



Utilization Management Program 2019



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SECTION 1 OVERVIEW OF UTILIZATION MANAGEMENT

ACN Group of California, Inc. d/b/a, Optum Physical Health of California (“Optum”), licensed as a specialized health care services plan under the Knox-Keene Health Care Service Plan Act of 1975 (“Knox-Keene Act”), as amended, reviews care for the quality and/or appropriateness of interventions based upon documentation submitted by, or obtained through dialogue with the provider. Optum’s clinical submission process addresses the total treatment plan, including goals and objectives, number and type of services, active and passive care, and duration of treatment program. Treatment goals are considered an integral part of the member/enrollee’s treatment plan and are an essential component of documentation.

In general, utilization review occurs as the services are provided (concurrent), or after the services have been provided (retrospective). It is important to keep in mind that none of the programs or services managed by Optum California requires *pre-authorization* for the chiropractor or therapist (physical, occupational, and speech therapy) to provide the service. The Utilization Review process for the chiropractor or therapist (physical, occupational, and speech therapy) requires contracted providers to submit the Optum Patient Summary Form at the beginning of a treatment plan (generally within the first 10 days). Utilization review shall not be conducted more frequently than is reasonably required to assess whether the health care services under review meet plan benefit coverage criteria. Acupuncture providers are not subject to the clinical submission requirement at this time for Knox Keene business and/or clients

Prior to submission of the Patient Summary Form, and while the form is being processed, the provider is obligated to provide necessary services to the member/enrollee. The provider is responsible to document the medical necessity of services through the Optum clinical submission process. The member/enrollee may not be billed for Covered Services that have not been approved by Optum secondary to the Provider’s failure to follow Optum’s documentation requirements.

The Quality Management Improvement Committee (QMIC), in conjunction with the Senior Clinical Director, has oversight of the Utilization Management (UM) Program, process, guidelines, appeals and outcomes. The QMIC annually reviews and evaluates the UM Program and recommends revisions as necessary to ensure that utilization processes, guidelines, and initiatives are accurately described in the program and that goals and objectives are met. The QMIC is responsible for approving all policies enforced by UM.

The Chair of the UM Committee has responsibility for the oversight and implementation of the UM Program and for the management of support resources in conjunction with the Senior Clinical Director.

The scope of the Utilization Management Program consists of a continuum of processes associated with utilization management. These processes include the review of relevant UM metrics and data, actions taken as result of the review including the development of projects as deemed appropriate.

SECTION 2 OBJECTIVES OF UTILIZATION MANAGEMENT

Optum’s Utilization Management program is designed to achieve an optimal outcome for the member/enrollee while using health care resources in a cost-effective manner. Optum’s Utilization

Management Program and Quality Management Improvement Programs (QMI) are based on the following principles:

- Clinical reviews are conducted by clinical peers.
- Clinical criteria and guidelines are determined by clinical peers.
- Clinical peer reviewers possess a minimum of three to five years of clinical experience.
- Optum Support Clinicians are available to discuss any aspect of Optum's Utilization Program with member/enrollees (where delegated) or the member/enrollee's designee (where delegated) or the member/enrollee's provider.
- No aspect of Optum's Utilization Program or QMI initiatives, including Utilization Review, shall contain any financial basis or incentive based on the amount or type of care not provided.

Optum Utilization Management objectives are to:

- Improve the member/enrollee's or dependent's outcome by identifying services that are medically necessary and/or appropriate.
- Offer a consistent, efficient clinical review process.
- Ensure services are delivered at an appropriate level.
- Promote cost effective services.
- Partner with network providers as an information resource and support.

SECTION 3 STRUCTURE AND STAFF QUALIFICATIONS.

Listed below are the key personnel within the Utilization Management Program and the criteria and qualifications for Optum Support Clinicians.

3.1 Regional California Clinical Director

The Regional California Clinical Director has oversight of the Utilization Management Program and works in conjunction with the Senior Clinical Director and Chief Executive Officer to coordinate and implement clinical and administrative activities.

Essential duties and responsibilities include the following. Other duties may be assigned.

- Ensure sound medical policy and standards for the day-to-day delivery of chiropractic services to members.
- Serves as chairman of the Quality Management and Improvement Committee ("QMIC"); participates in other sub and ad-hoc committees.
- Presents actions of the QMIC and its subcommittees to the President/CEO and the Board of Directors for review.
- Continuously monitors and works to improve the quality of care and service including access to contracting providers.
- Participates in the development of policies and procedures. Oversees the recruitment, selection and monitoring of contracting providers to ensure consistency with goals.
- Monitors provider patterns, presents data, analyses and interpretations to contracting providers.
- Assists in the development and implementation of provider education opportunities that support the Plan's managed care effectiveness.
- Provides supervision of the QMIC Administrator.

- Available to UM staff on site or by telephone

Supervisory Responsibilities:

Has management responsibility for the Quality Management and Improvement Administrator. Has management responsibility of all subcommittee chairs. Carries out supervisory responsibilities in accordance with the organization's policies and applicable laws. Responsibilities include interviewing, hiring and training employees, assigning and directing work; appraising performance, rewarding and disciplining employees; addressing complaints and resolving problems.

Qualifications:

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE

Have a Doctor of Chiropractic from an accredited chiropractic program. MBA or Medical Management degree preferred. Five years' experience as a private practitioner. Executive leadership experience with managed care desirable.

Certificates, Licenses, and Registrations:

Have a Doctor of Chiropractic license and must meet or exceed credentialing criteria.

3.2 Utilization Management Chair

The Utilization Management committee Chair is a California licensed provider who is charged with responsibility for all aspects of the Utilization Management Program, including:

1. Monitoring of Support Clinician training and performance.
2. Development, review and approval of Utilization Management policies and procedures.
3. Utilization Management Subcommittee activities.
4. Annual evaluation of the Utilization Management Program.
5. Coordination, review and approval of written clinical criteria.
6. Maintaining oversight of daily clinical support (treatment authorization) activities including
 - i. Meeting turnaround times
 - ii. Monitor daily workflow related to UM
 - iii. Returning network health care provider calls within set guidelines
 - iv. Consulting on difficult cases with support clinicians
 - v. Assisting other departments with clinical program related issues
 - vi. Oversight of clinical audits which are performed minimally semi-annually to determine that support clinicians are implementing policies consistently and correctly per policy. These audits include:
 - Case File Audits
 - Inter-rater Reliability Audits
 - Provider Communications Audits
 - Appeal Audits

3.3 Support Clinicians/Clinical Peer Reviewers

All clinical reviews are conducted by licensed peer reviewers who meet the Optum provider credentialing process. The Clinical Director and Senior Clinical Director can delegate additional responsibilities to support clinicians, as needed. Support Clinicians are clinical staff members of Optum.

Clinical assessments are completed by support clinicians licensed within the same specialty as the treating provider. Support clinicians undergo regimented training that results in a clear understanding of the vital components involved in providing clinical support. Clinical support requires a broad understanding of evidence-informed clinical resources utilized in Optum's clinical review.

Support clinicians have responsibilities for an extensive level of clinical and administrative tasks including but not limited to:

- Reviewing clinical submissions in a timely manner with appropriate and consistent responses.
- Distribution of clinical support resources.
- Educating providers regarding healthcare alternatives and applicable benefits.
- Completion of provider aggregate data reviews to assist participating providers in understanding their clinical profiles.
- Making determinations of medical necessity for managed indemnity and PPO insured individuals.
- Focusing on the complexity, intensity and expected outcomes of the services implemented (not just on diagnosis or billed services).
- Complying with the member/enrollee's benefit plan design and customer-specific account instructions, as well as state, federal, and CMS mandates.
- Providing network education and assisting with negotiation of services rendered by non-network providers.
- Conduct review for Out-of-Network programs (when applicable).
- Participation in Optum clinical committees when requested.
- Participation in Optum provider education activities.
- Provide assistance to supporting department regarding clinical issues.
- Additional duties as assigned by the Clinical Director or Senior Clinical Director

3.4 Credentialing Criteria for Support Clinicians

Support Clinicians are required to meet Optum credentialing criteria. Initial credentialing and recredentialing of Support Clinicians occur in order to validate credentials and competency. Credentialing criteria include the following:

1. Successful completion of Optum credentialing, including:
 - a. Primary source verification for valid license and Board actions.
 - b. Primary source verification with malpractice carriers.
 - c. Primary source verification of Medicare/Medicaid sanctions.
 - d. Review history of professional liability claims.
 - e. Review of education and training.
 - f. Review of work history for the past five years.
2. Graduation from an approved and accredited college applicable to the Support Clinician's discipline.
3. Having a valid license to practice with a minimum of three to five years clinical experience.
4. Absence of disciplinary action(s) from the Board of Examiners and review of any malpractice

carrier issues.

Verification of credentialing/recredentialing criteria is maintained by Network Management.

3.5 Training Program for Support Clinicians

Support Clinicians receive training in the review process, which includes workshop and individual training and self-study materials. The training materials are reviewed and revised as appropriate. Completion of the program for newly hired support clinicians must be within sixty (60) days of start and the reviewers must demonstrate mastery in the following areas:

1. Understanding of the information and reporting requirements contained in the Provider Operations Manual and the California UM Program.
2. Knowledge and application of Optum Utilization Management Policies and Clinical Support Program.
3. Application of current best practice, evidence based literature for the management of Acute, Sub-acute, Chronic, and Supportive cases.
4. Familiarity with all determination/authorization response codes and their appropriate application.
5. Full use of the Case Review System in reviewing patient history and subsequent recording of the case determination.
6. Knowledge of the various plans administered by Optum and any requirements specific to certain plans.
7. General understanding of relevant Optum administrative processes.
8. URAC and/or NCQA standards
9. Integrity, compliance and confidentiality awareness
10. Understanding of Optum Procedures and Job Aids as found on Nexus/Atlas

All Utilization Management Clinical Staff (Support Clinicians) will receive comprehensive initial and ongoing administrative and clinical training to ensure a complete understanding of processes and procedures.

3.6 Evaluation Program for Support Clinicians

The Chair of Utilization Management in conjunction with the Senior Clinical Director exercises oversight in ensuring Support Clinician evaluations/audits are conducted timely and appropriately. Support Clinicians evaluations/audits are comprehensive in scope, objective, and address the areas listed below:

1. Operations Manual requirements
2. Working policies and guidelines affecting Clinical Support and the Utilization Management program.
3. Ensure consistent application of current best practice evidence based literature.
4. Timeliness of the review as measured by turnaround times.
5. Appropriate use of submission response codes.
6. Compliance with administrative processes.
7. Communication skills and issue resolution through the review of CommLogs, complaints, appeals or other pertinent information.

8. General review of the employee's performance, including work quality/accuracy and productivity.

3.7 Administrative Support Personnel

All administrative personnel involved in the UM process are instructed, evaluated and required to attend periodic training concerning confidentiality of information as well as policies and procedures of data collection.

Non-clinical administrative personnel cannot render any clinical decisions. They are enabled to enforce plan benefit provisions and administrative policy.

SECTION 4 OVERVIEW OF CLINICAL PROGRAM

The Optum "Clinical Support Program" has been designed to assist in the delivery of effective and efficient services emphasizing evidence-informed care. The goal of Clinical Support is to assist contracted providers in delivering, and member/enrollees in obtaining, optimal outcomes from care while minimizing inefficiencies and unsupported clinical variance from evidence-informed care. The Clinical Support Program is built upon four core principles:

- **Practice According To Current Best Evidence:** Defining "best practices" in physical medicine and continually setting the information standard.
- **Accountability:** Encouraging providers to be accountable for their services and assisting member/enrollees to be knowledgeable health care consumers.
- **Education and Communication:** Engaging providers and member/enrollees, where delegated, in a learning culture, supplying them with evidence-informed health and well-being information.
- **Affordable Care:** Keeping costs manageable by streamlining processes and using communication, information, and education to lead providers and their patients to a "best practice" health care experience.

Support Clinicians use the following hierarchy of evidence to inform clinical decision making:

1. Specific Health Plan Benefit Coverage, Medical Policy or Clinical Guidelines
2. Optum UM Policy
3. National/Specialty Guidelines and Reports (e.g., AHRQ, USPSTF, ACR)
4. Evidence-Based Health Technology Assessments (developed from evidence-based sources i.e., clinical research publications health plan guidelines specific to area, etc.)

The Support Clinician's determination is recorded by entry of the applicable information into the Case Review System (CRS). It is the responsibility of the Support Clinician to adequately and clearly document the clinical rationale for all determinations. The clinical rationale must clearly reflect the criteria utilized by each clinical reviewer.

4.1 Automated Case Review

For certain uncomplicated cases for which a restricted period of treatment is projected prior to an anticipated discharge from passive care, the submission process is automated, which eliminates all unnecessary processing, including manual review. The clinical criteria are established and approved by the UM Subcommittee. Provider requests for clinical services that meet the established criteria are

approved. The established clinical criteria are reviewed by the UM Subcommittee for approval by the QMI Committee on an annual basis. The currently approved criteria include:

Chiropractic

1. Complete member/enrollee demographic information submitted
2. Complete member/enrollee clinical information required on 'Patient Summary Form' is submitted
3. Diagnosis is of a musculoskeletal condition commonly seen by Doctors of Chiropractic
4. Cause of current episode related to work or motor vehicle accident
5. Meets all administrative requirements
6. Frequency of overlapped cases
7. Frequency of denial cases
8. All manipulations per date of service that meet CPT code criteria of 98940-43

Therapy

1. Complete member/enrollee demographic information submitted
2. Complete member/enrollee clinical information required on 'Patient Summary Form' is submitted
3. Diagnosis is one commonly seen by the therapy provider
4. Cause of current episode related to work or motor vehicle accident
5. Meets all administrative requirements
6. Frequency of overlapped cases
7. Frequency of denial cases

4.2 Clinical Support Program

The Clinical Support Program provides guidance to health care providers in the evaluation, documentation, and treatment of their patients covered under a client health plan and:

1. Recognizes that providers and member/enrollees should be in the best position for clinical decision-making, including the determination of medical necessity of services.
2. Functions as a clinical information resource
3. Assists to improve the member/enrollee's overall health care experience

4.3 Profiling and Data Sharing

Optum uses data collected from claims and the clinical submissions to create reporting that summarize the processes of care and clinical outcomes of each provider. This reporting is useful to Optum for:

1. Recognition of superior provider outcomes and/or efficiencies
2. Communication to the Plan of network outcomes
3. Promotion of Physical Medicine inclusion in benefit structure
4. Selection of providers that may benefit from additional educational opportunities
5. Identification of providers with 'unsupported clinical variance', who haven't effectively adopted "best practice" approaches to delivering care
6. Assists in evaluating the quality of care provided to member/enrollees in general

This information regarding performance is made available to participating providers on a 24 hours/7 days a week basis via a password protected portal at www.myoptumhealthphysicalhealth.com. Formal aggregate performance report reminders are sent to peers with one or more areas of clinical variance at a minimum of twice annually.

4.4 Urgent/Expedited Care

Providers may request a visit on an urgent basis if, as applicable, the Department of Labor and/or Department of Managed Health Care urgent care definition is met. Care may qualify as urgent if the application of the time period for making a non-urgent care determination could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function. A determination for urgent care will be issued within 24 hours of Optum receiving all required information.

During Optum business hours California providers may contact their assigned support clinician at 800-428-6337. California providers may call 800-428-6337 during non Optum business hours and follow the instructions provided in the message.

SECTION 5 NOTIFICATIONS AND TIMEFRAMES

Unless specific state or federal law requires other timeframe and notification standards, the following will apply for Optum's UM determinations.

Optum uses one standard process that applies to both concurrent and retrospective review for chiropractic and therapy submissions. Optum acupuncture providers for Knox Keene business and/or clients do not currently participate in the clinical submission process at this time. The Optum Support Clinician completes the concurrent review process within five (5) business days of receipt of all necessary information. Retrospective reviews are completed within thirty (30) business days of receipt of all necessary information.

Responses regarding clinical decisions to deny, delay, or modify health care services requested by Providers prior to, retrospectively or concurrent with the provision of health care service to Members/Enrollees shall be communicated to the Member/Enrollee in writing, and to Providers initially by telephone, or facsimile within 24 hours of the decision. A Submission Response is sent to the Provider and Member/Enrollee in response to the clinical submission indicating the Support Clinician's decision within one (1) business day of the date of decision. The provider's written response is obtained by visiting their personal log on page on the Optum Provider Portal, U.S. Mail or facsimile. Written response is sent to the Member/Enrollee by U.S. Mail within two (2) business days.

The Submission Response to the Provider and the Member/Enrollee includes messages addressing any changes to the requested treatment plan. In addition, each response to the Provider includes the name of the Support Clinician and instructions and timelines for the submission of missing or additional documentation. Each response includes the following standard information:

- a. Date the documentation was received and processed.
- b. Dates of services authorized.
- c. Number of approved services for tier 2 providers.
- d. Description of the action taken on the request for submission and the reasons for the action.

- e. Instructions and timelines for submission of additional information needed to process the submission request.
- f. The name and direct telephone number or extension for reaching the Support Clinician responsible for the decision, the Member Provider Services Department or the member/enrollee's Health Plan as appropriate.
- g. Instructions for how to appeal with the appropriate telephone number.
- h. Information on how the member/enrollee may file a grievance with Optum or the member/enrollee's health plan.
- i. Notice that clinical rationale is available on request.
- j. If the submission is denied, delayed, or modified, a clear and concise explanation of the rationale for decision, including a description of the criteria or guidelines used, and the clinical reasons for any decision regarding medical necessity.

In the instance that Optum cannot make a decision to approve, modify or deny a request for submission, within the timeframes specified above. Optum shall, immediately upon the expiration of the specified timeframe or as soon as Optum becomes aware that it will not meet the timeframe, notify the provider and the member/enrollee, in writing. Optum shall also notify the provider and the member/enrollee of the anticipated date on which a decision may be rendered. Instances where the timeframe mentioned above may not be met are as follows:

- 1. Optum is not in receipt of all of the information reasonably necessary and requested
- 2. Optum requires a consultation by an expert reviewer
- 3. Optum has asked that an additional examination or test be performed

Upon receipt of all information requested, Optum will approve, modify, or deny the request for authorization within the applicable timeframe specified above.

A request for services may be denied on the basis that information necessary to determine medical necessity was not received. If Optum requests medical information from a provider in order to determine whether to approve, modify, or deny a request for authorization, Optum will request only information reasonably necessary to make the determination. A reasonable attempt to obtain the missing information from the member/enrollee's provider will be made prior to denying services secondary to lack of information. The request for information will be handled in accordance with Optum policy.

In the case of concurrent review, care shall not be discontinued until the member/enrollee's treating provider has been notified of Optum's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member/enrollee.

Urgent/expedited services are rare within the scope of conditions treated by Optum providers. Prior authorization is not required on the date of service; the provider has up to 10 business days to submit the Optum clinical submission forms.

SECTION 6 CLINICAL REVIEW CRITERIA

6.0 Overview

Throughout the utilization management process, Optum utilizes explicit clinical review criteria, in the form of clinical policies. These policies are based upon sound clinical principles and processes.

Optum clinical review criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Clinical criteria are reviewed and revised on at least on an annual basis.

Clinical review criteria represent the basis for non-certification utilization review determinations. Upon request, Optum discloses to the member/enrollee and/or treating provider the criteria (policy or policies) upon which a non-certification decision was based.

Written clinical review criteria consist of utilization management (clinical) policies that take into consideration: plan documents, nationally recognized standards of care established by government regulatory agencies, scientific evidence in peer reviewed literature, evidence-based guidelines, the positions of relevant professional organizations, health technology assessments, broadly accepted care pathways, decision support tools, local delivery system accommodations, and internal utilization data.

Clinical review criteria are applied in conjunction with the specific circumstances applicable to each member/enrollee's condition. Along with explicit criteria, decisions and determinations are also based upon the support clinician reviewer's knowledge and judgment on a case by case basis. Clinical reviewers use their clinical judgment when:

- Assessing and evaluating care and services outlined in the health care record
- Interpreting or applying clinical review criteria
- No applicable clinical review criteria are available

Support Clinicians are encouraged to use all available criteria required in making the most appropriate clinical determinations about medical necessity and/or appropriateness of health care services in accordance with the specific benefit plan design.

6.1 Development of Written Clinical Review Criteria

6.1.1 Oversight & Approval

The Utilization Management Committee and Quality Management Improvement Committee oversee the development and approval of all clinical review criteria utilized by Optum Care Solutions, Inc. Initially, development of clinical policies and other criteria takes place under the direction of the Utilization Management Committee. Advisory Councils, and/or ad-hoc work groups designated by the Quality Management Improvement Committee provide subject matter expertise informing the development of clinical criteria. The Quality Management Improvement Committee provides final approval of all clinical review criteria. Practicing health care providers are included as members of each of the committees involved in the development and approval of clinical review criteria and policies. The UM Program leadership will annually evaluate the program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity.

6.1.2 Process

Utilization management (clinical) policies are developed using transparent processes including descriptions of the methods employed to identify evidence, critically appraise research evidence, and rate the evidence. The basis for each policy statement is explicitly derived from information provided by the literature review, pragmatic judgments (whenever the research evidence is sparse, inconclusive, or inconsistent), and the appraisal

of the positions and policies of relevant professional societies and other health care organizations. An explicit methodology is used to align evidence review findings with the terminology stipulated in benefit documents.

Details of the process steps are described in Policy 429 - *Guidelines for Assessing Clinical Evidence in Policy Development*.

6.2 Dissemination

Approved policies are communicated to providers using various media. Summaries and/or notices about recently approved policies are included in the *provider newsletter*. Policies are posted in an open-access *web portal*. Recently approved policies are communicated to representatives of professional organizations, who are members of the Optum Care Solutions, Inc. *Committees*.

Providers can supply feedback about policies on a 24/7 basis via a dedicated email box, which is recorded on each policy.

Plain Language Summaries, appended to key policies, are intended to inform health plan member/enrollees about the clinical review criteria using straightforward terminology.

6.3 Review and Updating of Written Clinical Review Criteria

The review and updating of clinical review criteria used by Optum is conducted under the oversight of the Utilization Management Committee and Quality Management Improvement Committee on at least an annual basis.

The review process includes the appraisal of relevant information identified subsequent to the most recent approval of a policy (clinical review criteria). The search strategy, which is described in detail in policy 429 - *Guidelines for Assessing Clinical Evidence in Policy Development*, employs computer-aided searches of biomedical databases and registries. These include databases that are specific for physical and occupational therapy, chiropractic, speech therapy and complementary and alternative medicine. The identification of ongoing trials and searches of consumer-oriented websites are also components of the literature search.

Documents and information identified in the search strategy are used in the review and updating of clinical review criteria and includes but is not limited to:

- Research evidence e.g., systematic reviews, experimental and observational studies
- Evidence-based guidelines
- Technology assessments and evidence reports
- The positions and policies of relevant professional societies
- The policies of other health care organizations

Additionally, the consideration of new regulatory requirements and the analyses of internal data contribute to the review and updating of clinical review criteria.

6.4 Application of Clinical Review Criteria

Clinical review criteria are applied in the context of individual member/enrollee care management and benefit coverage. Standardized clinical forms submitted by the health care provider and/or member/enrollee health care records are evaluated by a qualified clinical peer

reviewer (support clinician). Clinical review criteria are employed in conjunction with support clinician judgment to arrive at determinations regarding the medical necessity of the requested services, the appropriate level of the requested services, and the outcome of care (for continuing care).

6.5 Practice guidelines and standards used for determination of medical necessity and appropriateness

A variety of Decision Support Resources are available to Optum Support Clinicians on-line and/or in hardcopy format. Decision Support Resources include, but are not limited to:

1. Standardized reporting forms submitted by provider
2. Peer-reviewed professional journals
3. Published treatment guidelines (e.g. Agency for Health Care Policy and Research, Low Back Guidelines)
4. Optum Operations Manual
5. Optum Mean Utilization Data
6. Optum Clinical Guidelines
7. Optum Clinical Policies

SECTION 7 DEFINITIONS

7.1 Utilization Management and Clinical Support Program

The purpose of the Utilization Management Program is to provide clinical support to providers in the provision of evidence-informed treatment of plan member/enrollees. For this reason, Optum will refer to its application of Utilization Management as Clinical Support. The overall goal of the Optum Clinical Support Program (CSP) is to provide collegial feedback to providers to support the current Best Practice treatment protocols for health care member/enrollees. The primary focus is on education and support. The Clinical Support Program places the focus on provider accountability. Case clinical submission is required within the program and the provider and member/enrollee receives a written response. Additional hallmarks of the CSP are peer-to-peer interactions in regard to aggregate practice data, as well as case-specific data.

7.2 Expedited Appeal

An appeal of an adverse determination in a case involving urgent care

7.3 Medical Appropriateness

Medically appropriate means that:

1. The expected health benefits from a medical service are clinically significant, and exceed the expected natural history of recovery, and the expected health risks by a sufficient margin.
2. The service is demonstrably worth doing and is superior to other health services, including no service.
3. Expected health benefits include:
 - i. Improved level of function.
 - ii. Meaningful relief of pain.

Note: Routine service decisions for determining medical necessity and/or appropriateness follow standard

protocol and the Support Clinicians, Director of Utilization Management, Clinical Director, and the Senior Clinical Director or their designee, are available to discuss member/enrollee's care and respond to phone calls. Each of the aforementioned clinicians has voice mail to receive calls and recorded messages after hours and respond to all messages.

No services require prior authorization for approval. Network providers have up to 10 days (unless otherwise specified) from the date of service to submit the Optum Patient Summary form on their patient.

7.4 Medical Necessity

Optum applies the definition of medical necessity that exists under the member/enrollee's medical benefit plan unless specific state or federal law requires other specific language. Unless otherwise provided under an applicable benefit plan, or state or federal law, "medical necessity" means:

- a. Chiropractic: necessary and appropriate for the diagnosis or treatment of neuromusculoskeletal disorders; established as safe and effective; and furnished in accordance with generally accepted chiropractic practice and standards to treat neuromusculoskeletal disorders.
- a. Therapy service: necessary, appropriate and required to prevent, diagnose, or treat a condition or clinical symptom in accordance with generally accepted professional standards of practice that are consistent with a standard of care in the physical therapy community.
- b. Speech therapy service: necessary, appropriate and required to prevent, diagnose, or treat a condition or clinical symptom in accordance with generally accepted professional standards of practice that are consistent with a standard of care in the speech therapy community.
- c. Acupuncture: Necessary and appropriate for the diagnosis or treatment of an accident, illness or condition; established as safe and effective; and furnished in accordance with generally accepted acupuncture practice and professional standards.

For these purposes "generally accepted professional standards of practice" means standards that are based on credible scientific evidenced published in peer reviewed medical literature generally recognized by the relevant provider community, specialty provider societies/associations and the view of practicing providers in the relevant clinical areas.

7.5 Support Clinician

A Support Clinician is a clinical peer who possesses an active, unrestricted license in the same specialty area as the treating provider.

7.6 Urgent Care

When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process (Not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received

services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.

SECTION 8 APPEAL OF ADVERSE DETERMINATION

Unless specific state or federal law requires other timeframe and notification standards, the following will apply for Optum's UM determinations.

An adverse determination by an Optum Support Clinician means one or more of the service(s) requested was determined to be not medically necessary or appropriate.

Benefit coverage determinations are made by Support Clinicians based upon Certificate of Coverage or Summary Plan Descriptions and may include an adverse determination due to a limitation in benefit coverage or an exclusion of benefit coverage. These are not medical necessity determinations.

Providers, member/enrollees or health plans may desire a review of the initial clinical determination made by Optum. Clinical determinations are decisions made with regard to the provider's requested duration of care, quantity or services or types of services. These requests may take the form of appeal.

8.1 Standard Appeals Process

Appeals which are initiated by a member/enrollee may be filed in writing, or by telephone, and must be submitted within 180 calendar days from the date of Optum's action or inaction regarding the claim or other dispute and must include all necessary information to file the appeal from said determination. Appeals initiated by the provider must be filed in writing, and must be submitted within 365 calendar days from the date of Optum's action or inaction regarding the claim or other dispute and must include all necessary information to file the appeal from said determination.

Clinical appeals abide by the following process:

1. They are reviewed by a Clinical Director or a delegated Support Clinician.
2. The Support Clinician reviewing the appeal will not be a subordinate to the original reviewer.
3. The Support Clinician will be one who did not make the initial determination.

The review process will include the following:

1. Appeal determination process will follow state regulatory requirements.
 - a. Written acknowledgement that Optum is in receipt of the appeal will be sent to member/enrollee or provider. Appeals initiated by a provider are sent acknowledgement of the appeal within 15 business days of the appeal request; member/enrollee initiated appeals are sent acknowledgement of the appeal within 5 calendar days of the appeal request.
 - b. Written notification of the appeal decision will be sent to the party who initiated the appeal. Provider initiated appeals are resolved within 45 business days of the appeal request; member/enrollee initiated appeals are resolved within 30 calendar days of the appeal request. Notification shall include, if the original adverse determination is upheld, the clinical rationale for such decision.
 - c. Notification of the right to appeal all first level appeal decisions.
2. If additional information is required in order to conduct the request for appeal, the appeal reviewers will abide by the following rules:
 - a. They are reviewed by the appropriate Clinical Director or a delegated Support Clinician.
 - b. The Support Clinician reviewing the appeal will not be a subordinate to the original reviewer.
 - c. The Support Clinician will be one who did not make the initial determination.
3. The review process will include the following:
 - a. Whenever necessary the member/enrollee, the member/enrollee's designee or the member/enrollee's provider will be asked to provide additional information in writing.
 - b. The requested information shall include only that information needed for proper review of medical necessity.
 - c. All requests for additional/necessary information will be made at the same time, if possible.
 - d. If requested information has not been received within ten (10) business days, the review will be conducted based upon the information available.
4. If the level one appeal upholds the original determination and if new information is provided that was not reviewed during the level I appeal (considered *de novo*), the new appeal will be reviewed by the Clinical Director or a delegated Support Clinician other than the reviewer involved in the initial and first level appeal determinations. The reviewer will not have previously been involved in the denial determination being appealed. The 2nd level review process will include the following:
 - a. Appeal determinations will follow state regulatory requirements.
 - b. Written notification of the appeal decision will be sent to both the member/enrollee and the provider. Provider initiated appeals are resolved within 45 business days of the appeal request; member/enrollee initiated appeals are resolved within 30 calendar days of the appeal request. Notification shall include, if the original adverse determination is upheld, the clinical rationale for such decision.
 - c. Failure on the part of Optum to make an appeal determination within the applicable time periods in accordance with state regulations shall be deemed to be a reversal of the original adverse determination. Written notification of the appeal determination will be

sent to the health care provider, and member/enrollee and/or the member/enrollee's designee.

In all cases, written notification shall be sent to the provider and member/enrollee. In the event, the claims administrator is other than Optum, written notification shall be sent to the Claims Administrator as well.

8.2 Expedited Appeals Process

An expedited appeal is one in which the health care provider or the member/enrollee believes that the clinical condition of the member/enrollee warrants an expedited appeal for continued, extended, or additional services and the request meets the Department of Managed Health Care criteria for an expedited appeal (involving an imminent and serious threat to the health of the member/enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function). The requests for an expedited appeal may be submitted over the telephone, via facsimile or by mail. Procedures followed for an expedited appeal include:

1. Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
2. A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.
3. Consideration by the plan of the enrollee's medical condition when determining the response time.
4. No requirement that the enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.
5. Each plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

During Optum business hours California Support Clinicians are available and can be reached at 800-428-6337. California providers may call 800-428-6337 during non Optum business hours and follow the instructions provided in the message. A California clinical director will respond to call in the specified timeframe.

8.3 Grievances and External Appeals

Nothing in this UM Plan shall be construed or applied to interfere with a member/enrollee's right to submit a grievance or seek an independent medical review in accordance with applicable law. Member/enrollees shall in all cases have an opportunity to submit a grievance to Optum or seek an independent medical review whenever a health care service is denied, modified, or delayed by Optum, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. All grievances shall be handled in accordance with Optum's Grievance Resolution Policies and Procedures, which are incorporated herein by reference. A request for an independent medical review shall be handled in accordance with Optum's policies and procedures on independent medical reviews or, if applicable, the policies and procedures on independent review of decisions regarding experimental or investigational therapies, each of which is incorporated herein by reference.

If Optum receives notice that an external appeal has been requested, OHCS-PH will provide all requested information to the independent reviewer that is conducting the review as required.

When Optum is informed of the outcome of the independent review, if the original denial is overturned, Optum will update our systems accordingly to allow for additional payment of services that were previously denied.

SECTION 9 BENEFIT COVERAGE DETERMINATIONS

Benefit coverage determinations are made by Support Clinicians based upon Certificate of Coverage or Summary Plan Descriptions and may include an adverse determination due to a limitation in benefit coverage or an exclusion of benefit coverage.

SECTION 10 CONFIDENTIALITY

The UM Program is subject to, and incorporates by reference, the Optum Policies and Procedures on Confidentiality, which comply with the following:

- State and Federal Laws and Regulations
- American Accreditation HealthCare Commission/URAC
- National Committee for Quality Assurance (NCQA)
- Optum corporate standards and criteria for health care delivery systems
- Health Insurance Portability and Accountability Act (HIPAA)

Optum's confidentiality policy encompasses all aspects of clinical and administrative operations. All medical and other private information regarding clients, member/enrollees, customers, and/or insured persons must be maintained as confidential. Information regarding the claims, medical history and medical condition of plan participants or their dependents must be preserved accordingly. Confidential medical information includes information that identifies, or can be used to identify, any medical condition or type of treatment pertaining to a covered person; this includes information requiring security clearance. Such information is confidential and should never be used or disclosed to others except as required to administer the Program, or as authorized by written consent of the member/enrollee or the member/enrollee's authorized representative. The individuals with job responsibilities involving payment of claims, maintenance of medical records, or the administration and/or audit of benefits may have access to confidential medical information.

Clinical information submitted for review and/or appropriateness, reconsideration, or appeal, is accessible only to Optum Support Clinicians or other clinical officers, and when necessary, support staff. Summary data shall not be considered confidential if it does not provide information to allow identification of individual member/enrollees.

In circumstances where re-disclosure of confidential medical information is required due to specific business transition, e.g., a change in the business relationship with the customer, or an outside auditor requests access to specific information, special hold harmless agreements may be required prior to the release of any confidential medical information. Redisclosure is otherwise permissible only in accordance with applicable law.

Information will be shared only within Optum on a need-to-know basis. Employees and committee members will sign a confidentiality statement. A breach of this policy may result in corrective/disciplinary actions. Confidentiality monitoring and support of confidential policies related to the UM process are

the responsibility of all management staff.

Provider-specific information, that is information wherein a provider's name and professional status and title are stated, is not disclosed to the general public or to entities outside of Optum except as required to administer the Program. Provider-specific information is treated as confidential information and shared within Optum on a need to know basis only within utilization management and quality management and credentialing. Provider-specific information will only be released externally in accordance with Optum's policies and approval system. The release of any provider-specific data will be in compliance with applicable state and federal laws.

SECTION 11 AVAILABILITY

Optum maintains a telephone system and toll-free telephone numbers for member/enrollee and provider telephone communications. The system has the capability to receive and process all telephone calls received. These calls are directed to the appropriate personnel or are forwarded to a specific individual's voice mail. After hours telephone calls include instructions for the use of the voice mail system. Voice mail is required to be retrieved at least daily and responses made within one business day regarding member/enrollee care. Optum provides TDD/TTY and language assistance to providers as needed

Optum's phone system is maintained Monday through Friday between the hours of 8:30 a.m. and 5:00 p.m. Pacific Standard Time.

Support Clinicians, the Chair of Utilization Management, Clinical Director, or Senior Clinical Director are available a minimum of 40 hours per week during normal business hours to discuss member/enrollee care and to respond to telephone requests. In addition, all peer reviewers have voice mail 24 hours per day, 7 days per week and are required to monitor it and respond within one business day regarding member/enrollee care.

Optum staff is trained in telephone etiquette to identify themselves by name when answering a call and by name and company name when placing a call.

When a call is received by Optum after normal business hours, urgent/expedited contact information for the clinical director is provided as part of a voicemail message.

SECTION 12 DELEGATION

Optum does not delegate any UM functions or processes.

SECTION 13 MEMBER HANDBOOK OR SUBSCRIBER CONTRACT

Optum will be a subcontractor to various full service health plans. Unless otherwise provided in an agreement with Optum, each health plan will be responsible for disclosures to its member/enrollees and prospective member/enrollees. Optum will assist health plans in developing disclosures and will be contractually obligated to comply with health plan requirements.