

Introduction: Utilization management is determined by the relationship of the contracted group to the Midlands Choice network. In April 2002, Midlands Choice contracted with ENCOMPASS to manage and coordinate utilization management for those contracted groups electing utilization management through Midlands Choice. Other contracted groups receive utilization management services through utilization management organizations most usually affiliated with the group's claims administrator (payer). Contact information for the entity providing utilization management is contained on the member's identification card. The Utilization Management Plan described below refers to the Midlands Choice Plan managed by ENCOMPASS.

1. Objectives: The primary objectives of the Utilization Management Plan are:

- a. To provide a monitoring system to determine that medical and hospital services are delivered at the appropriate level of care in a timely, effective, and cost-effective manner, to examine and improve the quality of medical care, and to evaluate practice patterns of health care delivery.
- b. To work with physicians, practitioners, hospitals, facilities, contracting groups, and patients regarding delivery of medical and hospital services in a timely, efficient, and cost-effective manner.

2. Policy: Utilization Management review determinations will be based on medical necessity and appropriateness. ENCOMPASS' nurse reviewers and physician consultants will complete utilization management determinations. ENCOMPASS Utilization Management Program is accredited by URAC and adheres to all applicable utilization review state and federal regulations.

3. Responsibilities:

a. ENCOMPASS: ENCOMPASS will provide support for the overall program of utilization and quality management including:

- i. Carrying out a program of utilization and quality management and evaluating the effectiveness of such management.
- ii. Selecting, monitoring, and evaluating criteria to be used in the evaluation of appropriate utilization.
- iii. Providing input into the selection, credentialing, training, monitoring, and evaluation of physicians to serve as physician consultants.
- iv. Reviewing and reconsidering individual cases according to accreditation standards and applicable state law.
- v. Participating in and monitoring the appeal process.

b. Physician Consultants: ENCOMPASS credentials physician consultants of sufficient specialties and certifications to serve as physician advisers. Physician consultants provide an objective review of cases referred to them by nurse reviewers, and make recommendations based on medical necessity and appropriateness. The Quality Management staff will evaluate the quality of medical reviews and evaluate any complaints related to the medical review process or Physician Consultants.

c. Director, Utilization Management Services: The Director of Utilization Management Services is responsible for overall management of the Utilization Review program including:

- i. Carrying out a program of Utilization Management through this Plan consistent with accreditation standards and applicable state and federal regulations.
- ii. Monitoring the reviews performed by the ENCOMPASS staff.
- iii. Establishing policy related to utilization management, and monitoring quality of the utilization management program.
- iv. Monitoring Physician Consultant referrals for compliance with policy.

d. Attending/Treating Physician or Practitioner: The attending/treating physician or practitioner is required to participate in and cooperate with ENCOMPASS in carrying out the Utilization Review Plan. This includes:

- i. Obtaining certification for hospital and medical services and treatments when required by the Utilization Plan, the Provider Office Manual, or the Benefit Plan.
- ii. Submitting timely, accurate, and complete medical records.
- iii. Participating in and complying with the utilization management and case management program procedures employed by ENCOMPASS as contained in this Plan and the Provider Office Manual.

4. Criteria: ENCOMPASS nurse reviewers use criteria to evaluate medical necessity. Cases that do not meet criteria are referred to an ENCOMPASS physician consultant. The ENCOMPASS physician consultant uses his or her professional expertise in evaluating the medical necessity of the specific case and patient needs. Only an ENCOMPASS physician consultant can make an adverse recommendation.

5. Utilization Review Procedures: All cases subject to review will be evaluated for medical necessity, appropriateness, timeliness of services, and level of care, as determined by the contracted group's health plan. Cases subject to review are dependent upon benefit plan design, but may include inpatient admissions, outpatient procedures, or other services, as the utilization management contract specifies.

- a. Procedure Review** - It is the policy of ENCOMPASS to perform procedure review for certain operations and diagnostic tests. The review determines

whether the requested service is medically necessary and delivered in the most appropriate setting. This is completed within the time frames specified by AAHC/URAC and state laws.

- b. Prospective Review** - It is the policy of ENCOMPASS to perform prospective or pre-service medical necessity reviews prior to an admission or proposed service. The review determines whether an admission or service is medically necessary and delivered in the most appropriate setting. This is completed within the time frames specified by AAHC/URAC and state laws.
- c. Concurrent Review** - It is the policy of ENCOMPASS to conduct concurrent medical necessity review after the patient/worker has been admitted to the hospital but prior to discharge or after medical services have been initiated but have not been completed. The review determines whether an admission or service is medically necessary and delivered in the most appropriate setting. This is completed within the time frames specified by AAHC/URAC and state laws.
- d. Continued Stay Review**- It is the policy of ENCOMPASS to conduct continued stay reviews (CSR) after the initial admission certification is completed. They are performed during the hospitalization to ensure the patient continues to meet medical necessity criteria and services continue to be delivered in the most appropriate setting. This is completed within the time frames specified by AAHC/URAC and state laws.
- e. Retrospective Review** - It is the policy of ENCOMPASS to conduct retrospective (also known as post service) medical necessity review when the initial notification occurs after the patient has been discharged or the services have been completed. The review determines if the admission/continued stay or services were medically necessary and whether care was delivered in the most appropriate setting. This is completed within the time frames specified by AAHC/URAC and state laws.

6. Request for Certification

- a. Responsibility for Obtaining Precertification.** It is preferable that the provider, whether physician office or hospital, complete precertification because of the medical and other information that needs to be provided to complete the process. However, the physician office, hospital, subscriber/patient and/or the patient's representative may initiate the precertification process with ENCOMPASS. The physician or hospital and subscriber/patient should consult to determine which party will be responsible to meet utilization review precertification obligations under the applicable medical plan. Penalties that may arise for failure to obtain precertification shall be the responsibility of the patient.
- b. Timing.** In general, requests for certification should be made a minimum of three working days prior to admission for routine or elective admissions. In the case of a medical emergency, notice should be given in advance of

admission where possible, or otherwise as soon as possible after admission, but in no event later than two working days after admissions.

7. Information Requested to Conduct Review. In performing reviews, ENCOMPASS will collect only the information necessary to conduct the review. Generally, this will not include a review of the medical record, but will be done with information submitted by the patient and the attending or treating physician.

8. Appeal Procedures. The patient/subscriber, worker/worker representative, attending physician, and/or facility or other health care provider may request an appeal. Clinical review is conducted by appropriate clinical peers who were not involved in physician review, when a decision not to certify a requested admission, procedure, or service has been appealed.

a. Urgent Appeal means an expedited appeal of a non-certification in a case involving urgent care. The urgent appeal recommendation and verbal/written notification will be made as soon as possible but in no case later than 72 hours after the receipt of an appeal request. This appeal can be performed telephonically.

b. Non-Urgent Appeal means an appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. ENCOMPASS allows at least 180 calendar days for the non-urgent appeals to be requested after the receipt of a non-certification notice. The non-urgent appeal can be initiated verbally or in writing. The non-urgent appeal recommendation and verbal/written notification will be made as soon as possible but in no case later than:

- 15 calendar days for Pre-Service reviews, and
- 30 calendar days for Post-Service Reviews.

c. Appeal Notification of Recommendation (i.e. appeal upheld, appeal modified or appeal reversed) must be sent for written notification. Written notification will be mailed in the timeframes stated previously. A second level of appeal should be requested through the contracted group's health plan.

9. Charges to Patients. Services to Plan Patients may be classified as non-covered because the group's health plan does not cover the services or because the patient's health plan has determined the services are non-covered as a result of their agreement with the medical management recommendation made by ENCOMPASS.

a. Plan Patients who choose to receive services not covered by their group's plan are liable for the cost of those services, and the Plan Provider may bill and collect from Plan Patients for those services.

b. When the Plan Patient has been notified in writing before the services are rendered that ENCOMPASS has recommended denial of services due to lack of medical necessity, and the Plan Patient obtains those services, the Plan Patient is

liable for the cost of those services, and the Plan Provider may bill and collect from the Plan Patient for those services.

c. In the case of continued inpatient stay review, when more than 24 hours has elapsed since the notice in writing to the Plan Patient that ENCOMPASS has issued a denial recommendation, and the Plan Patient continues to elect to receive inpatient stay services, the Plan Patient is liable for the cost of those services, and the Plan Provider may bill and collect from the Plan Patient for those services.

10. Review Hours: It is the policy of ENCOMPASS to provide a toll free telephone service for patients, providers and facilities to access services 24 hours a days, seven days a week. ENCOMPASS staff are available to accept review requests and clinical information during normal business hours in each time zone in which ENCOMPASS does at least two percent of its business. Normal hours of operation are Monday through Friday from 8:00 a.m. through 5:00 p.m. Central Time, excluding holidays. Telephone messaging is in place to receive calls after hours with follow-up the next business day.

11. Confidentiality.

a. Medical Records. All medical records will be kept confidential in accordance with applicable state and federal laws. ENCOMPASS will maintain compliance with applicable federal and state laws governing utilization review programs.

b. Utilization Management Information and Proceedings. All information and data collected, developed, or evaluated will be kept confidential and not be disclosed except as required to be disclosed under applicable law or in an appeal of the benefit determination.

12. Quality Assessment of Utilization Review Plan. ENCOMPASS shall maintain an ongoing program for assessment of the quality of reviews undertaken as a part of the Utilization Management Plan.