HERITAGE PROVIDER NETWORK
&
AFFILIATED MEDICAL GROUPS

UTILIZATION MANAGEMENT (UM) PROGRAM

2023

Approval Signature

02/27/23

Dr. Michael Wettstein, HVVMG Committee Chair Date

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INTRODUCTION

Heritage Provider Network, Inc.'s (HPN's) Utilization Management (UM) Program provides the structure and standards that govern utilization management functions of HPN & its affiliated Medical Groups. In addition, the Program provides a structure to monitor the efficiency and quality of UM services and includes components to ensure the delivery of quality health care and the coordination of resources to manage members across all aspects of the care delivery system. The UM Program, in conjunction with HPN's policies and procedures, are designed to meet or exceed federal, state, and accreditation requirements including those from the Department of Health Care Services (DHCS), the Centers for Medicare and Medicaid Services (CMS), the Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA).

UM 1: UTILIZATION MANAGEMENT PROGRAM STRUCTURE

HPN and its affiliates have the infrastructure necessary to provide ongoing monitoring and evaluation of utilization management activities of non-behavioral, behavioral, and pharmacy services as part of the medical benefit (where delegated), address over- and under-utilization, coordinate medical resources, support continuum-based care management activities, and maintain a systematic process for the education of HPN and its affiliates' staff and providers regarding UM. HPN and its affiliates will make utilization decisions affecting the health care of its members in a fair, impartial and consistent manner that is aligned with individual member needs.

HPN affiliates are defined as follows:

An affiliate is a subsidiary medical group with operations under the control and oversight by the larger corporation, namely Heritage Provider Network.

Program Structure

Governing Body

HPN's Executive Committee shall have ultimate authority and responsibility for the UM Program. The Executive Committee will establish and maintain an effective and efficient UM Program and will ensure that each of its affiliates receives and complies with all aspects of the Program. The structure and responsibilities of the Executive Committee are outlined in the Executive Committee Charter and made available to its committee members.

Utilization Management Committee

HPN's Utilization Management Committee (UMC) reports to the Executive Committee at least semi-annually. Any ad-hoc committees or sub-committees of the UMC will report to the Executive Committee via the UMC.

The UMC will meet at least four times per year to review, evaluate, and provide the Executive Committee with any recommendations for revisions to the UM Program. For urgent issues that require immediate updating, these will be addressed separately via ad-hoc committee meetings (either virtual or in person), utilizing appropriate practitioners (three (3) physicians across primary care and/or specialties) and/or sub-committee members.

Minutes and records are kept of all activities for which the UMC is responsible and are considered confidential. Such materials may be made available as required to appropriate staff or representatives from contracted health plans, regulators, or accrediting agencies. Each attendee, including guests, at each UMC meeting will sign confidentiality and conflict of interest statements.

The composition of the UMC shall include but is not limited to:

1. HPN's designated senior-level physician
2. Designated senior-level physicians from each affiliate
3. Designated behavioral health care practitioner(s) from HPN and/or affiliate(s)

Additional personnel from HPN and its affiliates may participate in the UMC as determined to be appropriate but are not considered voting members of the UMC. Health plan representatives may participate within areas that apply to individual health plans, upon invitation, at the individual affiliate level.

The responsibilities of the UMC shall include but are not limited to:

1. Overseeing the appropriateness of health care delivery and member and provider satisfaction with the UM Program
2. Reviewing, revising, and approving the UM Program and policies and procedures annually or more frequently as needed
3. Evaluating affiliates' UM activities to ensure they are being conducted in accordance with HPN's expectations and regulatory, accreditation, and policy standards
4. Reviewing regular reports from affiliates, which may include but are not limited to:
    a. Over-utilization
    b. Under-utilization
    c. Volumes and dispositions of authorization requests
    d. Behavioral healthcare
    e. Hospitalizations and other inpatient admissions
    f. Case management
    g. Emergency room, ambulance, and urgent care usage
5. Identifying opportunities for quality improvement

Designated Senior-Level Physician

HPN and each affiliate shall designate a senior-level physician (medical director, associate medical director, or equivalent) who holds an unrestricted license to practice medicine in the state of California issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act[1]. These individuals hold responsibility for implementation, supervision, and oversight of the UM Program as well as being involved in UM activities, setting and adhering to UM policies, supervising program operations, reviewing UM cases, participating on the UMC, and evaluating the overall effectiveness of the UM Program.

Senior-level physicians shall ensure that the process by which affiliates review and approve, modify, or deny requests prior to, retrospectively, or concurrent with the provision of health care services to members, based in whole or in part on medical necessity or on benefit coverage, complies with regulatory, accreditation, and policy requirements.

[1] California Health and Safety Code §1367.01(c)

Designated Behavioral Health Care Practitioner
HPN will designate a behavioral healthcare practitioner to implement and evaluate the behavioral health aspects of the UM Program. This individual must be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, or participating practitioner from the organization. HPN's affiliates may utilize HPN's designated behavioral health care practitioner or may contract with a vendor or provider meeting similar requirements.

The designated behavioral health care practitioner holds responsibility for setting and adhering to UM behavioral healthcare policies, reviewing UM behavioral healthcare cases, and participating on the UMC.

HPN's Affiliate UM Departments
HPN's affiliates will designate clinical (including licensed physicians and nurses) and non-clinical staff in their UM departments to execute UM activities. The affiliates' designated senior-level physicians (described above) shall provide primary oversight of the affiliates' UM Departments.

Affiliates' UM Departments are responsible for executing functions within the scope of HPN's UM Program, including but not limited to reviewing requests for authorization prior to, retrospectively, or concurrent with the provision of health care services to members in accordance with turn-around time requirements as outlined in policy.

The HPN UM Program will be a resource to affiliates to ensure compliance with the applicable regulatory and accreditation standards. HPN will distribute the approved UM Program and relevant policies and procedures to its affiliates to be implemented as directed by HPN's UMC and overseen by HPN's and each affiliate's designated senior-level physicians. Affiliates are responsible for distributing the UM Program to their staff and contracted providers at least annually to ensure that all are advised of utilization management requirements and processes. Each affiliate's designated senior-level physician will ensure that HPN's policies and procedures are reviewed and adopted and that all clinical and non-clinical staff responsible for UM activities are educated on the most current Program, policies, and procedures.

UM Staff's Assigned Activities
Non-clinical staff are responsible for intake and data entry of UM requests, evaluating member's eligibility and benefits, coordinating requests for additional information, routing requests to clinical reviewers, and coordinating delivery of notifications. Non-clinical personnel may have the authority to approve services that do not require prior authorization, do not require medical necessity review or where there are explicit criteria. Non-clinical personnel may also issue carve out and health plan responsibility notices, and make denial determinations when the decision is not based in whole or in part on medical necessity, such as eligibility denials.

Clinical staff are responsible for reviewing requests, researching and attaching clinical criteria, and may include relevant facts regarding whether or not requests meet medical necessity criteria. Clinical staff may have the authority to approve services that do not require prior authorization, do not require medical necessity review or when the service meets medical necessity criteria. Clinical personnel may also issue carve out and health plan responsibility notices, and make denial determinations when the decision is not based in whole or in part on medical necessity, such as

eligibility denials.

UM Staff Who Have the Authority to Deny Coverage

Non-licensed personnel may have the authority to approve but not to deny (or modify) requests based on medical necessity for items or services where there are explicit criteria. Decisions to deny (or modify) requests based in whole or in part on medical necessity will be made by a qualified physician, behavioral health provider, dentist, pharmacist, or other appropriate professional (as described further under UM 4: Appropriate Professionals) with a current California license who is competent to evaluate the specific clinical issues involved.

Affiliates may utilize contracted health care professionals and specialists to assist with clinical reviews and/or recommendations, but may not delegate or sub-delegate UM activities to any other entity.

Each affiliate will maintain a current UM department organizational chart and staffing plan identifying all key UM positions, decision makers, and department/staff oversight roles.

Each affiliate will have a process for assigning a licensed Care Manager to each CMC & SNP Enrollee. Assignment will be made to a Care Manager with the appropriate experience and qualifications based on a member's assigned risk level and individual needs. Affiliates shall ensure an adequate ratio of licensed Care Managers to Members to provide Care Coordination as required. Affiliates will monitor the ratio of licensed Care Managers to Members on a regular basis.

Services Requiring or Not Requiring Authorization

Affiliates will provide education to contracted providers and staff on services which require authorization as part of the UM process, such as:

1. Ambulatory Care
2. Inpatient Services
3. Skilled Nursing Facility Services
4. Home Health Care
5. Rehabilitative Services (such as physical, occupational and speech therapies)
6. Physician-administered drugs
7. Durable Medical Equipment and/or Supplies

This also includes distributing and educating staff and contracted providers regarding requests for services that do not require authorization but may be entered into the UM system for tracking purposes and care coordination. Such services may include but are not limited to the following, subject to the applicable line of business and network status of the treating provider:

1. Emergency Services
2. Family Planning
3. Sensitive Services and confidential service treatment (including those related to Sexual Assault or Sexually Transmitted Disease)
4. Preventive Services (including immunizations)
5. Basic Pre-Natal Care
6. HIV Testing/Counseling
7. Direct Access to Women's Health
8. Language Assistance Program/Interpretation Services

9. Health Education
10. Non-Facility Based Behavioral Health (including Mental Health Counseling and Drug and Alcohol Abuse Treatment)
11. Medi-Cal Carve Out Programs such as Long Term Services and Supports (LTSS), In-Home Supportive Services (IHSS), and Community-Based Adult Services (CBAS)
12. Urgent Care Services
13. Tobacco Cessation
14. Biomarker Testing for Food and Drug Administration (FDA)-Approved Therapy for Advanced or Metastatic Cancer

Appeals

HPN and its affiliates are not delegated for processing, rendering determinations on, or providing notification regarding appeals; however, policies and procedures are in place to assist contracted health plans with their efforts to process appeals in an appropriate and timely manner. Specifically, HPN's appeals policies and procedures provide for the following:

1. Issuance of denial, delay, and modification notices to providers and members that give a description of the applicable appeal rights and the instructions to submit a verbal or written appeal, including an expedited appeal if applicable, to the health plan.
2. Coordination with the health plan by immediately forwarding requests for appeals to the health plan.
3. Responding to inquiries from the health plan regarding initial decisions which have been appealed.
4. Continuation of coverage for the member, when applicable, pending the outcome of the appeal.
5. Effectuation of any overturned appeals from the health plan or any relevant higher level entity such as the Independent Review Organization (IRO).
6. In the event that in the future HPN accepts delegation of appeals, the appropriate policies and procedures are in place to ensure appropriate handling.

Oversight of appeal-related activities is the responsibility of HPN's Quality Improvement (QI) Program.

Processes and Information Sources for Determining Benefit Coverage and Medical Necessity

Consistent with HPN's policies and procedures, affiliates will utilize the regulatory requirements, contracted health plans' evidence of coverage and benefit limitations as well as approved clinical criteria, medical review guidelines, and policies in determining the appropriateness of services being requested. Affiliates may also adopt business rules for automatically approving requests or allowing non-licensed staff to approve requests without medical necessity review.

HPN and its affiliates do not develop their own clinical criteria or medical policies; however, HPN's policies and procedures define the hierarchy of criteria to be utilized by affiliates in rendering UM determinations based on regulatory and health plan-prescribed requirements. As part of this hierarchy, HPN reviews and approves the evidence-based criteria and resources to be used, as described further under UM 2: Clinical Criteria for UM Decisions.

Medical Necessity Review

Medical necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies. Medical necessity review requires that denial decisions be made only by an appropriate clinical professional. HPN's policies and procedures outline the applicable definitions of medical necessity.

Decisions about the following require medical necessity review:

1. Any covered medical benefits defined by the contracted health plan's Certificate of Coverage or Summary of Benefits, including but not limited to.
    a. Dental and vision services covered under medical benefits, including dental care or services associated with procedures that occur within or adjacent to the oral cavity or sinuses.
        i. If medical and dental benefits are not differentiated in the health plan's benefits, requests for care or services associated with dental procedures that occur within or adjacent to the oral cavity or sinuses are included in medical necessity review.
    b. Pharmaceuticals covered under medical benefits or, if delegated by the plan, covered under pharmacy benefits.
2. Pre-existing conditions when the contracted health plan has a policy to deny coverage for care or services related to pre-existing conditions.
3. Care or services whose coverage depends on specific circumstances.
4. Out-of-network services that are only covered in clinically appropriate situations.
5. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program, if delegated to make the determination.
6. "Experimental" or "investigational" requests covered by the contracted health plan, if delegated to make the determination.

Decisions about the following do not require medical necessity review:

1. Services in the member's benefits plan that are limited by number, duration, or frequency;
2. Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan;
3. Care or services whose coverage does not depend on any circumstances; and
4. Requests for personal care services, such as cooking, grooming, transportation, cleaning, and assistance with other activities of daily living (ADLs).
5. "Experimental" or "investigational" requests that are always excluded and never covered under any circumstances. If delegated by the contracted health plan to make these determinations, the affiliate will either:
    a. Identify the specific service or procedure excluded from the benefits plan, ***or***
    b. If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, notify the member that they have the opportunity to request information on excluded services or procedures based on the contracted health plans' internal policies or criteria for these services or procedures.

If the affiliates make an exception to authorize a service, grant an extension of benefits, or make an

exception to a limitation in the health plan's benefits plan (e.g., up to 20 visits are covered but the affiliate allows 21 visits), a subsequent denial of the same service or a request for an extension or exception is considered a medical necessity determination.

Medical Necessity Review of Requests for Out-of-Network Coverage
Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the contracted health plan's Certificate of Coverage or Summary of Benefits specifies that an out-of-network service is never covered for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

Behavioral Health Care

Where delegated, affiliates will process requests for behavioral health services utilizing processes aligned with those for non-behavioral health services, unless otherwise specified within HPN's UM Program or policies and procedures. So long as the member has appropriate eligibility/benefits at the time of service, affiliates do not deny requests for in-network, outpatient behavioral health consultations or ongoing in-network outpatient follow-up care. Affiliates will ensure coordination across the member's medical and behavioral health care services by sharing information/records across the member's practitioners, where documentation is obtained permitting the affiliate to do so.

Requests for specialty outpatient behavioral health care services and inpatient behavioral health care services will undergo medical necessity review by qualified professionals. Behavioral health care denials based in whole or in part on medical necessity will be reviewed by an appropriate reviewer as described under UM 4: Appropriate Professionals.

Triage and Referral
Triage and Referral (T&R) functions for behavioral healthcare services are provided via direct access or direct referral by a primary care physician, specialist, or medical group staff to the affiliate's behavioral health providers. Affiliates' staff provide information about the BH practitioners but do not make judgements regarding the needed level of care or type of practitioner the member should see.

Program Evaluation

HPN's UMC will continually evaluate the UM Program through ongoing reporting as well as UM Work Plans to be developed and submitted by each affiliate. The affiliates' UM Work Plans will document goals, objectives, areas of focus, planned monitoring, and action steps to be taken to ensure the appropriateness of UM activities and enable HPN to oversee such activities.

On no less than an annual basis, HPN will evaluate the UM Program to ensure that it remains current

and appropriate, including but not limited to assessment of:

1. Program structure
2. Program scope, processes, and information sources used to determine benefit coverage and medical necessity
3. The level of involvement of designated senior level physician(s) and designated behavioral healthcare practitioner(s) in the UM Program

HPN will also consider member and practitioner experience data when evaluating its UM Program, utilizing surveys from each affiliate designed to measure satisfaction and document positive and negative experiences of members and providers.

As areas for improvement are identified, HPN will make revisions to its Program, policies, or procedures and will undertake corrective action and follow-up on improvement opportunities with its affiliates.

Role in Quality Improvement Program

HPN recognizes the importance of collaboration between its UM and Quality functions to ensure that services delivered to members are high quality, appropriate, cost-effective, efficient, and accessible. To this end, HPN's QI Program has an infrastructure for ongoing monitoring of UM activities to ensure established metrics are met and to identify any improvement opportunities. HPN's UMC will collaborate with its Quality Improvement Committee (QIC) to:

1. Identify areas which overlap both UM and quality
2. Collectively monitor and evaluate identified areas on an ongoing basis through reporting from affiliates
3. Take action to resolve areas of concern and address opportunities for improvement

UM information to support QI activities may be collected through materials reported to the UMC, reports generated for other internal or external oversight activities, or direct analysis of UM data. Specific requests for UM information needed for QI Program activities may also be made and will be fulfilled by HPN or its affiliates as part the ongoing collaboration between the UM and QI Programs. Staff responsible for QI Program activities will leverage the UM information provided to compare performance to established metrics and benchmarks, perform additional investigation, where needed, and identify potential opportunities for improvement.

Activities undertaken by the UMC and QIC will be documented within the respective committees' meeting minutes. Additional reporting to the affiliates or to HPN's Executive Committee will be performed as determined to be appropriate.

UM 2: CLINICAL CRITERIA FOR UM DECISIONS

HPN uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria. Affiliates employ HPN's policies and procedures in applying objective and evidence-based criteria in evaluating the necessity of medical, behavioral healthcare, and pharmaceutical services requested. Criteria are applied taking into account individual circumstances and member needs (such as age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment) as well as an assessment of

local delivery systems and the ability of such systems to meet members' specific needs, including but not limited to:

- Availability of inpatient, outpatient, and transitional facilities
- Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of skilled nursing facilities, subacute care facilities, or home care in the affiliates' service areas to support members after hospital discharge
- Local hospitals' ability to provide all recommended services within the estimated length of stay

The approved and adopted clinical guidelines, criteria, or medical policies will be applied in accordance with HPN's approved policies and procedures on Utilization Management Review Criteria, which also defines the hierarchy under which criteria will be applied. Criteria to be considered when making UM determinations may include but are not limited to plan eligibility and coverage (benefit plan package), CMS criteria when applicable (National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs), Medicare Benefit Policy Manuals), state regulations, health plan criteria (e.g., coverage summaries, medical policies), and evidence-based criteria (e.g., MCG, InterQual

Annual Review of Criteria

Materials are reviewed, approved, and/or updated as needed but no less than annually. Appropriate practitioners with clinical expertise in the applicable areas, including practitioners on staff and participants in the network, are involved in the review, and adoption of criteria, as well as on instructions for applying criteria. Criteria comply with the applicable regulatory requirements for the given line of business, are reviewed against current clinical and medical evidence, and reflect new scientific evidence, as appropriate. If new scientific evidence is not available, a designated group may determine if further review of a criterion is necessary.

Upon final approval, all materials are made available to UM staff and practitioners in writing either by mail, fax, or e-mail or on the affiliates' websites according to standard communication/ dissemination processes.

Availability of Criteria

Upon request, HPN and its affiliates will make available all criteria, clinical review guidelines, and medical review policies utilized for decision making to members and practitioners, and to the public upon request. Communication methods with practitioners, members, and caregivers may include: in person, in writing by mail or by fax, by telephone, by electronic communication (e.g., email or voicemail message), or by TDD/TYY services for deaf, hard of hearing, or speech-impaired members. Criteria will be mailed to providers and members who do not have fax, email or internet access. Providing the criterion, or an excerpt specific to the denial reason with the denial notification is also acceptable.

Consistency in Applying Criteria

Affiliates will evaluate the consistency with which physician and non-physician reviewers apply UM criteria in decision making and will perform inter-rater reliability (IRR) audits at least annually as outlined within HPN's policies and procedures on UM Inter-Rater Reliability. Results of the IRR reviews will be presented to the affiliate's UMC for review and discussion within their organization, as well as to HPN's UMC. HPN and its affiliates will act on opportunities to improve consistency in applying criteria, and will monitor improvement activities undertaken.

HPN evaluates the consistency with which physician and non-physician reviewers apply UM criteria, and evaluates inter-rater reliability:

- Using hypothetical UM test cases, or
- Using a sample of UM determination files.
    - If using a sample of UM determination files, one of the following auditing methods will be used:
        - 5 percent or 50 of its UM determination files, whichever is fewer;
        - NCQA "8/30 methodology;" or
        - Another statistically valid method.

UM 3: COMMUNICATION SERVICES

Affiliates will provide members and practitioners seeking information about the UM process and the authorization of care with access to staff in accordance with HPN's policies and procedures on the Availability of UM Staff. Affiliates will ensure the following:

1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
2. Staff are available to receive inbound communication regarding UM issues after normal business hours, using appropriate communication methods including but not limited to telephone, email, or fax.
    a. Communications received after normal business hours are returned on the next business day and communications received after midnight on Monday-Friday are responded to on the same business day.
3. Staff identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.
4. Telecommunications device for the deaf (TDD) or teletypewriter (TTY) services are available for deaf, hard of hearing, or speech-impaired members. A separate phone number will be provided for receiving TDD/TYY messages or the state/711 Relay service will be utilized.
5. Language assistance is available for members to discuss UM issues during normal business hours, free of charge.

Member services staff may triage communications to UM staff. Communication services and availability will be posted on each affiliate's website, as well as included in HPN's Provider Manual and other materials as applicable.

In accordance with HPN's privacy and information security policies and procedures as well as all state and federal regulations regarding use and disclosure of protected health information (PHI), HPN and affiliates' staff and practitioners with access to patient information must maintain the confidentiality of member information and records in the course of any written, verbal, or electronic

communications.

UM 4: APPROPRIATE PROFESSIONALS

HPN requires that appropriately licensed professionals supervise all medical necessity decisions. Licensed health care professionals will supervise UM activities by:

1. Providing day-to-day supervision of assigned UM staff;
2. Participating in staff training;
3. Monitoring for consistent application of UM criteria by UM staff, specific to each level and type of UM decision;
4. Monitoring staff documentation for adequacy; and
5. Being available to UM staff on site or by telephone.

Licensed health care professionals will be used to make UM decisions that require clinical judgement. In addition to auto-approvals based on defined business rules as outlined within HPN's policies and procedures, the following staff may approve services:

1. Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are business rules allowing approval without medical necessity review, or explicit UM criteria and no clinical judgement is required.
2. Licensed health care professionals.

Written job descriptions will be maintained by affiliates with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:

1. Education, training, or professional experience in medical or clinical practice.
2. A current clinical license to practice.

The following practitioner types are considered appropriate for review of the specified UM denial decisions based in whole or in part on the medical necessity of the requested service:

1. *Physicians, all types*: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, and vision denials.
2. *Nurse practitioners (within the scope of their license)*: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, and vision denials.
3. *Doctoral-level clinical psychologists or certified addiction-medicine specialists*: Behavioral healthcare denials.
4. *Pharmacists*: Pharmaceutical denials.
5. *Dentists*: Dental denials.
6. *Chiropractors*: Chiropractic denials.
7. *Physical therapists*: Physical therapy denials.
8. *Doctoral-level board-certified behavioral analysts*: Applied behavioral analysis denials.

Documentation of the appropriate professional responsible for the denial will be maintained via either:

1. The reviewer's handwritten signature or initials;
2. The reviewer's unique electronic signature or identifier on the denial letter or on the notation of denial in the file; or
3. A signed or initialed note from a UM staff person, attributing the denial decision to the

professional who reviewed and decided the case.

Board-certified consultants will be used to assist in making medical necessity determinations, as appropriate, in accordance with HPN's policies and procedures on Board-Certified Consultants for UM Determinations.

UM 5: TIMELINESS OF UM DECISIONS

HPN affiliates will make determinations and issue notifications in a timely manner to accommodate the urgency of the member situation and in accordance with the timeliness standards applicable for each type of request and line of business (LOB) as outlined within HPN's policies and procedures on UM Turnaround Time (TAT) Standards. These policies and procedures are designed to meet all applicable regulatory and accreditation standards for pre-service, concurrent and post-service non-behavioral, behavioral healthcare, and pharmacy decisions and notifications. See HPN Policy & Procedure for detailed decision & notification TAT requirements.

Timeliness Reporting

HPN and its affiliates will monitor the timeliness of decision making and notification for all requests to calculate the percentage of decisions that adhere to the required timeframes for each type of request (e.g., urgent vs. non-urgent, pre-service vs. concurrent vs. post-service).

UM 6: CLINICAL INFORMATION

When making medical necessity determinations, HPN's affiliates use all information relevant to a member's care, obtaining relevant clinical information and consulting with treating practitioners as necessary prior to rendering a decision. Affiliates will make and document their attempts to gather the relevant clinical information to support UM decision making and may elect to take a delay/extension as permitted and applicable per HPN's policies and procedures. The relevance of clinical information is considered in terms of the criteria utilized to make the approval or denial decisions. Requests for clinical information are not intended to be burdensome and are intended to obtain the information necessary to evaluate the appropriateness of and the member's need for the requested care.

The clinical information which may be utilized to make UM determinations may include but is not limited to the following:

1. Office and hospital records
2. A history of the presenting problem
3. Diagnosis codes
4. Physical exam results
5. Diagnostic testing results
6. Treatment plans and progress notes
7. Patient psychosocial history
8. Information on consultations with the treating practitioner
9. Evaluations from other health care practitioners and providers
10. Operative and pathological reports
11. Rehabilitation evaluations

12. A printed copy of criteria related to the request
13. Information regarding benefits for services or procedures
14. Information regarding the local delivery system
15. Member characteristics and information
16. Information from family members

UM 7: DENIAL NOTICES

Affiliates will document and communicate the reasons for a denial (including modifications and delays/extensions where applicable) in accordance with HPN's policies and procedures. Members and practitioners are provided enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision. To this aim, denial notices are constructed based on the following criteria:

1. For denials resulting from medical necessity review, practitioners will be given the opportunity to discuss denial decisions with a physician or other appropriate reviewer either:
    a. In the denial notification;
    b. By telephone, which includes leaving a voicemail, if the organization documents the name of the individual at the organization who notified the treating practitioner or left the voicemail, and the date and time of the notification or voicemail; or
    c. In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.
2. Notifications of denials are provided to the member (or authorized representative) and/or the practitioner, orally, electronically, and/or in writing, based on the applicable regulatory and/or accreditation requirements for the given type of request, as outlined within HPN's policies and procedures on Provider and Member Notifications and UM Turnaround Time Standards.
3. All denial communications will include:
    a. A description of the service(s) being denied.
    b. A clear and concise explanation of the reasons for the denial decision that is specific to the member's diagnosis, condition or situation in easy to understand language, so that the member can understand the reason for denying the service. This includes a complete explanation of the grounds for the denial, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.
    c. A description of the benefit provision, criteria, or guideline used as a basis for the decision, the criterion referenced must be identifiable by name and must be specific to an organization or source. References to benefit documents must include the section title or page number.
    d. For denials resulting from medical necessity review of out-of-network requests, the reason for the denial must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the denial must address whether or not the requested service can be obtained within the organization's accessibility standards). The criteria reference may be excerpted from benefit documents that govern out-of-network coverage, health plan policies specifying circumstances where out-of-network coverage will be approved, or clinical criteria used to evaluate the

member's clinical need relative to available network providers and services. The reference must specifically support the rationale for the decision and must relate to the reason for the request.

e. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
f. Based on health plan-provided or approved denial notice templates, include:
    i. Information as to how the member may file a grievance/complaint with the health plan or external entity (e.g., applicable regulatory body) or how to request an administrative hearing and aid, pursuant to the applicable regulations;
    ii. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal and how to file an appeal with the health plan;
    iii. An explanation of the appeals process, including the right to member representation and appeal time frames;
    iv. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials, if the same process applies to standard and expedited appeals, there must be a description included in the letter that makes it clear that the process applies to both; and
    v. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
g. Additional inserts and attachments, as applicable and required.

4. For denials resulting from medical necessity review provider notification will include the name and direct telephone number of the health care professional responsible for the denial determination if the provider wishes to discuss the case.
    a. The practitioner may also be notified by telephone or in other materials of the opportunity to discuss a specific denial with the reviewer.
5. An alternative plan of care will be identified in the case of medical need issues.

The following information will be included in the denial file:

1. The denial notification, if the treating practitioner was notified of the opportunity to discuss a medical necessity denial in the denial notification.
2. The time and date of the notification and name of the individual at the organization, if the treating practitioner was notified of the opportunity to discuss a medical necessity denial by telephone.
    a. If the treating practitioner was notified by voicemail, the name of the individual who left the voicemail, and the date and time.
3. Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

UM 8: POLICIES FOR APPEALS

HPN and its affiliates are not delegated for processing, rendering determinations on, or providing notification regarding appeals; however, policies and procedures are in place to assist contracted health plans with their efforts to process appeals in an appropriate and timely manner. Specifically, HPN's process for handling appeals and making appeal determinations are outlined in the appeals

policies and procedures and provide for the following:

1. Issuance of denial, delay, and modification notices to providers and members that give a description of the applicable appeal rights and the instructions to submit a verbal or written appeal, including an expedited appeal if applicable, to the health plan.
2. Coordination with the health plan by immediately forwarding requests for appeals to the health plan.
3. Responding to inquiries from the health plan regarding initial decisions which have been appealed.
4. Continuation of coverage for the member, when applicable, pending the outcome of the appeal.
5. Effectuation of any overturned appeals from the health plan or any relevant higher level entity such as the Independent Review Organization (IRO).
6. In the event that in the future HPN accepts delegation of appeals, the appropriate policies and procedures are in place to ensure appropriate handling.

Oversight of appeal related activities is the responsibility of HPN's Quality Improvement (QI) Program.

UM 9: APPROPRIATE HANDLING OF APPEALS

HPN and its affiliates are not delegated for appeals but do have policies and procedures in place to support contracted health plans in their processing of appeals. In furtherance of those efforts, HPN's affiliates maintain documentation of any appeals received and forwarded to the health plan, copies of any appeals received from the health plan, and any activity taken as a result of the appeal (e.g., effectuation of overturned appeals). HPN's affiliates will also investigate appeals to evaluate the appropriateness of the initial determination and the care involved.

UM 10: EVALUATION OF NEW TECHNOLOGY

HPN and its affiliates are not delegated for this area, as HPN and its affiliates follow the benefit plans of contracted health plans.

UM 11: PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

HPN and its affiliates are not delegated for Procedures for Pharmaceutical Management.

UM 12: UM SYSTEM CONTROLS

HPN and its affiliates have controls in place to protect UM data from being altered outside of prescribed protocols. HPN affiliates follow HPN's policies and procedures regarding system controls specific to UM denial and appeal dates (when delegated); these policies and procedures specifically:

1. Define the date of receipt consistent with the applicable regulatory and/or accreditation requirements.
2. Define the date of written notification consistent with the applicable regulatory and/or accreditation requirements.
3. Describe the process for recording dates in systems.

4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.
5. Specify how systems track modified dates, including:
    a. What modification to a date was made;
    b. When the date was modified;
    c. The staff who made the modification; and
    d. Why the date was modified.
6. Describe system security controls in place to protect all UM system data from unauthorized modification, including processes for:
    a. Limiting physical access to the operating environment that houses UM data, including but not limited to, computer servers, hardware, and physical records and files;
    b. Preventing unauthorized access and changes to system data;
    c. Password-protecting electronic systems, including requirements to:
        i. Use strong passwords;
        ii. Avoid writing down passwords;
        iii. Create user IDs and passwords unique to each user; and
        iv. Change passwords when requested by staff or if passwords are compromised.
    d. Disabling or permanently removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.
7. Describe how HPN and its affiliates monitor compliance with its policies and procedures and the processes above and take appropriate action, when applicable.

At least annually, HPN and its affiliates monitor compliance with UM denial and appeal controls (when delegated), as described above, by:

1. Identifying all modifications to receipt and decision notification dates that did not meet policies and procedures for date modifications;
2. Qualitatively and quantitatively analyzing all instances of date modifications that did not meet policies and procedures for date modifications; and
3. Acting on all findings and implementing a quarterly monitoring process until improvement is demonstrated for a finding over three consecutive quarters.

UM 13: DELEGATION OF UM

HPN's affiliated Medical Groups are wholly owned and controlled. HPN develops all operational programs and policies to support its affiliates in executing upon all services as delegated by contracted health plans to HPN and its affiliates.