

**Product Lines Affected**

Medicaid	<input checked="" type="checkbox"/>	PHC (HMO)*	<input checked="" type="checkbox"/>
		MnCare	<input checked="" type="checkbox"/>
MSC Plus	<input checked="" type="checkbox"/>	Part D	<input checked="" type="checkbox"/>
PWSHC*	<input checked="" type="checkbox"/>	Other	
PHC (SNBC)*	<input checked="" type="checkbox"/>		

<b>Policy Name</b>	<b>Utilization Management Plan</b>		
<b>Policy Number</b>	UM01		
<b>Effective Date</b>	May 2009	<b>Revision Date</b>	April 2011
<b>Responsible Position</b>	Utilization Management & Pharmacy Managers		
<b>Regulatory Requirement(s)</b>	<p>Minnesota Department of Human Services (DHS) Families and Children contract</p> <p>DHS Minnesota Senior Health Options (MSHO) contract</p> <p>DHS Special Needs BasicCare (SNBC) contract</p> <p>Title 42 Code of Federal Regulations (CFR) Part 422.152</p> <p>MN Rules part 4685.1115; 9530.6600 – 6655</p> <p>MN Stat. sec 62M.04 – 62M.12; Chap. 62D</p> <p>National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans, UM Chapters</p>		

**Policy**

Pursuant to the above regulatory authorities, PrimeWest Health seeks to provide quality care and services to meet the health needs of its members. The Utilization Management (UM) Plan provides a comprehensive, systematic approach to the delivery of effective and appropriate care and services to members. It is designed to coordinate the provision of services to members; promote and assure service accessibility; provide attention to individual needs, continuity of care, and comprehensive and coordinated service delivery; provide culturally appropriate care; and assure fiscal and professional responsibility. Components of the UM Plan provide mechanisms for reviewing, monitoring, evaluating, and improving the utilization of all covered services. This includes behavioral health services, dental services, pharmacy services, chiropractic services, and all medical services.

The PrimeWest Health Joint Powers Board (JPB) has full and final authority for all UM activities and decisions. The JPB delegates responsibility for oversight of UM activities to the Quality and Care Coordination Committee (QCCC) and day-to-day operational activities to the Senior Medical Director and the Director of Care & Quality Management.

\*PrimeWest Health's name for the Minnesota Senior Health Options (MSHO) program

‡PrimeWest Health's name for the Special Needs BasicCare (SNBC) program for people *without* Medicare

‡PrimeWest Health's name for the Special Needs BasicCare (SNBC) program for people *with* Medicare

## Procedure

### A. Goals

1. Goals of the Utilization Management (UM) Plan are to improve the quality of health care for PrimeWest Health members through the following:
  - a. Provision of effective and appropriate care and services to members
  - b. Partnership with practitioners and providers, including local Public Health and Social Service agencies, to achieve optimum outcomes for members
  - c. Evaluation of the delivery and use of services to identify opportunities for improvements
  - d. Effective utilization of resources, focusing on both over- and under-utilization of services, and corrective actions proposed when these are identified
2. PrimeWest Health strives to provide access to members for medically necessary provisions of care. This includes all aspects of the care continuum, including behavioral health and chemical dependency (CD). The UM program ensures that health care related services are appropriately provided and monitored and professionally managed.

### B. Components

1. Inpatient review
  - a. All MinnesotaCare members are reviewed and flagged to ensure that inpatient cost limits do not exceed Minnesota Department of Human Services (DHS) contract thresholds.
  - b. All members are authorized for an inpatient stay based upon PrimeWest Health benchmarks for the admission diagnosis and reviewed periodically thereafter based on their changing conditions for continued stay determinations.
2. Outpatient review
  - a. Outpatient review includes the review of specific procedures and services, durable medical equipment (DME), and referrals. Examples may include reviewing for the use of multiple providers for the same diagnosis or emergency room use for typically non-emergency type services. PrimeWest Health identifies those instances when Service Authorization is required in specific policies and procedures. These are made available to members in the **Certificate of Coverage**, to practitioners in the **Provider Manual**, and on the PrimeWest Health website. Emergency and clinic services are evaluated through the claims data processing procedures.
3. Special review
  - a. Out-of-network care requires Service Authorization and is subject to special review, including continuity/transition of care and second opinions. Court-ordered treatment may not be subject to special utilization review processes. PrimeWest Health maintains defined policies and procedures for review of these identified circumstances. Out-of-network Service Authorization requirements are made available to members in the **Certificate of Coverage**, to practitioners in the **Provider Manual**, and on the PrimeWest Health website.
4. Care Coordination service
  - a. PrimeWest Health's Care Coordination service is designed to coordinate the provision of services to its members; promote and assure service accessibility; provide attention to individual needs, continuity of care, and comprehensive and coordinated service delivery; provide culturally appropriate care; and assure fiscal and professional accountability.

- b. PrimeWest Health's Care Coordination service is personal, one-to-one support from professional staff provided for members whose care is complex and/or high cost based on either actual or potential risk. PrimeWest Health coordinates care with members using family members/guardians, primary care practitioners, Public Health and Social Service case management programs, and other agency expertise to ensure the best outcomes through the PrimeWest Health Care Coordination model. Members may self-refer into PrimeWest Health's Care Management service, be referred by family members or practitioners, or be identified through screening of specific diagnoses and/or high-cost claims.
- c. Care Coordination includes functions relating to individual health and/or CD problems; transitional services; mental retardation; high-risk health problems ethnic/cultural special needs or identified issues related to difficulty living independently, functional problems, and language or comprehension barriers. Potential issues are found through analysis of Health Risk Assessment (HRA) surveys and pharmacy and medical claims data looking for both over- and under-utilization of services. The assessment may result in individual treatment plan development, establishment of treatment objectives, treatment follow-up, monitoring of outcomes, or revision of a previously established treatment plan.
- d. Other services tracked and analyzed include, but are not limited to:
  - i. Hospital emergency department utilization
  - ii. Inpatient stays
  - iii. Hospital readmission for the same or similar diagnosis
  - iv. Individual member claims totaling more than \$100,000.00 per year
  - v. High utilization of pharmaceuticals (both volume of fills and dollars spent)
  - vi. Home care services utilizations
- e. PrimeWest Health will follow members identified as having special needs after implementing a course of action to see how effective interventions were. Referrals to specialists are part of the interventions PrimeWest Health considers when developing its interventions. PrimeWest Health shall report to the State as part of its annual report efforts to identify members with special health care needs, the total number of adults identified, and the total number of assessments completed.

**C. Monitoring of Administrative Data**

1. Monitoring includes the production and review of quarterly and annual reports based on utilization of services using PrimeWest Health administrative data through a standard report package and ad hoc reporting. Program review and analysis is initiated by the Director of Care & Quality Management and the PrimeWest Health Senior Medical Director in coordination with other PrimeWest Health departments. Program monitoring oversight has been designated by the PrimeWest Health Joint Powers Board (JPB) to the Quality and Care Coordination Committee (QCCC). In accordance with Title 42 Code of Federal Regulations (CFR) Part 422.152 (b)(2), this review and analysis includes monitoring for patterns of care, including over-utilization and/or under-utilization, admission rates, average lengths of stay, and costs. The data may be analyzed by procedure, by member, by practitioner, or in other stratifications as determined by PrimeWest Health and required by contract or by regulatory requirements. PrimeWest Health chooses at least four relevant types of utilization data based on current National Committee for Quality Assurance (NCQA) **Standards and Guidelines for the Accreditation of Health Plans** in accordance with section 7.1.3 of the DHS Families and Children contract. Areas of focus are dictated by MN Rules part 4685.1115, subp. 2, and include at least one area of focus

related to behavioral health to monitor for each product line. Thresholds are determined based upon national benchmarks when available and/or prior utilization data for each product line and are annually quantitatively analyzed against the established thresholds to detect under- and over-utilization. This includes behavioral health. PrimeWest Health makes a reasonable effort to use Healthcare Effectiveness Data and Information Set (HEDIS) Medicaid rates from NCQA as its national benchmark data against which to measure its utilization experience.

2. PrimeWest Health reviews all data and examines possible reasons why they are not within thresholds. PrimeWest Health analyzes data not within thresholds by practice sites. PrimeWest Health will measure and take action to address identified problems with under- and over-utilization.
3. On at least an annual basis, PrimeWest Health evaluates the effectiveness of the actions taken. This evaluation may be in the form of medical record audits, continued monthly monitoring of administrative data, or developing ad hoc reports. If evaluation demonstrates that actions were ineffective in changing utilization trends, the UM Committee addresses alternate actions to be implemented. These actions are passed forward to QCCC for further discussion and analysis before being approved as policy changes.

#### **D. Evaluation**

1. Evaluation of the UM Plan is conducted on an ongoing basis through the monitoring activities described above. On an annual basis, a formal evaluation of the UM Plan is conducted. The annual evaluation includes review of the UM Plan document, review of annual reports of monitoring activities, and review of member and practitioner input gathered as a result of complaint trends and satisfaction surveys.
2. The identification and prioritization of opportunities for improvement is documented in the annual UM report, which is presented to QCCC for review and approval. Results of QCCC action are presented to the JPB, who retains full and final authority for UM activities.

#### **E. Utilization Review Process**

1. Utilization review processes, including the Service Authorization process, are well defined and documented to comply with applicable regulations. PrimeWest Health utilizes established policies and procedures that address the use of criteria, information collection, review determinations, notifications, and Appeals. All internal review processes are reviewed annually, at a minimum, to ensure adherence to all applicable components of MN Stat. Chap. 62M and related citations
  - a. Criteria
    - i. In accordance with MN Stat. Chap. 62M.09, PrimeWest Health utilizes written clinical criteria to ensure consistent, appropriate decision-making regarding care and services. PrimeWest Health uses nationally accepted criteria and follows written policies and procedures that reflect current standards of medical practice, such as InterQual, or other valid criteria (e.g., DHS guidelines) for utilization review decisions, in accordance with 42 CFR 422.152 (b)(1). All criteria are well-documented and include procedures for application of the criteria based on the needs of individual patients and characteristics of the local health care delivery system. Actively practicing practitioners from appropriate specialties are involved in the development or adoption of criteria and in the procedures for application of the criteria. The criteria are evaluated annually and updated as necessary to stay current with evolving standards of medical care. Criteria and/or professional treatment

- guidelines used to establish medical necessity, appropriateness, and efficacy of a procedure or service are made known to members, practitioners, and regulators upon request in accordance with MN Stat. sec. 62M.10, subd. 7. Only licensed practitioners make clinical decisions that require clinical judgment.
- ii. When required by contractual or regulatory requirements, PrimeWest Health utilizes criteria established by the State (e.g., assessment and placement of members for CD treatment). PrimeWest Health contracts with its county partner Rule 25 assessors for determining appropriate setting of care and treatment for CD. MN Rules parts 9530.660 – 6655 are followed.
  - iii. PrimeWest Health evaluates the consistency with which UM criteria are applied in decision making (Inter Rater Reliability (IRR)) through regular UM “rounds” attended by UM staff and Medical Director. In addition, monthly audits of randomly selected DTRs and authorizations are conducted against criteria. Determinations and problem cases are discussed and evaluated during these meetings as well as determining actions to take if opportunities are identified to improve consistency
  - iv. Policies, procedures, and criteria are reviewed, at a minimum, on an annual basis by the PrimeWest Health QCCC. Modifications will be developed and implemented as necessary. QCCC will address issues raised through data collection and through feedback from members, participating network providers, and the communities it serves.
  - v. Determinations affecting Medicare eligible members consider criteria published by the Centers for Medicare & Medicaid Service (CMS) as National Coverage Determinations and the Wisconsin Physician Services Insurance Company (WPS) for Local Coverage Determinations for select services during the decision making process to approve or deny in accordance with 42 CFR 422.101 (b).
- b. Triage and referral protocols for behavioral health care
- i. PrimeWest Health does not require referrals for either medical or behavioral health services provided within the network. PrimeWest Health members may see any contracted provider within the PrimeWest Health network for a covered benefit. PrimeWest Health does not make a determination regarding expedited versus standard review time frames. The health care provider requesting Service Authorization determines the level of urgency at which PrimeWest Health conducts the review. Any request received from a licensed health care provider marked as urgent will be handled in that manner in accordance with MN Stat. sec 62M.05. subd. 3b.
- c. Information collection
- i. In accordance with MN Stat. sec 62M.04, subd. 2, PrimeWest Health collects only the information necessary to authorize the care or service. Specific codes are not required on the authorization request but are requested to accurately assess the member’s condition and improve accuracy in types and length of services authorized. Complete copies of medical records are not routinely requested, but occasionally portions may be needed for prospective and/or concurrent review if difficulties develop in certifying the medical necessity or appropriateness of the admission or extension of stay. Copies of medical records or parts thereof may also be requested for retrospective review for a variety of purposes, such as ensuring compliance with utilization review procedures. PrimeWest Health will reimburse providers a reasonable amount for preparation and delivery of requested medical records. Requests

related to Appeals or audits of data discrepancies are exempt from this provision. PrimeWest Health staff generating calls regarding UM issues will identify him/herself by name and title and will state that he/she is a PrimeWest Health employee.

- ii. Unless allowed by other regulations, PrimeWest Health limits its data collection to elements and/or protected health information (PHI) defined by MN Stat. sec. 62M.04, subd. 3 which allows for the following:
  - Patient/member information that includes name, address, date of birth, sex, social security number or member identification number, and other information necessary to determine eligibility
  - Attending health care professional information that includes sufficient information to determine eligibility for payment and allow PrimeWest Health to accurately pay for services and report such payment to regulatory agencies
  - Diagnosis and treatment information that includes primary diagnosis with associated ICD-9 or DSM coding; additional diagnosis with associated ICD or DSM coding; proposed procedures or treatments with ICD or Current Procedural Terminology (CPT) codes; surgical assistant requirement, if any; anesthesia requirement, if any; proposed admission or service dates; proposed procedure date; and proposed length of stay and/or other information necessary to accurately determine claims payment
  - Clinical information that includes support and documentation of appropriateness and level of service proposed and identification of treating provider for detailed clinical information
  - Facility information that includes sufficient information to determine appropriateness of services and accurately pay the claim
  - Concurrent or continued stay review information that includes additional days, services, or procedures proposed; reasons for extension, including clinical information sufficient for support of appropriateness and level of service proposed; and diagnosis status. In accordance with MN Stat. sec. 62M.05, subd. 2, however, these concurrent reviews are not conducted on a daily basis.
  - For admissions to facilities other than acute medical or surgical hospitals, additional information that may include history of present illness, patient treatment plan and goals, prognosis, staff qualifications, and 24-hour availability of staff to allow PrimeWest Health to determine appropriateness of services
- iii. Other information may be required for other specific review functions such as discharge planning, second opinions, and case management/care coordination.
- iv. MN Stat. sec. 62M.04, subd. 4 authorizes PrimeWest Health to request additional information in those instances where there is a significant lack of agreement between PrimeWest Health and the practitioner regarding the appropriateness of authorization of care and/or services during the review or Appeal process. "Significant lack of agreement" means that PrimeWest Health has:
  - Tentatively determined through its professional staff that a service cannot be authorized;
  - Referred the case to a physician for review; and/or

- Talked to or attempted to talk to the attending health care professional for further information
- v. Failure of a practitioner or a member to provide necessary information for review may result in denial of authorization for the requested service until requested information is provided in accordance with MN Stat. sec. 62M.05, subd.4.
- vi. To comply with MN Stat. sec 62M.04, subd. 5, PrimeWest Health shares all available clinical and demographic information internally as necessary for business decisions to avoid duplicate requests for information from members or practitioners. For example, PHI collected to make Service Authorization decisions may be used to resolve Grievances or Appeals related to those services.
- vii. To comply with MN Stat. sec. 62M.08, PrimeWest Health takes appropriate measures to ensure confidentiality of patient-specific information, consistent with applicable federal and State laws, including Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. Information obtained during utilization review is used solely for the purposes of utilization review, discharge planning, case management, and quality assurance activities. The information is shared only with those organizations, practitioners, or persons that have the authority to receive such information. Summary data may be shared when they do not provide sufficient information to allow identification of individual patients.

#### **F. Review Determinations**

1. To comply with MN Stat. sec. 62M.05, subd. 1, PrimeWest Health has written procedures in place for consistent, appropriate reviews of requests for care and/or services. A practitioner acting on behalf of the member may submit a request to PrimeWest Health for authorization of care and/or services. Members and/or their responsible representatives (including family members) may initiate requests, but the practitioner must submit supporting medical documentation. The request may be submitted in writing or by telephone to PrimeWest Health and must include all information necessary to make a review determination. Failure to submit necessary information in a timely manner may delay authorization of the requested services.
2. Professional trained and oriented staff reviews the request, using established criteria such as InterQual. Only licensed practitioners are allowed to make clinical decisions that require clinical judgment. If the request meets criteria, the care and/or services are authorized. If additional information is needed in order to make a determination, that information is requested. In accordance with MN Stat. sec 62D.12, subd 19, PrimeWest Health does not deny or limit services based solely on failure to procure a prospective Service Authorization. The same criteria is used to determine medical necessity whether the request is submitted prior to or after the service is provided. PrimeWest Health does encourage the submission of requests prior to services being provided to limit provider or member liability in the case medical need is not established and a denial is deemed to be the appropriate course of action.
3. When a decision is made to authorize the requested care and/or services, the provider is promptly notified by telephone in accordance with MN Stat. sec. 62M.05, subd. 3a. Documentation is maintained regarding the notification, including date, person notified, and the health care provider requesting the Service Authorization. The information used to determine the level of urgency at which PrimeWest Health conducts the review includes member, service or procedure authorized, date of the service or procedure, and certification number, if applicable. A written notification

- follows the telephonic notification to the practitioner and the member. Notification may also be made by fax to a verified number or by electronic mail to a secure electronic mailbox.
4. If a denial of services based on lack of medical necessity is being considered, the request will be reviewed by a qualified physician reviewer licensed in the State of Minnesota who is reasonably available by phone to the requesting health care provider, if needed, in accordance with MN Stat. sec 62M.09, subd. 3, prior to a final decision being made. In cases involving outpatient behavioral health and substance abuse services, a psychiatrist certified by the American Board of Psychiatry and Neurology and licensed in Minnesota, or a doctoral-level psychologist licensed in Minnesota (if the treating provider is a psychologist) will review the case prior to a decision being made in compliance with MN Stat. sec. 62M.09, subd. 3a. Doctoral level psychologists shall not review any request or final determination not to authorize a mental health or substance abuse service or treatment if the treating provider is a psychiatrist.
  5. When the final decision is made to not authorize the requested care and/or services, PrimeWest Health notifies the practitioner and facility, when applicable, by telephone within one working day of the determination being made. MN Statute 62M.05 also allows initial notification to be made by fax to a verified number, or by electronic mail to a secure electronic mailbox. Written notification (by United States mail) follows the telephone notification to the attending health care provider and the facility as applicable. Written notification (by United States mail) is also sent to the member. MN Statute considers fax to a verified number or electronic mail to a secure mailbox as meeting the requirement for written notification. The written notification follows State requirements for notices of denial, termination, or reduction (DTR) of services and includes the principal reason(s) for the decision and the process for initiating an Appeal of the decision.
  6. To comply with MN Stat. sec. 62M.05, subd. 3a, for standard review determinations, utilization review determinations are communicated to the practitioner, the member, and the claims administrator within 10 business days of receipt of the request. In those instances where the attending practitioner requests an expedited review, decisions and telephone notifications are made within 72 hours of receipt of the request. In the event of a request for authorization after the service has already been provided (retro review), determinations will be communicated to the provider within 30 calendar days of receipt of the request.
  7. Upon request, PrimeWest Health will provide the practitioner and/or the member with the criteria used to determine the necessity, appropriateness and efficacy of the health care services and identify the professions treatment parameter, databases or other basis for the criteria. The right to request criteria is included in the member and provider written notice.
  8. If PrimeWest Health proposes to reduce or terminate a member's ongoing medical service that has been ordered by a participating or treating practitioner, PrimeWest Health provides notice 10 days prior to the proposed action. In accordance with MN Statute 256B.0659, PrimeWest provides notice 30 days prior to the effective date of the change for PCA services). If the member makes a formal written Appeal to PrimeWest Health or to the State prior to the date of the proposed action, PrimeWest Health will not reduce or terminate the service until 10 days after the Appeal is final and a written decision is issued if the member has requested that the services continue at the current level.
  9. PrimeWest Health maintains an audit trail of the determination, including notifications by telephone (or fax to a verified number, electronic e-mail to a secure electronic

mail box) that includes dates, name of the person spoken to, the enrollee, the service, procedure or admission that is authorized, and the date of service , procedure or admission.

### **G. Appeals**

Appeal decisions are made following PrimeWest Health Complaints, Appeals, and Grievances policies and procedures QMAG 01: Grievance System, which are in compliance with contractual and regulatory requirements. The appeals process is further defined in PrimeWest Health policies and procedures, which supersede any timelines and other requirements specified in this document.

1. To comply with MN Stat. sec 62M.06, subd. 1, PrimeWest Health maintains written policies and procures to handle Appeals of denied Service Authorization requests. Refer to QMAG01. Members, applicants, former members, attending health care providers, or anyone acting on behalf of the member has the right to Appeal a PrimeWest Health utilization review determination. The right to submit an Appeal and the procedure for initiating an Appeal are communicated to the member and to the practitioner with the denial notification. The Appeal rights shall follow State requirements for such notices. The request for an Appeal may be made in writing or by telephone to PrimeWest Health in accordance with MN Stat. sec. 62M.06, subd. 3. The request must include all information necessary for PrimeWest Health to conduct its review of the Appeal. To comply with MN Stat. sec. 62M.11, members may file a complaint regarding a determination not to certify directly to the commissioner responsible for regulating PrimeWest Health. Members are also informed of Appeal rights.
2. PrimeWest Health's Appeals and Grievances Coordinator reviews the Appeal request and gathers any information necessary for review of the Appeal, such as medical records. The Appeal request and related information are forwarded to the Senior Medical Director for review. The Senior Medical Director will determine the appropriate specialty physician or provider type to review the Appeal and related information and document his/her findings and decision on the Appeal issue. The individual making the decision will not be involved in any previous level of review or decision-making. (i.e., if a cardiologist is the attending provider, the Appeal case would be sent to a board-certified cardiologist to review prior to a denial being issued). In cases involving behavioral health services, dental services, and chiropractic services, a reviewer licensed and/or board-certified in that specialty in compliance with MN Stat. sec 62M.09, subd. 3a, subd. 4, and subd. 4a, will review the case prior to a decision being made. Any physician reviewers used by PrimeWest Health in the Appeals process will be board-certified by the American Board of Medical Specialists, the American Board of Osteopathy, or any other nationally accredited board acceptable to satisfy MN Stat. sec 62M.09, subd. 6 requirements.
3. Determinations not to certify services and procedures will be based on written clinical criteria and review procedures.
4. In those instances when the initial decision is not reversed, the member and the practitioner are provided with the following:
  - a. A complete summary of the review findings
  - b. Qualifications of the reviewers, including license, certification, or specialty designation

- c. The relationship between the member's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision
  - d. Notification of the right to submit the appeal to the external appeal process, and the procedure for initiating the process. This information is provided to the member and the attending health care professional as soon as practical.
5. Appeal decisions are made following PrimeWest Health Complaints, Appeals, and Grievances policies and procedures, which are in compliance with contractual and regulatory requirements. The appeals process is further defined in PrimeWest Health policies and procedures, which supersede any timelines and other requirements specified in this document.

#### **H. Delegation**

1. In selected instances, PrimeWest Health may choose to delegate UM functions to a third party administrator (TPA) or another health care entity. Prior to any delegation, PrimeWest Health will conduct a pre-delegation assessment to determine that the potential delegate meets all requirements of PrimeWest Health and any requirements of the State of Minnesota, including potential designation as a Utilization Review organization. When PrimeWest Health opts to delegate UM functions, a formal delegation agreement is implemented that provides specific requirements related to performance of utilization components and any reporting that is required. PrimeWest Health shall conduct oversight audits no less than on an annual basis. At all times, PrimeWest Health maintains accountability for decisions that are made.

#### **I. Utilization Management Staff**

1. Day-to-day operations of the UM program are the responsibility of the Senior Medical Director and the Director of Care & Quality Management. Others involved directly with UM functions are the UM Manager, Pharmacy Manager, UM care coordinators, and contracted physician reviewers. The Quality Manager is directly responsible for member Appeals and the subsequent review process. PrimeWest Health's Behavioral Health Medical Director is an integral member of the UM program and is actively involved in the development of behavioral health policies and procedures, UM service provision review, clinical guidelines, and care management activities.
2. To comply with MN Stat. sec. 62M.09, subd. 2, the Senior Medical Director and all physician reviewers are licensed in the State of Minnesota and are board-certified in their specialty by the American Board of Medical Specialties or the American Board of Osteopathic Medicine. Dentists, pharmacists, and chiropractors are utilized to review Appeals of PrimeWest Health denials of dental, pharmacy, and chiropractic services, respectively. Behavioral health professionals are utilized for review of service provisions as they relate to behavioral health issues. All reviews are based on the need for medical necessity. The Director of Care & Quality Management and the UM care coordinators are health care professionals, appropriately licensed in the State of Minnesota. UM staff receives orientation to UM functions and activities and receives continuing education on an ongoing basis. To comply with MN Stat. sec. 62M.09, subd. 1, 7, and 8, PrimeWest Health staff conducting reviews are properly trained, qualified, and supervised prior to conducting reviews. There is an established program for orienting and training Utilization Review staff. Ongoing training of UM staff includes annual review of and familiarization with InterQual

- criteria updates, review of DHS criteria changes on an ad hoc basis, and McKesson conference attendance for InterQual updates.
3. All UM decisions are based on appropriateness of care and service and existence of coverage. No individuals who perform utilization review for PrimeWest Health receive any financial incentives based on the number of denials of certifications made by such individuals in accordance with MN Stat. sec. 62M.12.
    - a. In order to promote objectivity in the utilization management decision-making process, PrimeWest Health has adopted a **Conflict of Interest Annual Disclosure** form. This form requires that medical reviewers submit a signed disclosure form when they are hired and annually thereafter to ensure that the design, conduct, and reporting of review activities will not be biased by the significant financial interests or obligations of any reviewer. See Attachment UM01 (a) – Conflict of Interest Form – Annual Disclosure of Financial Interests and Attestation of Compliance Regarding Utilization Management Decisions
  4. At a minimum, providers and members are surveyed annually for their satisfaction of the PrimeWest Health UM process. PrimeWest Health takes strong action to address satisfaction surveys for the purpose of evaluating current processes and implementing strategies to improve outcomes.
  5. To comply with MN Stat. sec. 62M.10, subd. 1 and 2, PrimeWest Health’s review staff and Senior Medical Director work a routine business day—8 a.m. to 4:30 p.m., Monday through Friday. Staff is available to providers, members, and regulators by toll free telephone at **1-866-431-0803** during this time period. In the event that such staff is unavailable, a confidential voicemail system is in place and timely return calls are placed when this is requested. For after hour communications, PrimeWest Health has a 24-hour toll free line that members or providers can call to leave a message.

### Violation of this Policy

No or only partial adherence to this policy may result in noncompliance with current regulatory requirements and subsequent penalties to PrimeWest Health. Remediation for violators will include, but not be limited to, disciplinary action up to and including termination depending on the circumstances of the situation at the time.

### Signatures



Signature Approval: \_\_\_\_\_

Date: 4-7-2011

Charles McKinzie, MD  
Medical Director/Designated Senior Physician



Signature Approval: \_\_\_\_\_

Date: 4-7-2011

Larry Kittelson  
PrimeWest Health Joint Powers Board of Directors