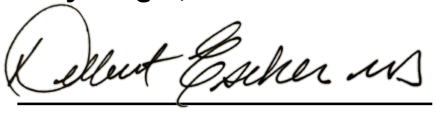
OrthoNet LLC* Utilization Management Program

APPROVED:

Vice President of Operations
Amy Wright, PT

3/19/25
Date



Senior Medical Director
Delbert Escher, MD

3/19/25
Date

* Optum™ Physical Health ("Optum") includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet LLC, OrthoNet of the South, Inc.

The OrthoNet Utilization Management Program
Table of Contents

ORTHONET 2025 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

I. INTRODUCTION

The OrthoNet Utilization Management (UM) Program guides and directs OrthoNet's Musculoskeletal Utilization Management and Care Management activities to ensure the provision of comprehensive, high quality, coordinated musculoskeletal care in the most appropriate and cost-effective setting. The Quality Improvement (QI) Program interfaces with the UM Program through ongoing monitoring, auditing, focused studies, and evaluation of provider satisfaction. The UM Program coordinates activities as delegated by the Managed Care Organizations (MCOs) to meet the musculoskeletal and rehabilitation needs of members. OrthoNet's policies related to the UM Program have been instituted according to the guidelines/standards established by the National Committee for Quality Assurance (NCQA), as well as the regulations and laws of the states in which we provide UM services and the Centers for Medicare and Medicaid Services (CMS).

OrthoNet's UM program has fully integrated into Optum's UM operation. OrthoCare Managers help to coordinate and authorize musculoskeletal and rehabilitation services in peer-to-peer review, under the direct supervision of OrthoNet's Medical Directors, Senior Medical Director, and the Vice President of Operations. The UM Program is a collaborative effort between OrthoNet practitioners and providers to help achieve favorable health care outcomes by utilizing OrthoNet's clinical criteria in a formal process that continually evaluates the necessity, appropriateness, effectiveness, quality, continuity, and timeliness of services rendered.

The UM Program Description in addition to the UM Program Evaluation and UM Work Plan, is reviewed annually by the UM committee and approved annually by the OrthoNet QI committee. The UM Program leadership will annually evaluate the program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity. It will also annually evaluate the level of involvement of the Senior Director in the UM program. The approved document is submitted for review and adoption to the Vice President of Operations.

OrthoNet was awarded a three-year NCQA accreditation certification from 7/11/22 to 7/11/25.

II. MISSION STATEMENT

OrthoNet is a national leader in medical benefit management, providing comprehensive clinical and payment integrity programs to health plans and other Payor organizations. OrthoNet seeks to achieve optimal outcomes for payors, providers, and members in a manner that combines efficient delivery of services, high quality care, and state of the art utilization- and cost-management tools.

III. GOALS OF THE UM PROGRAM

The goal of OrthoNet's UM Program is to promote the most suitable use of the managed care organizations' (MCOs) resources by utilizing a pre-approved plan of care, which provides an

assessment of the member's specific needs and resources, the setting of care, and consideration to local practice patterns. It will also administer the operational delivery of our Medical Management program and services, which will facilitate the provision of quality, cost-effective orthopedic medical care.

IV. OBJECTIVES OF THE UM PROGRAM

The objectives of the OrthoNet UM Program are:

- To comply with state and federal utilization review laws and regulations including regulations for the Centers for Medicare and Medicaid Services (CMS) as well as the National Committee for Quality Assurance (NCQA) standards.
- To monitor clinical care and services provided for effectiveness, consistency, and appropriateness.
- To involve practitioners, providers and administrators in the development, review, and implementation of utilization review criteria, program activities, and program assessments.
- To work with our clients to help to effect any necessary changes in utilization patterns and practice.
- To annually evaluate and approve UM criteria for appropriateness.
- To annually evaluate and approve the effectiveness of the UM program in addition to making changes to the UM Program description as applicable.
- To perform inter-rater reliability testing with clinical review staff to evaluate the consistency and appropriateness of UM decision-making.
- To improve the quality and safety of clinical care and the quality of service.
- To gather, analyze and report data pertaining to inpatient and outpatient quality of care, appropriate utilization and continuity of care.
- To aggregate and trend quality of care issues identified during the utilization review process.
- To communicate to Payor health plan members and providers UM decisions and appeal process information within the established time frames.
- To monitor potential under- and over-utilization of services and coordination of care.
- To maintain the confidentiality of protected health information relating to individual members and providers.

V. SCOPE OF THE UM PROGRAM

OrthoNet provides utilization management of Therapy and musculoskeletal services on behalf of Health Plans for commercial, Medicaid and Medicare lines of business in accordance with all applicable state and federal regulations including the CMS guidelines. OrthoNet will manage Utilization Review for Medicare membership as required based upon contract delegation with Health Plans. OrthoNet will comply with CMS regulations during utilization review services provided for Medicare membership and works with the Health Plan to ensure use of "CMS approved" Payor specific determination letters.

The OrthoNet UM Program includes monitoring and evaluation of the musculoskeletal health care needs of the members for whom UM is delegated to OrthoNet. OrthoCare Managers (OCMs) perform pre-authorization and utilization review of inpatient and/or outpatient services. These activities include the management of care provided for acute and chronic musculoskeletal conditions, as well as physical/occupational/speech therapy services provided by participating providers, hospitals, and skilled nursing facilities.

UM services are provided by OrthoNet through its OrthoCare Management System. These may include but are not limited to verification of benefits and eligibility, authorization of services, utilization review, initiation of discharge planning and identification of potential quality of care issues. OrthoNet seeks to help maximize the patient's functional status and outcome through assuring appropriate utilization and management of musculoskeletal providers and services. Based on the specific contractual agreement, some or all of the several main functional activities related to UM may be delegated to OrthoNet.

OrthoNet provides administrative services for business organizations. OrthoNet does not interact with consumers.

Administrative Services

OrthoNet's administrative personnel support the clinical review staff and all UM functions.
All administrative personnel involved in the UM process are instructed, evaluated and required to receive periodic training concerning confidentiality of information, policies and procedures of data collection. Audit reports reflecting performance of non-clinical UM staff will be generated and reported. Non-clinical administrative personnel will not render any clinical decisions. They may enforce plan benefit provisions and administrative policy.

Non-clinical staff provide administrative services that support the UR process. These functions include but are not limited to:

- Complete administrative processing/assessment of submission and notifications
- Update patient health plan information used for administrative and clinical assessment, claims payment, and applying appropriate appeal rights
- Prepare data and records for internal and external audits
- Manage response letter content, generate letters, and coordinate delivery to patients and providers
- Collect, assemble and disseminate data related to UM Program performance and characteristics

VI. ORGANIZATIONAL STRUCTURE, STAFFING & GOVERNING BODY ACCOUNTABILITY OVER UTILIZATION MANAGEMENT PROGRAM

Organizational Structure

The organizational structure of the UM Program involves various levels of oversight, roles, and functions.

A. The Vice President of Operations

The Vice President of Operations is the governing body for OrthoNet and is responsible for the direction and oversight of the QI Program goals and objectives. The Vice President of Operations ensures that:

- The QI Program is in place, works effectively to monitor and improve quality at OrthoNet,
- It annually reviews and approves the QI Program Description, standards of conduct, Work Plan, Evaluation and
- It delegates and authorizes oversight of the QI Program through the Senior Medical Director and the Quality Improvement Committee.
- The OrthoNet Senior Medical Director has responsibility for the implementation, supervision, oversight and evaluation of the UM program.
- The OrthoNet Senior Medical Director is also responsible for reviewing the results of the annual projects and UM processes.

B. Quality Improvement Committee (QIC)

Role

The Optum Quality Improvement Committee (QIC) coordinates the implementation of all quality improvement activities, identifies areas of improvement and evaluates the effectiveness of the quality improvement annually. The QIC has the responsibility of providing on-going reporting to the Vice President of Operations, developing the annual QI Program Description, Work Plan, and Program Evaluation. The committee also oversees compliance with contracted MCOs, accreditation procedures and related activities. The committee provides guidance to staff on quality management priorities and projects, approves QI projects, and monitors quality improvement goals and progress.

The QIC analyzes, receives input and evaluates key aspects of the quality of clinical care provided to members by participating practitioners and providers of our client MCOs, and key aspects of the quality of service provided by OrthoNet to members and practitioners.

C. Utilization Management Staff Roles & Responsibilities

OrthoNet devotes a variety of resources to promote an efficient use of staff and sharing of ideas regarding UM. The following staff is instrumental in conducting UM at OrthoNet:

OrthoNet Clinical UM Staff

The initial reviewer is a licensed healthcare professional who may approve requests for admissions, procedures, and services using explicit UM criteria and requires no clinical judgement. Requests that require clinical judgement are forwarded to a peer clinical reviewer.

OrthoNet's UM clinical staff is composed of physicians and registered nurses who have current, active and fully unrestricted clinical license. These professionals have a minimum of three to five years of clinical experience. OrthoNet's administrative staff supports the clinical review staff and all UM functions.

Roles and Responsibilities

Roles and responsibilities of UM positions are as follows:

Senior Medical Director (SMD)

The Senior Medical Director is a licensed physician who serves as the Chairperson of the QI committee and is accountable for establishing and maintaining oversight of the QI program, processes, and outcomes. The Senior Medical Director reports to the Vice President of Operations and is the designated senior clinical staff person that provides guidance for all clinical aspects of the QI program/committee activities. OrthoNet Medical Directors have periodic consultation with practitioners in the field.

Qualifications:

OrthoNet's senior medical director is a physician who has a current, active and fully unrestricted clinical license to practice. The senior medical director has a minimum of three to five years of clinical experience.

Responsibilities:

- Coordination of QI activities, including data collection / analysis and reporting.
- Development and refinement of interventions to support QI activities incorporating, wherever possible, monitoring and measurement.
- Communication of all relevant UM and QI policies and procedures to the appropriate individuals and/or committees.
- Initiation of corrective action plans to ensure compliance with established UM policies.
- Recommendation of appropriate staffing for all program activities.
- Periodic and / or annual review/revision of the QI Program and its related policies.
- Oversight of Clinical Informatics activities.
- Providing medical leadership for QI Program including member / provider appeals and associated QI activities.
- Oversight of the coordination of QI activities identified in the QI Program, Work Plan and Evaluation.
- Oversight of the development and monitoring of Clinical Practice Guidelines.
- Review and/or oversight of all decisions pertaining to denial (non-certification) and approval of services/care.
- Oversight of OrthoNet's contracted delegated activities as they apply to federal/state, NCQA standards for annual on-site audits, and the provision of requested information on a member-specific basis or in an aggregate form as required and/or requested by the MCO.
- That the clinical review and any issues related to quality of care and/or services are carried out within established timeframes and protocols, incorporating all aspects of QI activities into OrthoNet operations.
- Monitoring for potential over- and under-utilization and for ensuring adequate access and availability of services to members.
- Protecting the confidentiality of member information and adheres to company policies regarding confidentiality.
- Managing the day-to-day UM activities with management team.

In addition, the SMD is also involved with the development, adoption, revision and distribution of the specific QI initiatives. He / she will work to identify and measure clinical improvements and acts as the communications conduit to the provider community. Throughout the course of his work, he provides advice and consultation to assist with the management of all care and QI initiatives to assure that organizational goals are met.

Lead Medical Directors

OrthoNet's lead Medical Directors are responsible for supervision, oversight and/or operation of the day-to-day QI and UM activities of assigned UM Staff. Lead Medical Directors must be licensed to practice, meet the credentialing criteria set by OrthoNet and assist the SMD. The lead Medical Directors report to the SMD.

Qualifications:

OrthoNet's lead Medical Directors are physicians who have current, active and fully unrestricted clinical licenses. The lead Medical Directors have a minimum of three to five years of clinical experience.

Responsibilities:

- Supervision of the OrthoNet Clinical Staff to ensure that all cases not meeting medical necessity are reviewed by a Medical Director and that there is consistency and reliability in the decision-making process.
- Monitoring for consistent application of UM criteria by UM staff for each level and type of UM decision.
- Monitor documentation for adequacy
- Providing appropriate, cost-effective medical management through the medical management initiatives and achievement of desired performance in areas such as pre-authorization concurrent review, case management and discharge planning.
- Providing clinical guidance in operating effective medical management programs to achieve quality of care.
- Working with the SMD and OCMs regarding case specific clinical issues.
- Analyzing utilization data to track and identify trends regarding medical management.
- Participation in the UM and QI Committees.
- Oversight of investigations of potential quality of care and quality of service concerns.
- Making all decisions pertaining to denial (non-certification) of services/care.
- Protecting the confidentiality of member information and adhering to company policies regarding confidentiality.
- Maintaining compliance with: client requirements, applicable federal and state laws and regulations, OrthoNet policies and procedures and the requirements of the accrediting agencies (NCQA).
- Participate in the training and education of OrthoNet's staff and discussions with participating providers from the OrthoNet Delivery System or the client MCO provider networks.
- Available to UM staff on site or by telephone.

Board-Certified Physician Consultants

OrthoNet will use board-certified physician consultants of the appropriate specialty to perform consultant reviews for services based on medical necessity within the designated timeframe when requested by one of the contracted Payor plans, by an OrthoNet medical director, or when deemed appropriate to assist in the UM determination process.

Director, Clinical Operations

Director of Clinical Operations is responsible for the oversight of clinical contract management at OrthoNet. The Director of Clinical Operations must be a graduate of an approved school of allied health with substantial direct musculoskeletal clinical experience, and advanced skills/training in medical management, outcomes tracking, and program development. State licensure, certification or registration is required along with substantial experience in Health Care. The Director of Clinical Operations reports to the Executive Vice President and/or SMD.

Specific responsibilities include:

- Responsibility for maintaining the UM Program to ensure established goals are achieved.
- Maintaining compliance with applicable laws and regulations, OrthoNet policies and procedures and the requirements of the accrediting agencies (NCQA).
- Being instrumental in the development of inter-rater reliability testing on a quarterly basis for clinical staff.
- Directing the gathering and arrangement of healthcare data that supports UM and quality performance.
- Responsibility for the development, implementation, and monitoring of patient care programs.

- Ensuring UM staff is properly trained, oriented and provided with regular professional job development.
- The development and implementation of clinical management and care management plans.
- The management of all relevant QI Programs & clinical data reporting.
- Supervising the development, implementation and review of policies and procedures related to UM.
- Supervising of clinical department and maintenance of qualified clinical and non-clinical personnel.
- Protecting the confidentiality of member information and adherence to company policies regarding confidentiality.

D. Access & Availability of UM Staff

OrthoNet provides access to its UM review staff for members and providers seeking information regarding the UM process. OrthoNet will provide the following communication services:

- The UM review staff will be available no less than eight (8) hours a day, Monday through Friday (8 a.m. to 6 p.m.) in time zones where OrthoNet may conduct its review activities for inbound calls on business days.
- The UM review staff will identify themselves by first name/last name initial, job title, and company name when initiating or returning calls regarding UM.
- All OrthoNet UM staff members responding to UM inquiries will have a confidential programmed voice mail box to allow callers to leave a message when they are unavailable.
- The UM review staff may receive inbound calls regarding UM issues during the business day and after normal business hours. (After-hour access - 24 hours a day, 7 days a week, including holidays.) The UM review staff may conduct its outbound calls related to UM during a time providers would be available.
- A toll-free number will be available for all communications from member/providers related to UM.
- Have a Medical Director available to answer questions regarding urgent/emergent cases for providers.
- During non-business hours, calls are received by an automated system that, if necessary, can page the Senior Medical Director on call for immediate response. Telephone coverage provided by OrthoNet personnel during normal business hours combined with after-hours coverage ensures that qualified personnel are available to discuss patient care, allow response to expedited Medicare and commercial requests and expedited appeals and other telephone requests 24 hour a day, 7 days a week. (Note: A toll-free 800 number is available to contact OrthoNet at any time.)
- The UM review staff may verbally inform members, facility staff, attending physician, any other ordering provider and health professionals about specific UM requirements and procedures.
- OrthoNet will adjust staffing needs appropriately to handle the amount of cases/work received.
- OrthoNet maintains the capability to provide translation services and language assistance when necessary to members or providers requiring it in accordance with applicable healthcare regulations. OrthoNet will work closely with the applicable Health Plan to ensure that appropriate translation services are provided to all members when required (including but not limited to translation services made available at provider sites when applicable), in order to ensure that *"the member's rights to receive information on treatment options and alternatives in a manner appropriate to a member's condition and ability to understand"* are met. This will include making services available to members with hearing impairment.

E. Training

OrthoNet provides new-hire orientation for all UM staff. During the first 2 to 3 weeks on the job, department employees will work side-by-side with experienced department individuals to learn their position. Hands-on training in computer software applications is also conducted during this time. Formal training is delivered via face-to-face classroom sessions, "virtual" sessions, LearnSource modules, etc.

To ensure that all UM employees are periodically trained on the required timeframes to perform utilization review, department managers will review NCQA UM standards with the staff. Area(s) of particular concern may include, but not limited to: timeliness of UM decisions, clinical criteria, denial notices, confidentiality and appeals.

OrthoNet requires Annual Staff Training for all employees to measure their knowledge of the following subject matter:

- Conflict of Interest
- Code of Conduct
- Fraud Waste & Abuse
- Health Literacy
- Language Assistance
- NCQA
- CMS
- Safe and Secure With Me Information Privacy and Security

This training helps to ensure that employees are aware of keeping protected health information (PHI) confidential when performing their daily jobs.

In order to maintain consistent application of the criteria and delivery of the UM Program, OrthoNet monitors clinical review staffs' (OCMs and Medical Directors) consistency in the application of criteria for the UM Program. This is monitored and tracked by: 1) auditing random UM files to ensure the appropriate information created by the UM staff meet regulatory requirements, 2) inter-reviewer reliability audits to evaluate UM staff performance, and 3) staff discussions. When opportunities for improvement are identified, a re-training is conducted and an individual action plan is developed with the staff that scored below the anticipated benchmark. UM staff who do not meet OrthoNet's performance benchmarks are retested to assess the success achieved by the action plan.

OrthoNet has implemented the use of plain language templates instead of medical terminology, where possible, as the standard. Clinical Staff and Medical Directors are trained on the procedures for writing and editing using a 4th-8th grade level as appropriate, or plain language, wherever changes can be made, for all member correspondence without affecting state and federal regulations as well as OrthoNet's contractual requirements. Management uses written materials, power point training aids and staff meetings to accomplish health literacy training and reports the results to the Training Manager on a regular or on an as needed basis.

F. Report Analysis Capability

OrthoNet's Clinical Informatics Department supports UM Program activity to provide summary data on a daily, weekly, monthly and ad hoc basis. Data analysis of both inpatient and outpatient information is utilized to direct resources toward utilization problems or concerns regarding:

- Problem issue identification on the basis of cost, length of stay, and deviation from peers.
- Other factors identifying potential over-utilization and/or under-utilization of services.

The ongoing analysis of program information ensures that utilization patterns remain reasonable

and within generally accepted standards of quality and clinical appropriateness.

VII. UTILIZATION MANAGEMENT CLINICAL REVIEW POLICIES

A. Clinical Review Criteria

1.Overview

OrthoNet maintains written UM clinical criteria that are based on medical evidence and current clinical practices. OrthoNet utilizes written UM decision-making clinical criteria that are objective and based on medical evidence and procedures for applying and evaluating individual patient needs and an assessment of the local delivery system.

2. Development of Clinical Review Criteria

Sources for guideline development include Clinical Guidelines as established and published by the *American Academy of Orthopedic Surgeons (AAOS),* the *American Physical Therapy Association (APTA), the Association of Neurological Surgeons (AANS), and* the *American Academy of Neurology (AAN),* a review of the peer review literature and the clinical expertise of the OrthoNet Professional Clinical staff. OrthoNet also uses clients' MCG guidelines and CMS guidelines.

The OrthoNet UMC, under the direction of the Director of Clinical Operations, is responsible for ongoing development, review and evaluation of clinical review criteria. All written clinical review criteria undergo an annual review by the UMC. As part of the review process, potential over- and under-utilization is assessed using data collected through the UM process. In addition to the scheduled periodic evaluations, the review process may be initiated at any time based upon the results of QI studies or other monitoring and evaluation activities.

An initial draft of the required clinical criteria is developed with the assistance of appropriate professionals including but not limited to OrthoNet professional clinical personnel and board-certified clinical consultants. 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 the Optum Clinical Sciences Institute Clinical Guideline Development and Approval document, employs computer-aided searches of biomedical databases and registries.
Practicing practitioners with clinical expertise in the area being reviewed have the opportunity to advise or comment on the development or adoption of clinical criteria and on instructions for applying criteria. Once criteria are completed and fully prepared, OrthoNet will distribute copies for review and approval.

Upon acceptance by the UM Committee, the criteria are then sent to the Optum Quality Improvement Committee (QIC) for formal approval and incorporation into the OrthoNet UM process. OrthoNet also reviews and adopts *MCG* or other externally produced guidelines with modifications if indicated.

3. 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. Providers may request a copy of approved policies at any time via the Provider Support phone line or requesting from a customer service agent. Providers can supply feedback about policies by emailing: phpolicy_inquiry@optum.com

4. Review and Updating of Written Clinical Review Criteria

Annually the Director of Clinical Operations and Clinical Review staff team will meet to review the criteria for any revisions. If the clinical criteria requires revision or new clinical criteria needs to be developed, the Director of Clinical Operations, Peer Review Physician, and select Clinical Review staff will draft criteria and references based on cases reviewed. Once this review is complete, a member from the Clinical Review staff team will present the draft version(s) to one of the 1st quarter Utilization Management committee meetings for the year. During the Utilization Management Committee, the Clinical Review staff team member will discuss the purpose of the criteria and seek the committee's approval. If no additional recommendations are communicated, the clinical criteria will be officially approved at the Utilization Management Committee. The Director of Clinical Operations or medical designee will verbally provide his/her approval of all clinical criteria used internally. (**Note:** This will continue on an annual basis.) After the committee meeting, the Clinical Review staff team member will forward an electronic copy of the clinical criteria to the Regulatory Compliance department. The Regulatory Compliance department will update the Clinical Criteria. The Regulatory Compliance department will inform the OrthoNet Clinical Review staff and Denial/Appeal departments of all new changes via internal e-mail notice of re-approved and/or new criteria so that they can review them on their Clinical Criteria/Guidelines desktop folder. The department managers will initiate training or have an in-service on the criteria that was approved/re-approved for the year. (**Note:** Documentation of this training will be submitted to the Training Manager in the Regulatory Compliance department.)

5. Application of Clinical Review Criteria

OrthoNet clinical criteria is used to review requests to allow a designated clinical reviewer to approve care. These include federal/state mandates, member benefits, health plan policies/guidelines, and/or any other appropriate approved orthopedic, musculoskeletal neurosciences or medical/surgical guidelines.

B. Utilization Review Process

The OrthoNet clinical staff will also consider the characteristics of the actual local delivery system and their ability to meet the patient's specific health care need. These factors may include one or all of the following:

- Availability of specific types of facilities (e.g., SNF, subacute, home care services)
- Patient's coverage for various forms of non-acute services
- Hospital's ability to care for an inpatient and to provide the services needed within the estimated length of stay

The OrthoNet clinical staff considers any or all of the following characteristics when applying the clinical criteria to each individual :

- age
- co-morbidities
- complications
- patient progress in treatment
- psychosocial situation
- patient's home environment

These clinical criteria are derived from recognized professional standards that may include those from the *American Medical Association, the American Association of Orthopedic Surgeons* and the *American Physical Therapy Association*. The Medical Director(s) uses his/her expertise and clinical judgment to evaluate requests and ongoing care on a case-by-case basis. The Medical Director(s) also may, at his/ her discretion, uses the expertise of other Board-Certified Specialist Physicians or other suitably qualified practitioners to assist in the review

and decision process. A Medical Director will be available to requesting providers should there be a need for discussion with the treating clinician. A participating provider or other person if so permitted by federal/state, client, and NCQA requirements may receive, upon request, a copy of the clinical criteria used in making the utilization review decision. Utilization review will generally take place whenever a request is made for any of the following types of services under the terms and conditions of the specific MCO contract:

- inpatient surgical procedure
- ambulatory/outpatient surgical procedure
- ambulatory/outpatient pain management procedure
- treatment at any facility that charges a facility fee
- physical or occupational therapy
- speech therapy
- any other services that contractually require authorization

If a health care service has been specifically pre-authorized or approved for a member by utilization review during any retrospective review, OrthoNet will not revise or modify the specific standards, criteria or procedures used for the utilization review for procedures, treatment and services delivered to the member during the same course of treatment. OrthoNet will comply with rules, which require a licensed physician to make a determination on an authorization or adverse decision. ***[Note:*** *For those states where state specific license is required, an appropriately licensed Medical Director will supervise or render determinations for those members.]*

C. Standard Review Criteria

OrthoNet's clinical review criteria are policies to allow a clinical reviewer to approve care. The Medical Directors use his/her own expertise and clinical judgment to evaluate requests and ongoing care on a case-by-case basis. In addition, consideration is given to individuals based upon their specific needs and the characteristics of the local health care delivery system.

The Medical Director also may, at his/her discretion use the expertise of Board Certified Specialist Physicians or other suitably qualified professionals to assist in the review and decision process. A participating provider may also receive, upon request, a copy of the criterion used in making a clinical decision.

OrthoNet conducts periodic audits of UM functions. Clinical Review professionals involved in the UM process are assessed based on the consistency in which they apply UM criteria. Corrective action plans and retesting will also be implemented for those health care professionals who fall below the benchmark.

D. Medical Necessity Determination Process

In order to determine the medical necessity and appropriateness of care and the setting it is provided in, the clinical reviewer obtains and reviews any/all clinical information and uses clinical criteria, utilization review guidelines, and his/her own clinical expertise to evaluate the proposed care. Information used to render a decision for medical necessity may include, but not limited to objective clinical data, strength, active and passive range of motion, functional status including ambulation and balance. Clinical information may be gathered from a variety of sources including, but not limited to, the Primary Care Physician, other physicians, medical records, the facility, the facility's utilization review, clinical staff, and the member. If the clinical reviewer is unable to authorize the proposed care based on the information gathered, the reviewer may contact the provider to obtain additional information. If after receiving the requested additional information, the criteria have still not been met, the clinical reviewer will refer the case to a Medical Director

for review and determination.

E. Timeliness for Review Determinations **

OrthoNet has a process to review requests for medical services to ensure that decisions and notifications of the decisions are made in a timely manner in accordance with the following guidelines (unless more strict guidelines apply to a specific contract or jurisdiction or accrediting organization):

- Requests for authorization of pre-service non-urgent care decisions will be rendered and the decision communicated to the member, treating provider and/or the facility verbally, electronically, and in writing within fifteen (15) calendar days of receipt of the request.
- Requests for authorization of pre-service urgent care decisions will be rendered and the decision communicated verbally, electronically and written within seventy-two (72) hours of the request.
- Retrospective review decisions are rendered and the decision communicated to the member, treating provider and/or the facility verbally, electronically, and in writing within thirty (30) calendar days of receipt of the request.

When additional information is needed to render a determination for non-urgent pre-service and retrospective decisions, the timeframe may be extended. OrthoNet will notify the provider, member or member's representative in writing and describing the allotted timeframe and specific information that is needed within fifteen (15) calendar days of the pre-service or thirty (30) calendar days of the retrospective request. The provider, member or member's representative will be given forty-five (45) calendar days from receipt of the notice to submit the requested information.

When additional information is needed to render a determination for urgent care the timeframe may be extended. OrthoNet will notify the member or member's representative in writing and describing the allotted timeframe and specific information that is needed within twenty-four (24) hours of the request. The provider, member or member's representative will be given seventy- two (72) hours from receipt of the notice to submit requested information or in accordance with contract specific requirements which may be shorter.

The turnaround times for case review will comply with applicable federal/state regulations, NCQA standards, whichever is most restrictive. Prompt review is essential to ensure adequate notification of a review decision to both the treating physician and the member. In prospective or concurrent cases, review may be conducted by telephone, electronically, via fax or via overnight mail, depending upon the urgency of the member's condition.

For certification notifications, OrthoNet will communicate via fax and mail all relevant information including the authorization number on a timely basis to the attending/ordering provider, facility or member. All timeframes related to certification decision making and tracking may be monitored under the QI program.

Denial notifications (whether benefit or medical necessity) will be communicated in accordance with MCO contract specifications, federal/state regulations, and NCQA Standards.

Communications to involved parties may be made electronically, by telephone and/or in writing. Written denial notifications will include the following information:

- The reason(s) for the denial in an easy to understand language.
- Written reference to the benefit provision, criteria guideline or protocol used to base the denial determination.
- The opportunity for the member and/or provider to request copies at no charge of the criteria or protocol used in the denial determination.

- How to contact the Medical Director or appropriate UM Reviewer, along with phone number to discuss denial decision (e.g., the opportunity to submit information for reconsideration/peer-to-peer review).
- A description of the appeal rights, which will include the member/provider right to submit written comments, documentation and/or any other relevant information to support the appeal.
- An explanation of the appeal process that includes the right for member representation, the timeframes for appeal decisions.
- A description of the expedited appeal process for urgent pre-service (prospective) or urgent concurrent denials.
- The name and title of the person rendering the adverse determination / non-certification.
- An explanation of the appeal process, including the members' right to representation timeframes on appeal decisions and the right to bring a civil action under section 502(a) of ERISA, if applicable
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that an expedited external review can be filed concurrently with the appeals process for urgent care and ongoing treatment.

Employees and/or consultants providing utilization review services are not financially compensated in any manner based on the number of denials that are rendered.

*(**Note exceptions: Medicare/Medicaid and State Specific UM Timeframes will supersede the timeframes referenced in this document. Please refer to OrthoNet State Specific policy and procedure documents utilization review timeframes which apply.)*

VIII. COMPONENTS OF THE UTILIZATION MANAGEMENT PROGRAM

The scope of services administered by the OrthoCare Management staff is comprehensive in nature. OrthoNet UM Program components guide and monitor the individual member's musculoskeletal health and medical needs throughout the health care delivery system.

The components of the UM Program include:

A. Pre-Authorization Process

The pre-authorization process applies to specified elective inpatient, selected ambulatory medical services, physical/occupational/speech therapy, rehabilitation services and other services. It is designed to ensure that requested services are eligible for coverage, medically necessary, and are provided at the appropriate level of care and setting by a participating or otherwise contracted provider. The specific medical services requiring pre- authorization are determined on a contract-by-contract basis with each MCO.

Pre-authorization is conducted by OCMs and Medical Directors with the assistance of support staff using the OrthoNet clinical criteria or the other relevant criteria (e.g., MCG) as appropriate. The Medical Director reviews cases that cannot be approved by an OCM because they do not meet criteria for medical necessity or clinical appropriateness. Only a Medical Director may issue a denial. The pre-authorization process applies to some or all of the following:

- Acute care facilities
- Free standing ambulatory surgery centers
- Outpatient rehabilitation facilities/services
- Specialty Referrals

- Other services as specified by contract with MCO

OrthoNet does not require pre-authorization for emergency services. OrthoNet will facilitate the pre-authorization process as necessary in accordance with the requirements of applicable MCOs and NCQA policies.

B. Adverse Determinations

Adverse determinations or non-certifications occur when a decision is rendered by an OrthoNet Medical Director for therapy or other services requested by the provider for a member. Adverse determinations can be for either benefit (administrative) or medical necessity reasons. Medical necessity denials are denials of coverage for proposed and/or already provided services that do not meet accepted criteria for coverage. Benefit (administrative) denials are denials based upon a contractual or benefit exclusion, limitation, or exhaustion.

During the adverse determination process, a licensed physician/Medical Director is the only individual allowed to render a denial determination for reasons related to medical necessity. OrthoNet will ensure that all written notification letters of non-certification contain the following:

- The reason(s) for the denial in an easy to understand language.
- Written reference to the benefit provision, criteria guideline or protocol used to base the denial determination.
- The opportunity for the member and/or provider to request copies at no charge of the criteria or protocol used in the denial determination.
- How to contact the Medical Director or appropriate UM Reviewer, along with phone number to discuss denial decision (e.g., the opportunity to submit information for reconsideration / peer-to-peer review).
- A description of the appeal rights, which will include the member/provider right to submit written comments, documentation and/or any other relevant information to support the appeal.
- An explanation of the appeal process that includes the right for member representation, the timeframes for appeal decisions.
- A description of the expedited appeal process for urgent pre-service (prospective) or urgent concurrent denials.
- Notification that an expedited external review can be filed concurrently with the appeals process for urgent care and ongoing treatment.
- The name and title of the person rendering the adverse determination/non-certification.
- An explanation of the appeal process, including the members' right to representation timeframes on appeal decisions and the right to bring a civil action under section 502(a) of ERISA, if applicable.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- OrthoNet will provide translation services and written notification in a culturally and linguistically appropriate manner where necessary and as required in accordance with applicable healthcare regulations.

Note: Appeal rights will be sent based on the member's specific certificate. Refer to Section VII. UM Clinical Review Policies, *E. Timeliness for Review Determinations* for the timeframes.

C. Peer-to-Peer Review Process

OrthoNet offers peer-to-peer review during its non-certification process. Peer-to-peer review is where the provider is given the opportunity to speak with the Medical Director prior to or after issuing a denial for any covered services. The provider may wish to discuss the Medical Director's determination during notification and may request to speak with the Medical Director. The provider has the option of speaking either to the Medical Director who made the initial determination to deny

coverage or his/her designee, if the Medical Director who made the initial determination is not available. OrthoNet does not consider the peer-to-peer review process as an additional level of review or an appeal, but as a time for the provider and Medical Director to discuss the relevant clinical facts as well as options that may resolve the initial determination prior to the provider and/or member filing an appeal. OrthoNet follows client and regulatory peer-to- peer rules.

OrthoNet may also conduct reconsideration of the adverse determination prior to receiving an appeal. The Medical Reviewer who made the initial adverse determination may review the case for reconsideration and overturn the previous decision. If the decision is upheld, the member or provider can initiate an appeal.

D. Standard Appeals

OrthoNet shall comply with those standards established by governmental regulatory bodies and accreditation organizations to ensure the right of the insured, the insured's designee and/or the insured's health care provider to appeal an adverse decision. OrthoNet shall not take any action with respect to a patient or a health care provider, that is intended to penalize the insured, the insured's health designee, or the insured's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse decision. Failure on the part of OrthoNet 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 second level appeal determination will be sent to the healthcare provider, and patient and/or the patient's designee.

The member, their authorized representative or provider, acting on behalf of the member, have at least 180 calendar days from receipt of the notification of an adverse determination to request an appeal. Medicare and Medicaid members have at least 60 calendar days after notification of the denial to file an appeal. The member, their authorized representative or treating provider/practitioner have the opportunity to submit any additional written comments, documents or other information relating to the appeal.

All adverse decision communications (e.g., letters) will respect this timeframe along with the following methods for the member to exercise their rights to submit an appeal:

- The right to submit a written letter along with the pertinent information relevant to the appeal.
- An explanation of the standard appeal process (including timeframes for appeal determinations – within 30 calendar days for pre-service, within 60 calendar days for post-service and within 72 hours of receipt of the request for expedited).
- Right for member representation.
- A description of the expedited appeal process.

During the appeal process, a clinical peer reviewer who holds an active, unrestricted license to practice medicine or a health profession, who was not involved in the initial adverse determination and is not a subordinate of any person involved in the initial determination, will review and render a determination on the appeal. The clinical appeal reviewer will also be board certified (if applicable) by:

1) a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or
2) the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).

Appeals involving clinical issues (appeals with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary) will be reviewed by a clinical reviewer who has the expertise in the same or similar field of medicine involved in the case. If it is a "medical necessity" appeal, the medical reviewer will be in the same profession and in a similar

specialty as typically manages the medical condition, procedure, or treatment.

When clinical care is in progress, there is continued coverage of the service(s) at issue pending the outcome of the appeal for which coverage was previously approved.

The OrthoNet appeal reviewer will fully investigate the content of the appeal and will document its findings. OrthoNet's appeal review does not give deference to the denial decision.

The OrthoNet Appeal Department will document the request and the substance of the appeal and actions taken. Documentation of the substance of the appeal includes but is not limited to the member's reason for appealing the adverse decision and additional clinical or other information provided with the appeal request. Documentation of actions taken includes but is not limited to previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal. Documentation will also capture when members fail to submit relevant information by the specified deadline.

OrthoNet will resolve and notify (electronically and/or written) the member, authorized member representative, and/or provider using the following timeframes:

- Pre-service: within thirty (30) calendar days of receipt of the request for an appeal
- Post-service: within sixty (60) calendar days of receipt of the request for an appeal for commercial, Exchange and Medicare.
- Post-service: within thirty (30) calendar days of receipt of the request for an appeal for Medicaid.
- Expedited: within 72 hours of receipt of the request for an appeal

OrthoNet's Appeal Department will communicate electronically, by telephone, and/or in writing the decision of the appeal review. OrthoNet may extend the timeframe if additional information is needed to render a determination and if, (1) the member agrees that an extension may be necessary, or (2) if a federal program(s) is being reviewed, regulations allow for the request of additional information. The organization may deny the appeal and notify the member if it does not receive the information within the time frames.

All written appeal determinations will address the following information:

- Specific reasons for the appeal decision, in easily understandable language.
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
- Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.
- Notification that the member is entitled to receive reasonable access to and copies of all documents, free of charge upon request.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.
- How to contact the Medical Director or appropriate UM Reviewer, along with phone number to discuss denial decision (e.g., the opportunity to submit information for reconsideration/peer-to-peer review).
- A description of the appeal rights, which will include the member/provider right to submit written comments, documentation and/or any other relevant information to support the appeal.
- An explanation of the appeal process that includes the right for member representation by anyone they choose, including an attorney during all levels of the appeal process.
- The timeframes for appeal decisions.
- A description of the expedited appeal process for urgent pre-service (prospective) or urgent

concurrent denials.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that an expedited external review can be filed concurrently with the appeals process for urgent care and ongoing treatment.
- OrthoNet will provide translation services and written notification in a culturally and linguistically appropriate manner where necessary and as required in accordance with applicable healthcare regulations.

E. Expedited Appeals

In addition to the standard appeals process, members or providers acting on behalf of the member may request an expedited review of an urgent adverse decision in accordance with their MCO contracts, applicable federal/state regulations and NCQA regulatory standards. OrthoNet will grant an expedited review for cases that involve, but are not limited to the following:

- Circumstances in which a health care provider believes an expedited appeal is warranted because a delay would significantly increase the risk to the member's health or the member's ability to regain maximum function, based on a layperson's judgment.
- Continued/extended health care services for an inpatient member who received emergency care but was not released from the site of service.
- Procedures/treatments or additional services for members currently undergoing a course of treatment that would subject the member to severe pain if the request for services is not managed expeditiously.
- Admission to a Rehabilitation Facility, Skilled Nursing Facility or Home Healthcare Agency.

OrthoNet accepts written and/or verbal requests from the member, member's representative or provider for the initiation of an expedited appeal. A Medical Director renders expedited appeal determinations and notification to the member and provider are communicated as soon as possible but not to exceed 72 hours from the time the member's request is received followed by a written confirmation of the notification within 3 calendar days.

Expedited appeals that do not result in a resolution satisfactory to the appealing party, may be further appealed to the health plan and/or state appellate organizations.

Failure on the part of OrthoNet to make an expedited appeal determination within the applicable time periods in accordance with state, federal, or CMS 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 the patient and/or the patient's designee.

F. Retrospective Review

Retrospective review is a process of examining the records of medical services and/or claims after the service has been provided. This process includes eligibility and benefit determination, determination of medical necessity including the appropriateness of care and/or its setting, as well as a determination of compliance with administrative policies and procedures specific to the MCO's contracts.

The process of retrospective review may be performed when any of the following occur:

- A provider or facility that is non-participating or is out of the service area has submitted a claim.
- Faxed or telephonic review could not be done at the time services were initially requested because the required notification was not given to OrthoNet or the MCO or because there was insufficient information available at that time to make a determination.

- Procedures that have already occurred without prior required notification have been submitted for claims payment.

G. External Appeals

When appropriate and in accordance with applicable laws, OrthoNet has implemented an external appeals process to meet state, federal and CMS requirements. An external appeal is a request for an independent review or reconsideration of services denied by a health insurance carrier for medical necessity or experimental and investigational reasons. Reviews are conducted by external appeal agents that are certified by the state and have a network of medical experts to review the denial. If OrthoNet receives notice that an external appeal has been requested, OrthoNet will provide all requested information to the independent reviewer that is conducting the review as required. When OrthoNet is informed of the outcome of the independent review, if the original denial is overturned, OrthoNet will update our systems accordingly to allow for additional payment of services that were previously denied.

H. Emergency Services

OrthoNet complies with the appropriate state laws and regulations in relation to emergency admission authorizations. All OrthoNet contracts are aware of these rules.

OrthoNet is committed to ensuring that necessary musculoskeletal medical care is available to all members 24 hours per day, 7 days per week. Members requiring emergent care services are encouraged to seek services from a network provider unless the member is out of the service area network, however, applicable state rules will govern all access to emergency services. Subject to any modifications required by applicable state law or regulation, OrthoNet defines “Emergency Condition” using the following statutory language:

- “Emergency Condition” is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person’s bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person. (NYS Consolidated Laws 4900(c))
  Emergency services, which are necessary to screen and stabilize members, do not require pre- authorization in cases where a prudent layperson, acting reasonably, believes that an emergency condition exists. Emergency services that a practitioner or other authorized representative of the MCO authorizes or directs are also treated as eligible services not subject to pre-authorization.

I. Communication of Determinations

Communications are an integral part of the OrthoNet’s UM Program. Payor health plan members are informed of care and services approved as covered by their physician or provider receives verbal and/or written notification of the benefit coverage approval decision with regard to all requests made to OrthoNet for services to be covered under a member’s benefit plan. OrthoNet records the information in its information system.
The treating physician is notified by telephone or by fax of any coverage denial decisions prior to the written notification. The fax notification to the provider contains the rationale for the denial decision, a process to speak with the physician reviewer for medical necessity denials, and a description of the appeal/expedited appeal process consistent with applicable state and federal laws. When appropriate, or required by a state regulatory requirement, verbal notification is completed to the member for denial decisions. Both the physician and member are given written notification of denial decisions. The written denial notification to the physician and member

contains the rationale for the denial decision, the process to speak with the physician reviewer for medical necessity denials, and a description of the appeal/expedited appeal process consistent with applicable state and federal laws.

(Note: More information regarding adverse determinations/peer reviews/appeals process can be reviewed in parts E. Adverse Determinations, F. Peer-to-Peer Review, G. Standard Appeals and H. Expedited Appeals.)

OrthoNet maintains the capability to provide translation services and language assistance when necessary to members or providers requiring it. OrthoNet will work closely with the applicable health plan to ensure that appropriate translation services are provided to all members when required in order to ensure that the member's rights to receive information on treatment options and alternatives in a manner appropriate to a member's condition and ability to understand are met. This will include making services available to members with hearing impairment. OrthoNet will provide written notification in required languages where necessary and as required in accordance with applicable healthcare regulations.

J. Claims

The Claims staff conducts retrospective review of claims for previously authorized care. Payment for those services may be denied if it is found that information provided at the time of the initial review if the actual care provided was materially inconsistent with the authorization or not medically necessary.

K. Out-of-Network Services

The Care Management staff utilizes the same pre-authorization process as is applied to in-network services when OrthoNet is involved in the utilization management of such activities:

Under the terms of their plan, the use of non-participating providers in non-emergency situations must generally be approved in advance by the MCO for consideration of reimbursement at the rates set for in-network providers:

- If a member or provider believes out-of-network services are required, the provider proposing to render them must forward a request (if at all possible in writing) to the OrthoNet Care Management Department.
- Clinical Personnel will review the details of the request and collect all relevant data. Where it is relevant, the OrthoNet network and MCO network of providers will be canvassed to identify comparable participating providers who appear to be able to provide the requested services.
- In the event that a MCO has not contracted with a provider with appropriate training and experience to meet the particular musculoskeletal health care needs of a member, the MCO will refer the member to an out-of-network provider. The member may be charged no more for the services of this non-participating provider than what he or she would have been charged if the services were provided within the network.
- If there are no comparable providers in the OrthoNet or MCO network who can provide the covered service or if the request represents a case of ongoing care by a non-participating provider, then OrthoNet may, with the approval of the MCO, chose to approve the services of a non-participating provider. All approvals will be for a predetermined period and specified services.
- For all out-of-network services, the OCM will try to approve a request, however, they may forward the request to the Medical Director for review if the information provided cannot lead to an approval in accordance with the MCO's policies.
- The Medical Director's decision and reason for approval or denial will be communicated verbally and also in writing to the member, PCP and non-participating provider.

Members/providers will be notified of their appeal rights.

- Members currently receiving on-going treatment from a non-participating provider will generally be granted approval for continued care for that episode of care. Such approvals will be in accordance with the MCO's policies and applicable state regulations.
- Out-of-network emergency services may be reviewed retrospectively. All payment decisions will be based on the member's contract, the MCO's policies and procedures, and applicable laws and regulations.

The member and the provider initiating the request will receive notification of the approval or denial. Written denial notification will include the appropriate appeal information and other information required by either the MCO or applicable law and regulation.

L. New Technology Evaluation

The UM Program will evaluate selected new technologies for presentation to the UMC and possible integration into the UM Program. New Technology evaluation results will be presented to MCOs as recommended by the UM Committee.

M. Behavioral Health Care and Pharmacy Services

OrthoNet does not manage behavioral health (BH) care or Pharmacy services. OrthoNet will however, forward any issues related to BH or Pharmacy directly to the Payor for immediate attention and, if appropriate, will co-manage member's cases.

N. Workers' Compensation

OrthoNet does not generally manage Workers' Compensation (WC) cases. OrthoNet will, however, forward any related WC cases directly to the Payor and, if appropriate will co-manage these types of cases.

O. Handling Complaints from Member, Members Representative, Provider and/or Client

This process applies to plans where OrthoNet is delegated to manage complaints.

Upon receipt of a complaint from a member, member representative, provider, or client, it will be acknowledged within 24 hours by the product contact. The Optum Complaint team will triage the complaint issue(s). The complaint is reviewed, categorized, and assigned to a lead team member who oversees the investigation and resolution process. Complaints are resolved within 30 calendar days from the date of receipt, and a final communication is sent to the complainant detailing the resolution.

P. Quality Improvement Indicators

Clinical and service indicators of quality are established and monitored on a regular basis in order to assess OrthoNet's performance in the management of clinical care and service. The QIC reviews and makes recommendations on clinical indicators. Indicator results are trended and reported to the QIC. Some indicators are developed into quality improvement projects. These QIPs exemplify the process of continuous quality improvement, which in turn allows OrthoNet to be able to refine and maintain quality consumer, client and health care services.

1. Quality of Care Indicators

OrthoNet may track, trend, and report potential quality of care concerns to the QIC for review. Some examples of potential quality of care concerns may include, but not limited to surgical

situations of note which may include:

- Unplanned surgery/invasive procedure
- Wrong surgical procedure and/or code
- Complication of surgery or unplanned return to operating room
- Re-admits

2. Service Quality Improvements

OrthoNet will measure the quality of service provided to members and will demonstrate service improvements that positively affect services that members receive. OrthoNet will accomplish this input by monitoring call center telephone statistics responsiveness and decision-making and notification timeframes. Key metrics will include:

- Average Speed of Answer (ASA), Telephone Abandonment Rate, and Turn Around Times (TAT).
- Monitoring turnaround times for Complaint Resolution.
- Monitoring turnaround times for Appeals.
- Monitoring turnaround times for availability of telephone advice after hours.
- Monitoring Provider claims turnaround time.
- Monitoring claims processing turnaround times.

This information will be monitored, trended, and reported to the QIC on a regular basis for each contracted health plan. Indicators that do not meet target performance goals will be addressed.

3. Clinical Quality Improvements

With assistance from the health plan, OrthoNet will develop one or more “pilot program” activities related to orthopedic care that will show meaningful activity improvement. In addition, OrthoNet may also focus on continuity and coordination of care performance improvements.

4. Over- and Under-Utilization

OrthoNet’s Clinical Informatics team has created reports for the monitoring and detection of potential over- and under-utilization of services. OrthoNet will identify applicable utilization data, establish thresholds and monitor against these thresholds to detect potential over- and under-utilization. Monitors may include data to manage utilization, service measures, tracking/trending member/provider complaints, and provider satisfaction with the UM process.

IX. DELIVERY SYSTEM INTERFACES

There are many OrthoNet functional areas that provide essential support for the UM Program. They include:

A. Quality Improvement

Key quality indicators and guidelines have been established through OrthoNet's QI Program. These indicators are incorporated into the UM Program during prospective, and retrospective reviews. The Medical Management, Compliance, Quality and Audit team staff conducting these reviews are responsible for identifying and sharing any quality issues with the QI staff who will research, follow up and report at the UMC as appropriate.

UM Medical Management, Compliance, Quality and Audit team staff will also monitor key indicators

as part of the retrospective review process as appropriate. These indicators, which are performed at least annually, include:

- Assessing potential under- and over-utilization
- Assessing continuity of medical care
- Assessing OCMs and Medical Directors “inter-rater” consistency in decision-making
- Assessing provider satisfaction with UM processes
- Assessing service/processes
- Maintaining delegated program processes by the Payor health plan through compliance with NCQA, CMS, health plan and regulatory standards (if applicable)
- Assessing other areas or activities with frequencies as identified by the health plan
- Ongoing monitoring of regulatory and accreditation compliance.

Data from these activities are routinely analyzed and reported to the QIC. This information is also shared with other internal departments when appropriate to assure effective integration and communication. When opportunities for improvement are identified, interventions are implemented with follow up to ensure they have been effective.

B. Operations

The UM staff also relies on many other functional areas to provide ongoing support to the UM program. These include:

- Provider Customer Service
- Information Systems
- Clinical Informatics
- Data Analysis
- Regulatory Compliance
- Internal and External Audit
- Claims
- Marketing & Sales
- Finance
- Focused Claims
- Quality Improvement

X. PROVIDER SATISFACTION

It is OrthoNet’s goal to help to ensure that the MCO’s clients’ members receive quality health services and that these services are rendered in the most medically appropriate and cost-effective setting. For client satisfaction, OrthoNet will work with the contracted Payor health plan, as necessary, to assist in the improvement of client satisfaction.

XI. ANNUAL EVALUATION OF THE UTILIZATION MANAGEMENT (UM) PROGRAM

The UM Program Evaluation is completed annually by members of the UMC and QIC to determine the overall effectiveness of the program in meeting the established goals and objectives based on outcome information from the following components:

- Evaluation of the UM Program structure and function
- Review and assessment of UM activities

- Evaluating the consistency of inter-reviewer reliability in applying criteria in making UM decisions
- Tracking and trending of measures to assess overall UM performance
- Monitoring patterns of care for potential over- and under-utilization
- Monitoring coordination of care and access and availability
- Recommendations on program objectives and direction for the following year
- Identifying parts of the program that will need follow-up and/or revision
- Provider satisfaction surveys

The evaluation is reviewed by the UMC and approved by the QIC. The UM Evaluation will be evaluated against the regulatory requirements of CMS, and NCQA to ensure compliance with agency UM standards.

OrthoNet conducts an annual evaluation of the UM Program in which the UM Work Plan forms the basis for the evaluation, which is designed to:

- Evaluate the overall effectiveness of the UM Program
- Encourage periodic re-evaluation of policies and workflow
- Allow exploration of barriers and limitations to meeting the stated goals and objectives
- Develop program objectives, activities, and targets for the upcoming year

The UM Program Evaluation will also include a written description of how OrthoNet implements and meets the objectives of the UM Program from the previous year. This document may be updated during the year to reflect new activities. The Vice President of Operations and the Senior Medical Director sign, date and approve the evaluation.

XII. ANNUAL UTILIZATION MANAGEMENT (UM) WORK PLAN

The UM Work Plan outlines the UM Program goals and objectives, and planned activities and projects in order to develop a strategic plan for the coming year. The Work Plan includes anticipated action steps, performance goals, identifies staff, target dates for completing activities and the dates for committee review and approval. The timeframes that are utilized allows for the documentation of changes and status updates of activities throughout the year.
The Work Plan will also provide the company with a structure for measuring progress towards achieving program objectives through the annual UMC meeting and quarterly reviews by the QIC. The UM Work Plan is developed annually and reviewed and approved by the QIC.

XIII. POLICIES & PROCEDURES

OrthoNet policies and procedures are reviewed and updated at least annually. UM policies and procedures define the procedures for applying review criteria. The written policies may include, but are not limited to, procedures to evaluate medical necessity, criteria used to make a UM determination, use of nationally recognized and locally approved information sources and the processes used to review and approve the provision of medical services. The QIC gives final approval and approves all UM program policies.

XIV. CONFIDENTIALITY

OrthoNet's UM program deals with highly sensitive information concerning providers and members. Member information obtained during UM activities shall be restricted to those individuals and/or committees charged with the administrative and legal obligations of OrthoNet. Individual practitioners' records shall be restricted to those individuals and/or committees charged with reviewing for credentialing and re-credentialing purposes. The

documents that are created and reviewed as part of the QI/UM process are confidential and privileged information and are not considered discoverable. Committee records are available only to authorized personnel and maintained in compliance with appropriate local, state, federal, and other regulatory agencies.

All those with access to sensitive information, whether OrthoNet employees, committee members, and/or consultants, are required to complete an electronic attestation for the Confidentiality Statement at the start of their employment or relationship with OrthoNet, verifying their understanding of the Confidentiality Policy. A signed reaffirmation of commitment to the Confidentiality Policy is required annually.

Medical records, provider records, clinical files and other patient-specific information or materials used in the QI and UM process at OrthoNet are considered strictly confidential and are retained in a secure environment. All records will be maintained for a minimum of seven years or later as required by law contract provision or regulation. Confidential documents include but are not limited to:

- Data, reports, or other information (electronic, hard copy, or verbal) that identify an individual patient, provider or reviewer.
- Reports and recommendations relative to care management processes.
- Proprietary work product documents, data and reports.
- Medical Management proceedings, including discussions and communications authorized by the QI/UM Committee including review notes and meeting minutes.

XV. STATEMENT OF NO FINANCIAL INCENTIVES FOR UTILIZATION REVIEW DECISIONS

It is OrthoNet's policy that all clinical personnel who make UM decisions for OrthoNet annually sign a statement affirming that (NCQA Standards and Guidelines, MED 9 (Element D #1-3), Core 33 – Financial Incentives):

- All UM reviews are based only on appropriateness of care and service and existence of coverage.
- That OrthoNet does not reward clinical personnel or other individuals for issuing denials of coverage.
- That financial incentives for UM decisions makers do not encourage decisions that result in under-utilization.

XVI. CONFLICT OF INTEREST / ETHICS

OrthoNet clinical employees and consultants that are engaged in the peer review and/or the medical necessity determination process shall do so without conflict of interest. No clinical staff employee will participate in the review of a case in which he/she has provided direct care or has a financial interest or relationship with the individual whose services are being determined. The case and/or request must be referred to another employee or consultant.

In addition, all OrthoNet employees are prohibited from working for other companies while employed at OrthoNet where that employment may be construed as a conflict of interest. A "Non-compete – Non-solicitation" attestation is signed annually by all staff.

XVII. DELEGATION

OrthoNet may delegate specific processes outlined in the Utilization Management Program Description. OrthoNet maintains necessary and appropriate oversight of all delegated activities.

APPENDIX A

ORTHONET
UM PROGRAM COMMITTEE
STRUCTURE
&
COMMITTEE DETAILS

UTILIZATION MANAGEMENT PROGRAM ORGANIZATIONAL STRUCTURE & PROGRAM DETAILS

Appendix A. Utilization Management Program Organizational Structure

OrthoNet's Utilization Management program organizational structure is as follows:

Clinical Leadership

National Director
Amy Wright, PT (VP)

Regional Clinical Directors
Delbert Escher, MD, MS (QIC Chair)
Colin Kanar, MD (Med Dir)
Luciana Gay, RN (UMC Chair)

ACCOUNTABILITY OF GOVERNING BODY, UM COMMITTEE STRUCTURE ROLES & RESPONSIBILITIES

A. The Vice President of Operations

The Vice President of Operations is the governing body for OrthoNet and responsible for the direction and oversight of the QI Program goals and objectives and ensures that:

- The QI program is in place, works effectively to monitor and improve quality at OrthoNet,
- It annually reviews and approves the QI Program, standards of conduct, Work Plan, and Evaluation, and
- It delegates and authorizes oversight of the QI Program to the OrthoNet Senior Medical Director and the QIC.

Meeting Frequency

Annual or as needed

Quorum

A quorum is required for all committee meetings. Two-thirds of voting committee members constitutes a quorum.

B. Quality Improvement Committee (QIC)

Role

The Quality Improvement Committee (QIC) coordinates the implementation of all QI activities, identifies areas of improvement and evaluates the effectiveness of the QI Program annually. The QIC has the responsibility of providing on-going reporting to the Vice President of Operations, developing the annual QI Program Description, Work Plan, and Program Evaluation. The committee also oversees compliance with contracted MCOs, accreditation procedures and related activities. The committee provides guidance to staff on quality management priorities and projects, approves quality improvement projects, and monitors QI goals and progress.

The QIC analyzes, received input and evaluates key aspects of the quality of clinical care provided to members by participating practitioners and providers of our client MCOs, and key aspects of the quality of service provided by OrthoNet to members and practitioners.

Meeting Frequency

Committee meetings will be held at a minimum of four (4) times annually. The QIC reports directly to the Vice President of Operations.

Quorum

A quorum is required for all meetings. Seventy-five percent of members present at meetings will constitute a quorum.

Minutes

Minutes are recorded at all committee and subcommittee meetings using a standardized format including topic, discussion, and follow up. Follow-up items will become topics for the next committee meeting. All minutes are signed, dated and maintained in a confidential manner.

C. Utilization Management Committee (UMC)

Role

The Utilization Management Committee (UMC) coordinates the implementation of all UM activities. The UMC determines the effectiveness of the program and identifies areas for improvement. The UMC will assess and evaluate any clinical issues identified during OrthoNet's potential utilization process including evaluation of continuity and coordination of care, including under- and over- utilization. The UMC has the responsibility of developing and approving the annual UM Program Description and of developing the Work Plan and Program Evaluation. The committee oversees compliance with contracted MCO accreditation procedures and related activities. The UMC shall utilize consultants from appropriate specialty areas where necessary to provide expertise and interpretation in the review of cases and UM data presented to the committee for review.

The Committee analyzes and evaluates summary data from the following activities:

- Review and revise Optum Utilization Criteria
- Assessment of reviewers applying UM criteria for decision-making.
- Internal audits of approval, denial and appeal files (using both hard copy and on-line data).
- Analysis of annual quality management project reports including outcome studies.
- Assessment of required reports to MCOs which may include, but are not limited to:
  - Authorization and Denial activity reports
  - Turn Around Times (TAT) for authorizations and other reviews
  - Telephone Call Center Reporting
  - Tracking and trending provider complaints

Meeting Frequency

Committee meetings will be held once annually. *(Urgent UM Issues which arise shall be addressed immediately by the designated OrthoNet Medical Director/consultant to ensure timeliness.)* The UMC reports directly to the QIC.

Quorum

A quorum is required for all meetings. Seventy-five percent of members present at meetings will constitute a quorum.

Minutes

Minutes are recorded at all committee and subcommittee meetings using a standardized format including topic, discussion, and follow up. Follow-up items will become topics for the next committee meeting. All minutes are signed, dated and maintained in a confidential manner.

APPENDIX B

Revision History

3/8/2022 - Final UM Committee Approval

7/19/22 - Updated the OrthoNet UMPD on page 27 under XV. STATEMENT OF NO FINANCIAL INCENTIVES FOR UTILIZATION REVIEW DECISIONS to remove the word "specifically" and update to: "That OrthoNet does not reward clinical personnel or other individuals for issuing denials of coverage."

3/9/23 - Utilization Management Committee Update and Approval

4/27/23 - Quality Improvement Committee Update and Approval

- **Changed year to 2023 from 2022 and combined the Optum UM Program and the OrthoNet UM Program documents.**
- **As OrthoNet received their NCQA Accreditation for their UM Program through 7/11/25, updated all URAC references to NCQA in the OrthoNet UM Program.**
- **Removed references to Medical Advisory Group (MAG) and Payor Specific Patient Management Sub-Committee (PMSC)**
- **Removed references to OrthoCare Management System Treatment Guidelines as OrthoNet has adopted Optum clinical policies**
- **Added required language to bring the two programs into alignment in sections: Introduction, G. Standard Appeals, H. Expedited Appeals, J. External Appeals**

6/29/23 - Utilization Management Committee Update and Approval.

- **The licensing team requested that the 2023 Optum UM Program document be separated into two individual UM Program documents - an Optum UM Program and an OrthoNet UM Program.**
- **The product team requested the following edit to XVII. Delegation in the OrthoNet Program: Removed sentence: "OrthoNet does not delegate any functions related to UM to an outside entity." Added sentence: "OrthoNet may delegate specific processes outlined in the Utilization Management Program Description. OrthoNet maintains necessary and appropriate oversight of all delegated activities."**

7/27/23 - Quality Improvement Committee Update and Approval.

- **The licensing team requested that the 2023 Optum UM Program document be separated into two individual UM Program documents - an Optum UM Program and an OrthoNet UM Program.**
- **The product team requested the following edit to XVII. Delegation in the OrthoNet Program: Removed sentence: "OrthoNet does not delegate any functions related to UM to an outside entity." Added sentence: "OrthoNet may delegate specific processes outlined in the Utilization Management Program Description. OrthoNet maintains necessary and appropriate oversight of all delegated activities."**

APPENDIX B

Revision History

6/13/24 - Quality Improvement & Utilization Management Committee Update and Approval.

- **Removed references to the therapy program (including physical, occupational and speech therapy), rehabilitation, and concurrent care, care management, and therapy advisory board members as the therapy program has been removed by the client**
- **Updated Optum references to OrthoNet as OrthoNet is managing its own QIC/UMC**
- **Removed references to provider network (provider availability) and member and provider satisfaction surveys as the health plan owns the network management**
- **Removed references to discharge planning, in-patient services, diagnostic testing, emergency admissions as these programs have been removed by the client**
- **Added a UM Staff Roles & Responsibilities section**

7/25/24 - Quality Improvement & Utilization Management Committee Update and Approval.

- **Added back in references to the therapy program (including physical, occupational and speech therapy), since Orthonet LLC is still contracted as a delegated entity for the review of therapy services for an existing client.**

8/15/24 - Quality Improvement & Utilization Management Committee Update and Approval.

- **Added in reference to Administrative Services performed by OrthoNet non-clinical staff.**

3/14/25 - Quality Improvement & Utilization Management Committee Update and Approval

VI. Organizational Structure, Staffing & Governing Body Accountability over Utilization Management Program:

- **Section C Utilization management staff roles & Responsibilities was updated to clarify OrthoNet Clinical UM Staff section. Defined qualifications and responsibilities for Senior Medical Director and Lead Medical directors.**

VII. Utilization Management Clinical Review Policies:

- **Section A Clinical Review Criteria: Added sub section 3. Dissemination and 4. Review and updating of written clinical review criteria and reformatted the entire section.**
- **Section B Utilization Review Process: Added sections on clinical staff considerations.**

VIII. Components of The Utilization Management Program:

- **Section B Adverse Determinations: Added statement regarding translation services and written notification in a culturally and linguistically appropriate manner to members**
- **Section C Peer-to Peer Review process: Added process to include reconsideration information.**
- **Section D Standard Appeals: edited section for clarity and included more clarification on reviewer requirements, appeals review process, turn-around time, translations services.**
- **Section I Communications of Determinations: Removed redundant information**
- **Section O Handling Complaints from Member, Members Representative, Provider and/or Clients: New section**

APPENDIX C

Definitions

Medical Necessity: Optum applies the definition of medical necessity that exists under the patient's medical benefit plan unless specific state, federal, or CMS law requires other specific language. In general, medical necessity is defined as health care services and supplies that Optum defines as:

- Necessary to meet the basic health needs of the covered person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health service.

Consistent with scientifically based guidelines of national, professional, research, healthcare coverage organizations or government agencies.

- Consistent with the diagnosis of the condition.
- Demonstrated through prevailing peer-reviewed medical literature to be either:
    - safe and effective for treating or diagnosing the condition for which their use is proposed.
    - safe with promising efficacy in a clinically controlled research setting and using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

Medical Appropriateness: Medically appropriate means that:

- 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.
- The service is demonstrably worth doing and is superior to other health services, including no service.
- Expected health benefits include: improved level of function and meaningful relief of pain.

Routine service decisions for determining medical necessity and/or appropriateness follow standard protocol and the Support Clinicians, the Directors of Utilization Management and the Senior Director, or their designee, are available to discuss patient care and respond to phone calls.

Urgent Care: Urgent care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.