obtain prior authorization per their benefit summary may be penalized by UM Reviewers as stated in the Member's Schedule of Benefits

6. Technology Assessment
    a. Policy CM.ADM.010 documents the existence of the Pharmaceutical & Technology Assessment Committee and its role at GHC-SCW
    b. Peer reviewers/specialists provide clinical information on new technologies/procedures/trends within medical, pharmacy and behavioral health fields

7. Inter-rater reliability
    a. Policy CM.ADM.011 Inter-rater Reliability documents the process that GHC-SCW uses to review and assess the consistency of personnel involved in making utilization review determinations.

8. Monitoring for adverse effects and sentinel events
    a. Policy CM.ADM.018 Quality of Care Issues establishes procedures for dealing with "adverse events" associated with the care of members within GHC-SCW clinics/services or contracted medical staff and facilities.

UM Clinical Criteria Review

UM staff makes determinations based on medical necessity and appropriateness for inpatient and outpatient care including behavioral health and SUD. Staff use clearly written, published criteria which is evidence-based to evaluate the necessity of medical services. These criteria sets are intended to be used as guidelines, and in combination with professional clinical judgment, applied when determining necessity of requested services. Adaptation of these guidelines may be necessary based on individual needs and standard of care within the local delivery system. Criteria review is also documented in policy CM.ADM.002.
The Care Management Manager annually reviews the criteria and the procedures for applying them and updates the criteria as appropriate. The criteria used are the most current versions of:

- ✓ Member Benefit Certificate
- ✓ Forward Health Online Handbooks and Forward Health Provider Updates (if Medicaid Badger Care Plus)
- ✓ Care Management Medical Policies
    - ◦ Specialist Consultants
    - ◦ Pharmaceutical & Technology Assessment Committee Decisions
- ✓ MCG (Milliman Care Guidelines)
- ✓ Hayes Technology Reviews (symplr.com)
- ✓ Reference to other Health Plan policies (comparing accepted standards)
    - ▪ Aetna
    - ▪ Quartz
    - ▪ Dean Health Plan

The UM decisions are determined with the use of nationally developed guidelines/criteria, as well as GHC-SCW's consideration of the following additional information regarding individual members:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

GHC-SCW also considers the characteristics of the local delivery system such as:

- Availability of skilled nursing facilities (SNF), sub-acute care facilities, or home care to support the member upon discharge.
- Awareness of individual coverage of benefits for SNF, home care and sub-acute facilities to support medical/behavioral health services when appropriate.
- The availability of services within local hospitals to provide members with needed care.

Active practitioners and specialists are members of the PTAC which meets at least quarterly to review new technology and services available to GHC-SCW members. This committee is involved in the development, adoption and review of MCG revisions and nationally developed standards. Criteria used to make UM determinations available to practitioners on the GHC-SCW Clinical Resources Dashboard and upon request. Practitioners and members are informed on how to request the UM criteria within every denial letter.

Inter-rater Reliability

At least annually, GHC-SCW evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. This process includes physicians, UM clinical staff consisting of Social Workers, RNs, and pharmacists making medical and behavioral health and or SUD determinations. Cases are reviewed at identified intervals as part of a group educational process. These include, but are not limited to, thrice weekly UM Medical Rounds, and daily Mental Health Rounds to evaluate determinations and problem cases. When areas of improvement are identified, processes and/or interventions are developed, or policies are revised. The changes are implemented after staff training is provided. Monitoring of these improvements occurs during the weekly Rounds.

The goals of inter-rater reliability include, but are not limited to:

1. Consistence in the application of clinical guidelines.
2. Evaluation of reviewers' ability to identify potentially avoidable utilization thus reducing costs.
3. Evaluation of reviewers' ability to identify quality-of-care issues.
4. Identifying specific areas in need of improvement.
5. Identifying areas where additional training is needed.

In addition, the CM department has an inter-rater reliability tool available through MCG which provides on-line hypothetical case scenarios. MD Reviewers and UR staff are assigned a set of cases according to their usual area of review. They are expected to select and apply the appropriate guidelines and are scored per correct application of the guidelines. Health care professionals involved must receive at least 90% as a standard passing score for all UR personnel. Additional learning modules are available through MCG and assigned to staff that need additional education to improve consistency. Newly hired staff are assigned the initial learning modules to assist in learning the UM criteria review processes.

The Care Management Manager reviews all additional visit requests as a means of conducting randomized audits. When issues or concerns are identified, a one on one with involved reviewer will take place as an educational opportunity. If the same concern arises continually then a process improvement plan will be

implemented for the involved employee to rectify the concern. The department conducts weekly staff meetings where areas of concern and issues regarding UR are discussed as a group and additional education is provided to the staff as needed. Minutes of the weekly meeting are available for staff to review as needed. Additionally, the Care Management Manager distributes a "Friday Wrap-Up" which includes any changes or updates discussed during the weekly meeting. Appropriate changes are made within the department's processes per CM.ADM.011; Inter-Rater Reliability.

Communication Services

Care Management staff are accessible to members and practitioners/providers to discuss UM issues. (See CM.ADM.021, *Communication Services*)

- Care Management staff is available electronically or by phone between the hours of 8:00 am and 5:00 pm, Central Standard Time, Monday through Friday, excluding holidays. There are both local and toll-free phone numbers for the Care Management Dept.
- During weekends, holidays, and non-working hours, the Care Management Department has confidential electronic and voice mail boxes which are responded to within 24 business hours from receipt of the message. Staff have the availability to access their voicemail remotely in case of unexpected absences; callers can be referred to alternate staff for assistance if needed.
- Care Management staff identify themselves by name, title, department, and organization when initiating or returning phone calls.
- The Care Management Department has a dedicated fax machine located within the department, which is available 24 hours per day, 7 days per week.
- GHC-SCW's Member Services Department screen incoming phone calls and will transfer calls to Care Management personnel when appropriate.
- GHC-SCW offers TDD/TTY services for deaf, hard of hearing or speech-impaired members.
- GHC-SCW offers free of charge language assistance for non-English speaking members to discuss UM issues.

Appropriate Professionals

Qualified, licensed healthcare professionals make Utilization Management determinations. These professionals include physicians, genetic counselors, appropriate behavioral health practitioners, physical/occupational therapists, or pharmacists. The appropriate professional reviews medical or behavioral health denials based on medical necessity. The health plan utilizes Board-certified physician specialists to assist in making medical necessity determinations per CM.ADM.017 Appropriate Professionals.

- Three (3) GHC-SCW Physician Reviewers are available for making medical necessity determinations.
- Board-Certified Physicians from the University of Wisconsin (UW) Hospital and Clinics and UW Medical Foundation may be used as consultants, when necessary, to assist in making determinations of medical necessity when situations occur where the clinical judgment is sufficiently specialized such that primary care physicians are unable to address the issues in question. GHC-SCW's Medical Staff Administrator maintains the list of UW specialists and makes it available to the physician reviewers and department managers on an as needed basis.
- Medical Review Institute of America, LLC is used, as needed, to provide same or similar specialty external reviews, or when there is a general question regarding evidence available to support certain requests or for assistance with policy development.
- UM decision making is based only on appropriateness of care and service and existence of coverage. GHC-SCW does not use incentives to encourage barriers to care and service nor does it make decisions about hiring or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff supports, or tends to support denial of benefits.

- GHC-SCW has written job descriptions identifying the qualifications required for a practitioner to review denials of care as related to their specific professional experience.
- Practitioners must have a current license to practice without restrictions.
- New employees and practitioners are presented the Affirmative Statement Regarding Incentives (policy (CM.ADM.020) during their orientation; the Affirmative Statement is signed annually thereafter.
- GHC-SCW does not offer any type of incentive to encourage denials or placement of barriers for members to receive care.
- GHC-SCW ensures that a physician, appropriate behavioral healthcare practitioner or pharmacist, as appropriate, reviews any behavioral healthcare denial of care based on medical necessity.
- A benefit denial is a requested service which is specifically excluded from a member's benefit plan, which GHC-SCW is not required to cover under any circumstances. These may be limited by numbers, duration, or frequency in the benefit; limited to no extensions beyond specific date, time, or number and/or specified as an exclusion in the benefit plan.

Timeliness and Notification of UM Decisions

CM staff and physician reviewers make timely and consistent determinations for all UM activities requiring review to assess the medical necessity and/or appropriateness of care or services. These determinations apply to both urgent and non-urgent requests, and extensions of time may be requested if a determination cannot be made in a timely manner due to the lack of necessary information. In whole or in part decisions and notifications are communicated to appropriate members, practitioners, and providers in a timely manner to accommodate the clinical urgency of the situation to minimize any disruption in the provision of health care.

Medical Necessity/Medically Necessary means a service, treatment, procedure, equipment, Prescription Drug (or combination thereof), device or supply provided by a Hospital, Provider or other health care Provider that is required to identify or treat a member's illness, disease, or injury and which is, as determined by the GHC-SCW Associate Medical Director to be:

a. Consistent with the symptom(s) or diagnosis and treatment of the Member's illness, disease, or injury
b. Appropriate under the standards of acceptable medical practice to treat that illness, disease, or injury
c. Not solely for the convenience of the Member, Provider, Hospital, or other health care Provider; and
d. The most appropriate service, treatment, procedure, equipment, Prescription Drug (or combination thereof), device or supply which can be safely provided to the Member and accomplishes the desired result in the most economical manner. This means if there is more than one medically established standard treatment approach available nationally, and these approaches are equivalent in terms of proven medical outcomes, GHC-SCW will make the determination on the selected approach to be covered.
e. The Wisconsin Department of Health Services Medicaid Managed Care medical necessity and prior authorization requirements are dictated within the Forward Health Online Handbook.

1. Determination of medical necessity is based on specific criteria. Timeliness of Decision Making for Medical, Behavioral Health & Pharmacy UM Decisions:
   a. For non-urgent pre-service decisions, GHC-SCW makes decisions within 15 calendar days of receipt of the request. For Medicaid non-urgent pre-service decisions, GHC-SCW makes decisions within 14 calendar days of receipt of the request.
   b. For urgent pre-service decisions, GHC-SCW makes decisions within 72 hours of receipt of the request.
   c. For urgent concurrent review, GHC-SCW makes decisions within 24 hours of receipt of the request. This is regardless of the members insurance plan type including Medicaid and Medicare.
   d. For post-service decision, GHC-SCW makes decisions within 30 calendar days of receipt of the request.

2. Notification of Medical, Behavioral Health & Pharmacy Decisions:

    a. For all determinations, GHC-SCW gives electronic or written notification of the decision to practitioners and members within the time frames listed under 1a-d above, as per NCQA guidelines.
    b. Notification of urgent request decisions, GHC-SCW may notify the practitioner only of the decision since NCQA assumes the treating or attending practitioner is acting as the member's representative.
    c. If the decision for urgent care requests is either concurrent or post-service (retrospective) and the member is not at financial risk, GHC-SCW is not required to notify the member. GHC-SCW must notify the members in all other cases.
    d. If requests for health care services come from a practitioner, GHC-SCW may send the request for additional information to the practitioner; but must notify the member if it denies the services.

Care Management accepts non-urgent prior authorization requests via fax or electronic entry. Fax requests are accepted and processed on the same day or the next business day. On weekends and holidays, fax requests are entered the next business day.

GHC-SCW reviews requesting services for our members in the following ways:

Referrals: Referrals result from written orders from a Primary Care Provider when requesting a member to see in-plan specialty care. The referral/order is sent to the Specialist when requesting an appointment. The word "referral" is at times incorrectly substituted for the term prior authorization (PA) as not all referrals require PA review, or they serve only as proof of GHC-SCW's intent to pay for the requested service.

Prior Authorization: When a "referral" is sent to the insurance company for approval, a determination will be made based on meeting medical necessity. The basic tenets of prior authorization review include eligibility verification, benefit interpretation and administration, medical necessity review of both in and outpatient services. A Prior Authorization list is available on GHC-SCW's website for providers and our members' convenience with a disclaimer that indicates that the Member's Certificate supersedes the PA list as it is not inclusive for all products or all benefit certificates that GHC-SCW offers. Requests for services requiring prior authorization and determination are evaluated by using appropriate clinical criteria applied by UM personnel. Any additional services or extension of services beyond initial authorization will require submission of clinical documentation for medical necessity review.

Pre-Service Review Determinations

1. Pre-service urgent determinations are defined as any request for medical care or services whereby application of non-urgent time periods could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, **or,** 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 condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

2. Pre-service non-urgent determinations are defined as those required for a request presented prior to the member receiving medical care or services.

Concurrent Review Determinations

1. Concurrent review determinations are any review for the extension of a previously approved ongoing course of treatment over a set period or number of treatments. These reviews are typically associated with inpatient admissions or ongoing ambulatory care.
2. Concurrent urgent determinations are defined as any request for medical care or services whereby application of non-urgent time periods could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
3. Concurrent non-urgent determinations are defined as those requests that do not meet the above definition for urgent care and may be handled as a new request and decided within the time frame appropriate to the type of decision.
    a. For termination, suspension, or reduction of previously authorized Medicaid-covered services for Badger Care Plus Members, GHC-SCW shall send a notice at least 10 days before the date of action, except as permitted in the Wisconsin HMO Member Grievances and Appeal Guide.

Post-Service Review Determinations (Retrospective Reviews)

Utilization Staff and physician reviewers make timely and consistent determinations for all UM activities requiring review to assess the medical necessity and/or appropriateness of care or services requested that have already been provided to the member. Extensions of time may be requested if a determination cannot be made due to lack of necessary information. Decisions and notifications are communicated to appropriate members, practitioners, and providers in a timely manner.

Extension of timeframes

Extension of timeframes for non-urgent preservice and post-service decisions, or Urgent preservice/concurrent decisions are acceptable if the organization is unable to decide due to the lack of necessary information. Extensions are not allowed for urgent concurrent decisions for *Commercial and Exchange members.* Members may also voluntarily agree to extend a decision timeframe if they need to obtain information or be evaluated by specialists.

Clinical Information

Relevant clinical information that is pertinent to an identified episode of care is collected from the treating physician and other appropriate practitioners and documented to support accurate and appropriate UM determinations of coverage based on medical necessity for medical or behavioral health services see CM.ADM.013. Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.
- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.

- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures including the Forward Health Online Handbook for Medicaid (Badger Care Plus)
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Diagnosis codes.

Behavioral Health

GHC-SCW *does not* have a centralized triage and referral process and has numerous ways for our members to obtain Behavioral Health services. GHC members can use the GHC-SCW website and locate a BH provider from our BH Provider Hub. No prior authorization is required for any GHC-SCW member seeking BH outpatient therapy and/or psychiatry services.

a. GHC-SCW members have direct access to behavioral health care at GHC-SCW owned clinics, and any contracted BH provider in-network.
b. GHC-SCW Commercial & Exchange members can use GHC Care On-Demand for direct access to telehealth services with licensed therapists or psychiatry which is available 24 hours every day of the year. **Note:** GHC Care On-Demand is not available to Medicaid Badger Care Plus members.
c. GHC-SCW members can call or walk in-to a clinic to obtain behavioral healthcare. After hours, GHC-SCW members calling the 24-hour crisis line with behavioral healthcare inquiries are routed to an on-call behavioral healthcare practitioner.
d. GHC-SCW Member Service staff provides members with information about in-network behavioral healthcare practitioners and how to access care, and do not make judgments about the level of care needed or type of practitioner that the member should see.
e. GHC-SCW members may access any contracted Behavioral Health Care provider regardless of the member's primary care clinic location.
f. GHC-SCW members can contact the 24-hour crisis line with behavioral healthcare inquiries and have access to GHC-SCW Nurse Connect, a 24-hour health information line.

Denial Notices

The Utilization Review staff clearly documents and communicates the reasons for each denial and provides members and their treating practitioners with the opportunity to discuss a denial with an appropriate reviewer. A copy of the benefit language or criteria on which the denial determination was made is sent to the provider, member, and practitioner upon request. This applies to all UM denials: medical, pharmaceutical, and behavioral health and SUD. Members and providers are directed to the GHC-SCW Member Services Department for appeal submission and resolution.

1. Utilization Review staff provide written denial notifications for all medical necessity denials that include the following:
    a. The specific reasons for the denial, in easily understandable language.
    b. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.

c. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request.
d. For lack of information denials, reference to the clinical criteria that has not been met must be included. If we are unable to provide a specific policy, we describe the information needed to render a decision.

2. Staff use of denial templates ensures every denial letter will auto attach specific written appeal information in all denial notifications which include:
    a. Description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.
    b. Explanation of the appeal process, including the right to member representation, and time frames for deciding appeals
    c. If a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process is included. (Per policy MS.MS.001)
    d. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.

3. For medical necessity denials, UR staff notify practitioners of the availability of an appropriate reviewer for discussion of the denial and how to contact that reviewer either via written directions in the denial letter, staff messages in the Epic system, or a phone call to the practitioner's office. Staff will document the time and date of both the denial notification, the offer of reviewer availability, as well as conversations with the practitioner regarding the specific case while the denial decision was pending.
    a. The Associate Medical Director is available for discussion of medical necessity denials.
    b. The Behavioral Health Medical Director, Director of BH, UR staff and appropriately qualified clinical mental health staff are available for discussion of behavioral health/SUD denials.
    c. The Manager of Pharmacy Services and administrative pharmacists are available for discussion of pharmaceutical denials.
    d. GHC-SCW Practitioners are informed of the denial and appeal process during their initial orientation and periodically in the "Practitioner Update" newsletter.
    e. Member appeals/grievances will be accepted by Member Services without time limitation.

4. The External IRO appeal process is administered by the Federal Government Office of Personnel Management (OPM). The member or representative has the right to request an independent review. An insured member may authorize another individual to request an independent review in any written form that is signed by the insured member. (CM. ADM. 003 Denial and Timely Appeal Notification)
    a. A written request must be submitted within 4 months of notice of the adverse benefit determination or final internal adverse benefit determination.
    b. The request for an external review must be submitted in writing or electronically to: DisputedClaim@opm.gov; by fax to 202-606-0036; or by mail to PO Box 791, Washington, DC 20044.
    c. If there are any questions during the external review process, the member or representative may call toll-free 877-549-8152.
    d. If additional written comments are submitted to the external reviewer at the mailing address above, it will be shared with GHC-SCW to give GHC-SCW the opportunity to reconsider the denial.
    e. The IRO's decision is legally binding on both the complainant and the insurer.

Appropriate Handling of Appeals

GHC-SCW's Appeals policies (MS.MS.001 & MS.MS.048) outline the organizations procedures for thorough and timely resolution of appeals including a description of the system controls utilized to store and secure UM appeal information and dates. GHC-SCW has a full and fair process for resolving member disputes and responding to members' requests to reconsider a decision they find unacceptable regarding care and service. The documentation, investigation and appropriate response to an appeal are coordinated through the Member Services Department.

Member Appeal Manager annually audits appeal records for inappropriate documentation and updates to the UM appeal receipt and notification dates. The Member Services Manager conducts qualitative analysis of inappropriate documentation and updates to the UM appeal receipt and decision notification dates.

If necessary, the Member Services Manager implements corrective actions to address all inappropriate documentation and updates, and then 3-6 months after the initial annual audit will repeat and audit to evaluate the effectiveness of the corrective actions

The member appeal and grievance processes for the Medicaid product line are dictated by the State of WI "HMO Member Grievances and Appeals Guide." This guide outlines template letters and workflows contracted health plans must follow for appeals and grievances. At large, the process for Medicaid HMO appeals and grievances mirrors the commercial and exchange HMO product lines, however, Medicaid members only have 60 days to file an appeal after an adverse determination.

Evaluation of New Technology

GHC-SCW has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. The Pharmaceutical & Technology Assessment Committee (PTAC) meets at least quarterly or as needed, to conduct assessments by Policy CM.ADM.010.

GHC-SCW's written process for evaluating new technology and the new application of existing technology for Inclusion in its benefits plan includes an evaluation of the following:

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

The current PTAC is responsible for review and approval of pharmaceuticals and related pharmacy management procedures.

1. Technology Categories: technologies encompass medical procedures, behavioral health procedures, pharmaceuticals, and devices.

2. Review Categories:
    a. Proactive reviews are usually initiated when a new technology is identified from published scientific evidence or an appropriate government regulatory body.
    b. Reactive or urgent reviews are triggered by a provider's request for the use of new technology, a new application of an existing technology, or a special review case.
    c. Retrospective reviews are conducted when the request was received after the service was provided.

d. Scheduled review of established GHC-SCW technology assessments.

3. Technology Evaluation Sources include but are not limited to:
    a. Hayes Incorporated, which is a major vendor of technology assessments.
    b. The Food and Drug Administration (FDA) information is contained in the Hayes & TEC reports.
    c. Technology Evaluation Center (TEC) is sponsored by the Blue Cross/Blue Shield Association and Kaiser Permanente.
    d. Reports from governmental agencies and medical associations, i.e., Center for Disease Control (CDC), American College of Obstetricians & Gynecologists or recognized sites like Medline may be utilized.
    e. Medical literature published in peer reviewed journals or by other health plans i.e., Aetna, Cigna, United Healthcare, CMS, Medline, etc.
    f. Local medical expert opinion or specialty physician consultants, including use of MRIoA for technology evaluation.
    g. Up to Date® which is an evidence-based clinical decision support resource authored by physicians to help healthcare practitioners make the best decisions at the point of care by combining the latest clinical knowledge with innovative technology.
    h. CMS-Medicare regulatory rules
    i. Milliman Care Guidelines (MCG)

4. Review Criteria for Determinations: technology assessment decisions are based upon the following criteria:
    a. The technology must have received final approval from the appropriate government regulatory bodies, if applicable, e.g., FDA, AMA, CMS (formerly known as HCFA).
    b. The scientific evidence must permit conclusion concerning the effect of technology on health concerns.
    c. Technology must be as beneficial as any established alternative.
    d. Technology must improve the net health outcome of the patient.
    e. Technology must be attainable outside the investigational setting.

Procedures for Pharmaceutical Management

A complete description of GHC-SCW's Pharmaceutical Management Program including the UM system controls and oversight monitoring utilized for pharmacy denials is outlined in policy PH.INS.008 (former CL.PH.BEN.008). This policy is posted on GHC-SCW's website as a provider resource.

GHC-SCW *does not* manage the formulary or administer the pharmacy benefit for the Medicaid HMO. The WI Department of Health Services Medicaid Program carves out pharmacy services.

Information Integrity of UM Denials

Group Health Cooperative of South-Central Wisconsin has policies and procedures in place to manage UM medical necessity decisions in the scope of NCQA's health plan guidelines for Timeliness of UM Decisions. These controls protect UM denial data from being altered outside of prescribed protocols. GHC-SCW utilizes the Tapestry platform within Epic as our UM system for medical and behavioral health. The following mechanisms are used to maintain and safeguard information used in UM denial decision processes against inappropriate documentation and updates.

1. **The date of receipt consistent with NCQA requirements**

1) The date of receipt is defined as the date of arrival on which GHC-SCW initially receives written notification of a referral request from a provider.
2) Referral requests received via fax are stamped at the top of the incoming fax and this date is entered into by the Care Management Associate creating the referral. This field is the "referred on date". The system is programmed to only allow one-time entry by the CMA staff at the time the referral is created to allow for proper dating of requests that have been submitted after hours or over the weekend

2. **Written Notification: The date of written notification is consistent with NCQA requirements**
    a. The date of written notification is defined as the date on which the decision letter is generated to the practitioner and member by GHC-SCW or if electronic notification is used, the date posted in the electronic system.
    b. Decision dates are time/date stamped within Tapestry and **cannot be altered once accepted.**
    c. Members who choose to receive information via MyChart will receive denial letters immediately upon generation of the decision letter in this format, along with a notification that a message has been delivered to their in-basket.
    d. Decision notification is made via RightFax™ immediately upon generation of the decision letter. If fax is unavailable, or, member has chosen to not sign up for MyChart, letters are generated each business day and mailed within 24 hours.
    e. Concurrent decision may be communicated via telephone with the ordering provider.

3. **Tracking Modifications (Process for recording dates in the system)**
Upon each entry, the Tapestry system stamps the date and time of the entry along with the name of the person entering the information. This cannot be changed by ANY Utilization Management staff, including MD and Manager. This information is viewable within the audit trail of the referral.
    a. The system tracks a history of all people working within the referral and each step they have taken such as changing provider information, creating a note, generating a letter, or adjusting the status of the referral. The system is detailed and tracks all entries made within a referral. This information is available under the "history" tab of every referral.
    b. UM Denial receipt and notification dates are automatically recorded by the system and the system does not permit changes under any circumstances,
    c. Adjustments made by entering CMA staff at time of referral creation do not require a note to be made, however notes are required by UM staff to explain any changes made and cannot be edited once the entry is closed.

4. **Appropriate Modifications**
    a. Care Management department employees can change specific dates within a pending or approved referral request. Changes can include start date and end date, bed days information, and discharge dates. Examples where this would be appropriate include:
        1) When a scheduled surgery has been changed to another time
        2) When a provider notifies GHC-SCW of a change in scheduled procedures
        3) When approved services are extended such as in skilled nursing stays or hospitalizations.
        4) When a referral is received via Epic Link or via fax, the CMA staff review all entries to assure they align with the request being made. Adjustments are made at this time of review by the CMA.
    b. Creation of Notes:
        1) When (e.g., date and time) the information was updated
        2) What information was updated
        3) Why the information was updated
        4) Staff who updated the information

c. Level of staff authorized to make appropriate modifications
    1) All users can enter dates that are associated with their specific job functions
    2) Titles and roles of those who are authorized comprise of the organization's
        a) Care Management Manager
        b) UM RN Team Leaders
        c) UM RN
        d) Behavioral Health UM Reviewer
        e) Care Management Associate (CMA)
        f) Medical Directors
    d. Authorized modifications are considered those made by an employee named under 4c. and pertain to appropriate changes identified under 4a and 4b

5. **Inappropriate Modifications:**
    a. Unauthorized modifications are classified as any that do not meet the criteria above.
        1) The Tapestry system has built controls which restrict any employee from changing any dates within a denied referral. The only thing able to occur in a denied referral is to add a note. Instances where a note may be appropriate to add to a denial may include:
        2) The "referred on date" which reflects when a request was received by the organization cannot be altered by anyone including the manager. The system is locked down once a referral is created and tis "referred on date" is unchangeable by anyone.
    b. Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
    c. Creating documents without performing the required activities (approving referrals without applying criteria)
    d. Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices)
    e. Attributing review to someone who did not perform the activity (e.g., appropriate practitioner review)
    f. Updates to information by unauthorized individuals

6. **Information Integrity**
    a. GHC-SCW has systems in place to prevent physical access to work areas. These practices include employee badge identification requirements to access the physical workspace located behind locked doors.

    b. GHC-SCW has systems preventing unauthorized access and changes to data. Software systems have password requirements with login ID's that are managed through the IT Security department.

    c. GHC-SCW's Password Policy IT.IS.008 applies to all company computers and devices that store company information and all users that have access to the network. External logins require two factor identification and password changes are required every 180 days and cannot be duplicated with any password used within a three-year period.

    d. GHC-SCW practices the policy of disabling passwords of employees who leave their role or the organization. Managers submit an offboarding request to the IT Security Administrator and access is ended within one business day. HR Policy mandates that employees being terminated have their access removed immediately. IT Staff who oversee computer security are responsible for changing passwords when requested if a password has been compromised.

    e. GHC-SCWs Compliance Department also conducts random audits of employees accessing member records to ensure employees are only accessing records related to their work.

7. **UM Denial System Information Integrity Monitoring and Oversight**

a. Oversight of the UM program is the responsibility of the Chief Medical Officer. System monitoring for both Medical and Behavioral Health processes will be the responsibility of the Care Management Manager who would report to the Chief Medical Officer any actions taken or plans to address modifications that do not meet policies and procedures, if applicable.

b. The Tapestry platform of our UM system has advanced control capabilities that prevent changes or editing of original information or any notes or attachments once an entry has been closed. The system also automatically stamps the date and time along with the name of the staff member who entered the record upon each entry and all this information is viewable within the audit trail of the referral.

8. **Auditing Process**

a. At least annually within the look back period, Audits are conducted by the Care Management Manager to review the processes and procedures related to the UM denial system controls. These audits are presented annually to the CMO and CSQC.

b. The Care Management Manager audits this report to ensure the following are true.

1) The correct staff authorized any modifications

2) The correct staff modified the changes

3) That all modifications were appropriately documented and tracked during the audit period

c. The audit scope includes all aspects of the UM information integrity including:

1) Date of receipt and written notification

2) Authorization and tracking of date modifications

3) System security controls

4) Inappropriate Documentation

d. Audit Methodology

1) The Care Management Manager will download a system generated report of denials with decision notification dates within the look back period in a spreadsheet format. Information included in the report will be member number and denial number only.

2) The Care Management Manager will manually audit 5% of this list or 50 denials, whichever is less.

e. The Care Management Manager will provide an audit report that includes:

1) The report date

2) The title of the person conducting the report

3) The 5% or 50 file auditing methodology (Auditing period, File Universe Size, and Audit sample size)

4) The audit log includes the file identifier, the type of dates audited and the findings for each file (rationale for inappropriate documentation or inappropriate updates)

5) The number or percentage and total number or percentage of inappropriate findings by date and type.

6) Any NCQA reportable events will be reported to NCQA as the standards require.

9. **Qualitative Analysis**

The Care Management Manager will annually provide a Qualitative Analysis of each instance of inappropriate documentation and update identified in the audit under 8.e to determine the cause. The analysis report will include the title of the UM staff involved in the qualitative analysis and the cause of each finding.

10. **Improvement Actions:**

a. The Care Management Manager will present the Audit and Analysis reports listed above to CSQC annually to obtain feedback on determining areas of improvement.

b. The Care Management Manager will present the completed Audit and Analysis reports to the UM staff. The Manager and UM Team will develop and implement a corrective action plan to address any issues identified during the audit.

c. GHC will monitor effectiveness of corrective actions on all findings by repeating an audit within 6 months of annual audit by randomly selecting a sample of 5% or 50 files from all UM denial decisions (based on the denial decision notification date) since the last annual audit.

d. Continuing education for UM staff will be provided addressing the discrepancies found during the auditing process.

e. Care Management staff are trained annually according to the *Annual Competency Training for Care Management* plan. See Appendix A.

f. Employees found to be repeatedly inappropriately documenting despite ongoing training will be counseled according to the GHC employee disciplinary policy up to and including termination.

g. Incidents of fraud will be reported to the Care Management Manager and the FWA Department.

h. Incidents of system wide fraud will be reported to NCQA

Delegation of UM

Group-Health-Cooperative of South-Central Wisconsin began delegating to PRIME Rx Management, LLC, UM functions specific to the prior authorization of specialty medical pharmaceuticals in 2018. A formal written delegation agreement and any amendments made delineate which activities have been delegated and includes the responsibilities for both GHC-SCW and PRIME as defined under the NCQA standards for Delegation of UM.

PRIME Rx Management LLC has its own policies and procedures for systems controls specific to UM pharmacy denial notification and receipt dates and is required to share with GHC-SCW a description of the security controls they have in place to protect data from unauthorized modifications and the methods they use to monitor compliance. GHC-SCW annually reviews PRIME's' UM Program and monitors their system security controls to ensure compliance is consistent with the delegation agreement or with their policies.

Prime Rx Management provides semiannual reports demonstrating the effectiveness of the agreement. Prior authorization statistics, rebated opportunities and customer response rates are reviewed during quarterly meetings with Prime personnel. Specific information provided quarterly includes

- Number of UM cases handled by type (preservice, urgent concurrent or post service)
- Number of denials issued.
- Number of denials appealed.

GHC Pharmacy Admin and Care Management Manager meet semi-monthly for one hour to discuss concerns and issues, which creates a collaborative space where timely feedback to both teams is encouraged. Member concerns are brought up during these meetings. Additionally, the Prime team is available by email or phone to address any member experience concerns as they arise.

PRIME Rx Management, LLC became NCQA Accredited in Utilization Management as of October 2019 and is responsible for maintaining their Accredited status with respect to the agreement or amendments made with GHC-SCW.

GHC-SCW delegates to Navitus Health Solutions LLC, the responsibility to provide pharmaceutical safety notifications related to drug recalls or withdrawals from the market per FDA notice pursuant to GHC-SCWs Pharmaceutical Management policy and the NCQA UM Element "Pharmaceutical Patient Safety Issues." Navitus is also NCQA Accredited in Utilization Management.

Quality of Care Issues

Care Management (CM) staff monitor, identify, document, and report potential quality of care issues to the Associate Medical Director and Medical Staff Administrator. These issues are referred to as Adverse Events and include issues related to medical and behavioral health care and services provided to members.

1. An Adverse Event is an untoward event with a less-than-optimal outcome.
2. CM staff report on the following adverse events for potential evaluation by the CMO or Associate Medical Director under policy CM.ADM. 018
    a. Unplanned hospital readmission within 10 days
    b. Unplanned return to the operating room during the same hospital admission
    c. Unexplained in-hospital deaths
    d. Trauma or injury suffered while in a healthcare facility/practitioner office/HMO site

e. Surgery on a wrong body part
f. Surgery on wrong patient
g. Loss of function not related to illness or condition
h. Rape in 24-hour care facility
i. Suicide in 24-hour care facility
j. Infant abduction or discharge to wrong family
k. Hemolytic transfusion reaction related to wrong blood type of incompatible blood products

3. The log of Adverse Events and Quality of Care concerns will be reviewed every 6 months by the Chief Medical Officer. If a trend is identified, the Chief Medical Officer will create a separate report and/or memo (as appropriate) which will be provided to the Director of Quality and Population Health and noted in the tracking log