### Policy Name
- Utilization Management Structure/Plan

### Policy Number
- UM01

### Origination Date
- May 2009

### Revision Effective Date
- November 5, 2020

### Responsible Position
- Chief Senior Medical Director, Director of Quality & Utilization Management, Utilization Management Manager, and Pharmacy Manager

### Regulatory Requirement(s)
- 2020 Minnesota Department of Human Services (DHS) Families and Children contract
- 2020 DHS Minnesota Senior Health Options/Minnesota Senior Care Plus (MSHO/MSC+) contract
- 2020 DHS Special Needs BasicCare (SNBC) contract
- 2020 National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- MN Rules parts 4685.1115 and 9530.6600 – 9530.6655
- MN Stat. sec 62M.04 – 62M.12; Chap. 62D
- Title 42 Code of Federal Regulations (CFR) Part 422.152

### Cross-References
- CC01: Care Management
- CC09: High Risk Care Coordination
- CC28: Complex Case Management
- QMAG01: Grievance System
- CC02: Serving Special Populations
- QM03: Quality Assurance Plan
- UM18: UM Staff – Clinical and Non-Clinical
- UM19: Peer-to-Peer Conversation
- UM13: Notices of Denials, Terminations, or Reductions (DTRs) of Services
- UM01a: Utilization Management Affirmative Statement

### Policy
Pursuant to the above regulatory authorities and accreditation requirements, 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 ensure service accessibility; provide attention to individual needs, continuity of care, and comprehensive and coordinated service delivery; provide culturally appropriate care; and ensure 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.

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1This program was formerly called the Prepaid Medical Assistance Program (PMAP)
2PrimeWest Health’s Minnesota Senior Care Plus (MSC+) program for members who have only Medicaid coverage through PrimeWest Health
3PrimeWest Health’s Minnesota Senior Health Options (MSHO) program for members who have both Medicaid and Medicare coverage through PrimeWest Health
4PrimeWest Health’s Special Needs BasicCare (SNBC) program for members who have only Medicaid coverage through PrimeWest Health
5PrimeWest Health’s Special Needs BasicCare (SNBC) program for members who have both Medicaid and Medicare coverage through PrimeWest Health
1. **UM Governance and Committees**

   a. **Joint Powers Board (JPB).** The PrimeWest Health UM program is governed by the JPB, PrimeWest Health’s governing board. The 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). Day-to-day operation activities are overseen by the Chief Senior Medical Director and the Director of Quality & Utilization Management.

   b. **QCCC.** The JPB has delegated responsibility for developing, implementing, monitoring, and reviewing the Quality program to QCCC. The UM Structure/Plan is an integral part of the Quality program. QCCC meets on a bimonthly basis, and in an advisory capacity provides activity reports and makes recommendations to the JPB at least quarterly. QCCC includes participating practitioners or provider administrative staff representing primary and specialty care and behavioral health providers, as well as representatives from community service organizations, county Public Health and Human Services agencies, and community at-large members. PrimeWest Health staff on QCCC includes the following:
   
   i. Chief Senior Medical Director
   ii. Assistant Chief Senior Medical Director
   iii. Family Medicine Medical Director
   iv. Psychiatric Medical Director
   v. Director of Quality & Utilization Management
   vi. Director of Care Management
   vii. Manager of Quality Management
   viii. Pharmacy Manager
   ix. Corporate Compliance Officer
   x. Utilization Management Manager

   c. **UM Committee.** PrimeWest Health’s UM program assumes an organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of member care. As such, the UM Committee has representation from all PrimeWest Health departments in order to ensure that the delivery of services is accessible, acceptable, appropriate, effective, and efficient.

   In order to evaluate the overall UM program, UM goals are formulated with specific processes.
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 through the assessment of the characteristics and needs of the member population and subpopulations
   b. Partnership with practitioners and providers, including local Public Health and Social/Human/Family services 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 underutilization of services, and proposal of corrective actions when 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 substance use disorder (SUD). The UM program ensures that health care-related services are appropriately provided and monitored and professionally managed.

B. Components
1. Inpatient review
   Inpatient stays that are less than 48 hours and in-network inpatient stays for medical and behavioral health are reviewed on a retrospective basis
   a. Inpatient stays at out-of-network facilities (outside of Minnesota, Wisconsin, North Dakota, South Dakota, and Iowa) are reviewed on admission and periodically thereafter based on the member’s changing condition 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 a review checking for the use of multiple providers for the same diagnosis or emergency room (ER) use for typically non-emergency type services. PrimeWest Health identifies those instances when Service Authorization is required in specific policies and procedures. This information is made available to members in the Evidence of Coverage/Member Handbook and to practitioners in the Provider Manual. These documents are posted on the PrimeWest Health website. Emergency and clinic services are evaluated through claims data processing procedures.
3. Special review
   a. Most out-of-network care requires a 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 Evidence of Coverage/Member Handbook and to practitioners in the Provider Manual. These documents are posted on the PrimeWest Health website.
4. Care Management services
   a. PrimeWest Health’s Care Management services are designed to coordinate the provision of services to its members; promote and ensure service accessibility; provide attention to individual needs, continuity of care, and comprehensive and coordinated service delivery; provide culturally appropriate care; and ensure fiscal and professional accountability.
   b. For Families & Children (F&C) and MinnesotaCare members, PrimeWest Health provides Care Management services through personal, one-on-one support from professional staff for members whose care is complex and/or high cost, based on actual or potential risk. For members ages 65 and over and those in Special Needs BasicCare (SNBC), Care Management services are offered to all members upon enrollment and annually. PrimeWest Health coordinates care with members using family members/guardians, primary care providers, Public Health and Social/Human/Family Services case management programs, and other agency expertise to ensure the best outcomes through the PrimeWest Health Care Management model. Members may self-refer into PrimeWest Health’s Care Management program, be referred by
family members or practitioners, or be identified through screening of specific diagnoses and/or high-cost claims (F&C and MinnesotaCare members).

c. Care Management includes functions relating to individual health and behavioral health/SUD, transitional services, developmental disabilities, high-risk health problems, special ethnic/cultural needs, 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 (including the potential high-risk member report) looking for both over- and underutilization of services. The assessment may result in individual treatment plan development, establishment of treatment objectives, treatment follow-up, monitoring of outcomes, and/or revision of a previously established treatment plan.

d. Other services tracked and analyzed include, but are not limited to, the following:

   i. Hospital ER utilization
   ii. Inpatient stays
   iii. Hospital readmission for the same or similar diagnosis
   iv. Individual member claims totaling more than $100,000 per year
   v. High utilization of pharmaceuticals (both volume of fills and dollars spent)

e. As part of Care Management, PrimeWest Health implements a course of action for members identified as having special needs and follows these members to gauge the effectiveness of the interventions. PrimeWest Health considers referrals to specialists when developing interventions. As part of its annual report, PrimeWest Health reports to the State efforts to identify members with special health care needs, the total number of adults identified, and the total number of assessments completed.

5. Complex case management process (see PrimeWest Health Policy and Procedure CC28: Complex Case Management)

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 Quality & Utilization Management and the PrimeWest Health Chief 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 overutilization and/or underutilization, 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 7.1.4 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 overutilization. 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 overutilization.

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
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. This evaluation is written by the UM Manager with review and input from the Chief Senior Medical Director, Pharmacy Manager and the Director of Quality & Utilization Management. 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 prior authorization of services process, 62 M.07 a. (1 – 5), are well defined and documented to comply with applicable regulations. PrimeWest Health utilizes written policies and criteria to determine whether care is appropriate, reasonable, or medically necessary. The policies address the system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee or enrollee’s designee of Appeal procedures under clause. PrimeWest Health complies with section 62M.05 subdivisions 3a and 3b regarding time frames for approving and disapproving prior authorization requests. PrimeWest Health has written procedures for Appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285 regarding release of summary review findings. PrimeWest Health has procedures to ensure confidentiality of patient-specific information, consistent with applicable law, 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. PrimeWest Health cannot conduct or require prior authorization of emergency services for confinement or emergency treatment. The enrollee or the enrollee’s authorized representative may be required to notify PrimeWest Health as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible, per 62M.07 b. If prior authorization for a health care service is required, PrimeWest Health must allow providers to submit request for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This does not apply to dental service covered under MinnesotaCare or Medical Assistance.
   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, including InterQual and InterQual updates, 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. To obtain the criteria used to make a decision, members may call 1-866-431-0801 (toll free); practitioners may call 1-866-431-0803 (toll free) to request the criteria. The criteria will be sent out in the method requested. 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 Substance Use Disorder [SUD] treatment). PrimeWest Health contracts with its county partner Rule 25 assessors and SUD providers to conduct comprehensive assessment for determining appropriate setting of care and treatment for SUD. MN Rules parts 9530.6600 – 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 the Chief Senior Medical Director. In addition, monthly audits of randomly selected denial, termination, and reduction of services (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 are developed and implemented as necessary. QCCC addresses 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 Minnesota-specific Medicare Administrative Contractor (MAC) 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 referral for either medical or behavioral health services provided within the network. Prime West Health does not triage behavioral health or the mental health service provision. 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 a 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 with a supporting statement that indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the member or their ability to regain maximum function is 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. Numerical codes for diagnoses or procedures are not required on the authorization request but are requested, if available, to more 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 reimburses 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 Utilization management staff who generate or receive incoming calls regarding UM issues identify him/herself by name and title and 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 allows 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 or DSM coding if these codes are available; additional diagnosis with associated ICD or DSM coding if these codes are available; proposed procedures or treatments with ICD or Current Procedural Terminology (CPT) codes if these codes are available; 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. This may include but is not limited to: Office and hospital records, history, clinical exam, diagnostic testing results, treatment plans and progress notes, operative and pathological reports, information regarding benefits for services or procedures.

• 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. Additional information may be required for other specific review functions such as discharge planning or catastrophic case management and second opinions.

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 people 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 is 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 do 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 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 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. Requests for covered outpatient drugs are evaluated in time to comply with 42 USC § 1396r-8 (d)(5),including providing a response to a prior authorization request within twenty-four (24) hours of the request and authorizing a seventy-two (72) hours supply of a covered prescription drug in emergency situations. In the event of a request for authorization after the service has already been provided (retro review), determinations are communicated to the provider within 30 calendar days of receipt of the request.
7. Upon request, PrimeWest Health provides 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 profession’s treatment parameter, databases, or other basis for the criteria. The right to request criteria is included in the member and provider written notice.

8. Practitioner can request UM criteria that is utilized within the UM program at any time. To obtain a copy of UM criteria, practitioners may call 1-866-431-0803 (toll free) to request the criteria. The criteria are provided by fax or email.

9. 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 Stat. sec. 256B.0659, 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.

10. PrimeWest Health maintains an audit trail of the determination, including notifications by telephone (or fax to a verified number, electronic email to a secure electronic mail box) that include 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, which are defined in QMAG01: Grievance System, and 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 QMAG 01. Members, authorized representatives, or attending health care providers have 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 follow State requirements for such notices. The request for an Appeal may be made in writing or by telephone or fax 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 (A&G) staff 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 Chief Senior Medical Director for review. The Chief Senior Medical Director determines the appropriate specialty physician or provider type to review the Appeal and related information. The specialty reviewer documents his/her findings/recommendation and provides them to PrimeWest Health. The PrimeWest Health Medical Director that was not involved in any previous level of review or decision making considers the specialty reviewer’s findings/recommendation and makes a decision on the Appeal. The individual making the decision is not involved in any previous level of review or decision making (e.g., 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, reviews the case prior to a decision being made. Any physician reviewers used by PrimeWest Health in the Appeals process are 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 are 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.
   e. In the case of a Prime Health Complete or PrimeWest Senior Health Complete member Appeal for a Medicare covered service that is not overturned, a notice is provided to the member and treating provider that the case file will be forwarded to CMS’s Independent Review Entity (IRE).

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 conducts 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 conducts 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 PrimeWest Health Chief Senior Medical Director and the Director of Quality & Utilization Management. Others involved directly with UM functions are the Pharmacy Manager, Utilization Management Manager, UM care coordinators, and contracted physician reviewers. The Chief Senior Medical Director is involved in UM activities that include management and oversight of individual and population-based activities involving care coordination, case management, behavioral health (in direct collaboration with the Psychiatric Medical Director), and pharmacy. The Chief Senior Medical Director provides clinical leadership for the system-wide Quality program by active participation in development and oversight of the implementation of the Quality Assurance Plan, Annual Quality Assessment, Annual Quality Work Plan, and all committee activities that support the Quality program. The Chief Senior Medical Director ensures that UM staff conduct Utilization review according to policy. The UM Manager provides day-to-day supervision of assigned UM staff, with activities such as ensuring consistent criteria application for each level and type of UM decision, participation in staff training, and monitoring documentation adequacy. The Chief Senior Medical Director conducts day-to-day operation of utilization management review of over- and underutilization; oversees concurrent and retrospective review process; coordinates denials, terminations and reductions in services notifications; and oversees the Service Authorization process for medical health. The Manager of Quality Management is directly responsible for member Appeals and the subsequent review process. PrimeWest Health’s Psychiatric Medical Director is an integral member of the UM program and provides direction for the development and management of PrimeWest Health mental health/substance use disorder related services for all PrimeWest Health members. This position is actively involved in development and implementation of the PrimeWest Health Quality Plan, Annual Quality Work Plan, development of behavioral health policies and procedures, and UM Plan including development, analysis, and interventions of quality studies, standards, outcomes, and systems as they may relate to mental health and substance use disorder services. Refer to UM18: UM Staff-Clinical and Non-Clinical.
2. To comply with MN Stat. sec. 62M.09, subd. 2, the PrimeWest Health Chief 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 and chiropractors are utilized to review Appeals of PrimeWest Health denials of dental 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 Chief Senior Medical Director, Assistant Chief Senior Medical Director, UM care coordinators, Utilization Management Manager, and the Pharmacy Manager are health care professionals, appropriately licensed in the State of Minnesota. UM staff receives orientation to UM function 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 Change Healthcare conference and webinar 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 Utilization Management Affirmative Statement 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 UM01a: Utilization Management Affirmative Statement.

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 Chief Senior Medical Director work a routine business day—8 a.m. – 4:30 p.m., CST Monday – Friday. Staff is available to providers, members, and regulators by calling 1-866-431-0803 (toll free) during this time period. In the event that such staff is unavailable, a confidential voicemail system is in place and return calls are placed within one business day when a return call is requested. (e.g., if a provider is calling to inform UM staff about a discharge date, a return call would not be made). For after-hours communications, PrimeWest Health has a 24-hour toll-free line that members or providers can call to leave a message.

J. Updates to UM Plan Based on 2019 UM Annual Program Evaluation

1. Create two new automation categories for the Service Authorization portlet. This will increase the number of Service Authorizations providers can submit via the portlet. Updates to the Service authorization portlet save time for providers as they are able to submit requests electronically via the portlet instead of submitting manually. Electronic submissions also save PrimeWest Health staff time as they do not have to manually enter information into CareConnect.

2. Upgrade current InterQual Review Manager Software to InterQual Connect. This web-based product allows updates to criteria to be available to us immediately when released, rather than waiting for an update to be released and then downloaded into the program, as is the case with InterQual Review Manager. With this update, we will always be working with the most recent updates when applying criteria.

3. Create additional PrimeWest Health criteria not available in InterQual Connect in order to have specific criteria based on service rather than general medical criteria.

4. Continue to monitor over-utilization of psychotherapy to identify outliers. When identified, PrimeWest Health can intervene and provide outreach to members and providers to assess if members need other type of supports.

5. Continue to monitor E/M outliers for providers who have been identified as high utilizers of higher levels of E/M services. Identified high utilizers will be monitored for patterns of services and possible medical record review for medical necessity.
6. Continue to monitor over-utilization of chiropractic services for over-utilization of services and provide outreach to the providers identified or conduct chart review for medical necessity.

7. Continue reviewing Service Authorization list to see if there are services that are always approved or have low utilization. Removal of prior authorization may prevent a delay in service a member may need.

8. Automate and streamline online Service Authorization requests for the following: inpatient, Restricted Recipient Program, targeted case management, and enteral nutrition. PrimeWest Health is currently working on phase two of upgrades and automation.

9. Automate approval letters to providers through the Service Authorization portlet instead of sending through the mail. This gives providers instant access to letters and helps improve the billing process.

10. Require second opinions for spinal fusion surgeries in an attempt to reduce the number of unnecessary costly surgeries.

11. Utilization Management staff will present quarterly data, broken out by county, at Public Health and Human Services meetings to monitor admissions, emergency room use, acute inpatient average lengths of stay, SUD inpatient discharges, and mental health inpatient average lengths of stay. PrimeWest Health will continue to work with county partners to identify any potential inappropriate emergency room use or other outliers and, once identified, further develop initiatives to address any issues.

12. UM staff involvement in a workgroup that created a Social Determinants of Health (SDoH) assessment to get a better understanding of our members and refer members to appropriate Public Health services in their county of residence.

13. Continue to make outreach calls to members who have a chronic condition and have not seen their primary care provider within the past year.

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

Signatures

Medical Director Approval: [Signature]
Susan Paulson, M.D.  
Chief Senior Medical Director  
Date: 11/05/2020

Board Approval: [Signature]
Brent Olson, Chair  
PrimeWest Health Joint Powers Board of Directors  
Date: 11/05/2020