Product Lines Affected

F&C	X	PHC (HMO SNP)[4]	X
MSC+[1]	X	MnCare	X
PWSHC (HMO SNP)[2]	X	Part D	X
SNBC[3]	X	Other	

Gray text indicates quoted regulatory, statutory, or other language not subject to change

Policy Name	**Utilization Management Structure/Plan**
Policy Number	**UM01**
Origination Date	May 2009
Revision Effective Date	March 5, 2026
Responsible Position	Chief Senior Medical Director, Director of Quality & Utilization Management, Utilization Management Manager, and Director of Pharmacy Management
Regulatory Requirement(s)	2026 Minnesota Department of Human Services (DHS) Families and Children contract 2026 DHS Minnesota Senior Health Options/Minnesota Senior Care Plus (MSHO/MSC+) contract 2026 DHS Special Needs BasicCare (SNBC) contract 2026 National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans Utilization Management Standards 1 and 2 Title 42 Code of Federal Regulations (CFR) Part 422.152, 438.210, 438.330, 438.404, 422.101, and 422.137; 45 CFR 155.260, and 160.103 Title 42 United States Code (USC) Section 1396 MN Rules part 4685.1115, subp. 2 MN Stat. sec. 245G.05 MN Stat. secs. 62M.02, subds. 1 – 5, 7 – 12, 13, 14 – 18, and 21; 62M.04; 62M.05, subds. 1 – 4; 62M.06, subds. 1 – 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; 62M.17, sub. 2; and 62M.18* **MN Stat. secs. 62M.02 – 18 are not effective until January 1, 2026*
Cross-References	CC01: Care Management CC06: Service Authorization CC09: High Risk Care Coordination CC28: Complex Case Management QMAG01: Grievance and Appeal System CC02: Serving Special Populations QM03: Quality Assurance Plan UM18: Utilization Management Staff – Clinical and Non-Clinical UM19: Peer-to-Peer Conversation UM13: Notices of Denials, Terminations, or Reductions (DTRs) of Services UM01a: PrimeWest Health Affirmative Statement Regarding Incentives PM01: Medicare Part B Step Therapy Centers for Medicare & Medicaid Services (CMS) Memo dated November 15, 2023: Additional Operational Instruction on the Utilization Management Committee Structure

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.

[1]PrimeWest Health's Minnesota Senior Care Plus (MSC+) program for members who have only Medicaid coverage through PrimeWest Health
[2]PrimeWest Health's Minnesota Senior Health Options (MSHO) program for members who have both Medicaid and Medicare coverage through PrimeWest Health
[3]PrimeWest Health's Special Needs BasicCare (SNBC) program for members who have only Medicaid coverage through PrimeWest Health
[4]PrimeWest Health's Special Needs BasicCare (SNBC) program for members who have both Medicaid and Medicare coverage through PrimeWest Health

1. **UM Governance and Committees.** 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 program has representation from all PrimeWest Health departments in order to ensure that the delivery of services is accessible, acceptable, appropriate, effective, and efficient.
   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 Plan is an integral part of the Quality program. QCCC meets on a bimonthly basis and evaluates the UM program structure, scope, processes, and information sources used to determine benefit coverage (e.g., limits on services) and medical necessity. The committee also reviews UM rates and identifies needed actions based on the evaluation. The committee, 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. Assistant Medical Director
      iv. Behavioral Health Medical Director
      v. Director of Quality & Utilization Management
      vi. Director of Care & Population Health Management
      vii. Manager of Quality Management
      viii. Director of Pharmacy Management
      ix. Pharmacy Manager
      x. Corporate Compliance Officer
      xi. Utilization Management Manager
   c. **Part B Pharmacy and Therapeutics (P&T) Committee.** PrimeWest Health's P&T Committee reviews drugs for Part B step therapy and develops criteria to ensure appropriate, cost-effective use of Part B medications, such as injectable immune therapies. Membership includes at least two pharmacists and two physicians. The P&T Committee: (1) includes a majority of members who are practicing physicians, (2) includes at least one practicing physician and one practicing pharmacist who are independent and free of conflict relative to PrimeWest Health or its plans, (3) includes at least one practicing physician and one practicing pharmacist who are experts regarding care of elderly or disabled individuals, and (4) includes members representing various clinical specialties (e.g., primary care, behavioral health). As allowed by the CY2024 final rule, PrimeWest Health's P&T Committee serves as the UM Committee for the purposes of compliance with Title 42 Code of Federal Regulations (CFR) Part 422.137. PrimeWest Health is permitted to leverage existing committees to satisfy this regulatory requirement. PrimeWest Health may adapt or alter existing committees, including committees required by accrediting bodies and existing P&T committees. Recommendations made by the P&T Committee are reviewed by the QCCC and JPB prior to implementation.
   d. **UM Committee.** As allowed by the CY2024 final rule, PrimeWest Health's P&T Committee serves as the UM Committee for purposes of compliance with 42 CFR 422.137. PrimeWest Health is permitted to leverage existing committees to satisfy this regulatory requirement. PrimeWest Health may adapt or alter existing committees, including committees required by accrediting bodies and existing P&T committees. The UM Committee reviews and approves all UM policies and procedures in use by PrimeWest Health on an annual basis, including the establishment of internal coverage criteria when there is no national or local coverage determination (NCD/LCD) or other published criteria for coverage PrimeWest Health is required to adhere to. Recommendations made by the UM Committee are reviewed by the QCCC and JPB prior to implementation.
   e. **Utilization Review (UR) 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 UR Committee has representation from all PrimeWest Health departments in order to ensure that the delivery of services is accessible, appropriate, effective, and efficient.

Definition(s)

Prior authorization: Has the same meaning as Service Authorization

Service Authorization: A Service Authorization or prior authorization is a member’s request, or a provider's request on behalf of a member, for the provision of services and the determination of the medical necessity for the medical service prior to the delivery or payment of the service

Procedure

In order to evaluate the overall Utilization Management (UM) program, UM goals are formulated with specific processes.

A. Goals

1. The goals of the 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. Refer to Policy and Procedure CC06: Service Authorization for specifics on Service Authorization requirements.
   e. Evaluation of the UM program, which includes evaluations of UM rates and identifying needed actions based on the rates
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 ***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 ***Member Handbook*** and to practitioners in the ***Provider Manual***. These documents are posted on the PrimeWest Health website.
4. Care & Population Health Management services
   a. PrimeWest Health's Care & Population Health 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 and MinnesotaCare members, PrimeWest Health provides Care & Population Health 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 & Population Health Management services are offered to all members upon enrollment and annually. PrimeWest Health's chronic condition management program (Focused Wellness)

is available for PrimeWest Health members in all programs; the program helps members improve condition management while helping members work toward self-selected health-related goals. 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 & Population Health 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 (Families and Children and MinnesotaCare members).

c. Care & Population Health Management includes functions relating to individual health and behavioral health 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 & Population Health 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 (refer to 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, Manager of Utilization Management, Director of Pharmacy 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 438.330[b][3]), 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 7.1.3 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 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 to impact utilization trends. 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 UR 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. This evaluation is written by the UM Manager with review and input from the Chief Senior Medical Director, Director of Pharmacy Management, 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, (42 CFR §438.210), 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 42 CFR §438.210(d) and, effective January 1, 2026, MN Stat. sec. 62M.05 regarding time frames for approving and disapproving prior authorization requests. Refer to PrimeWest Health Policy and Procedure CC06: Service Authorization. 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 42 CFR 438.404 regarding release of notice of an adverse benefit determination. 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 Statutes, MN Rules and Code of Federal Regulations 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 treatment as reasonably possible, per. MN Rule 4685.1010, subp. 7. 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.
2. Criteria
    a. 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 422.101(b), 422.152 (b)(1), and 438.210. 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. This could include, but is not limited to, the availability of highly specialized services such as transplant facilities and cancer centers, the ability of local hospitals to provide all recommended services

within the estimated length of stay, or the availability of outpatient services in lieu of inpatient services (e.g., surgical centers versus inpatient surgery). 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 by the UM Committee annually, including InterQual and InterQual updates, and updated as necessary to stay current with evolving standards of medical care. Internal coverage 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 on PrimeWest Health's website and upon request in accordance with PrimeWest Health Policy and Procedure CC06: Service Authorization and 42 CFR 438.404. To obtain the criteria used to make a decision, members may visit PrimeWest Health's website or call **1-866-431-0801** (toll free); practitioners may review the criteria on the PrimeWest Health website or 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.

b. 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) or the Centers for Medicare & Medicaid Service (CMS) (e.g., LCDs/NCDs). PrimeWest Health utilizes qualified assessors and SUD providers to conduct comprehensive assessments for determining appropriate level of care and treatment for SUD. MN Statute 245G.05 is followed.

c. PrimeWest Health evaluates the consistency with which UM criteria are applied by UM nurses, medical directors, and dental reviewers through annual inter rater reliability (IRR) testingand through regular UM "rounds" attended by UM staff and the Chief Senior Medical Director. 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.

d. 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.

e. 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 and internal clinical criteria, if applicable, for select services during the decision making process to approve or deny in accordance with 42 CFR 422.101 (b).

3. Triage and referral protocols for behavioral health care.
   a. PrimeWest Health does not require referral for either medical or behavioral health services provided within the network. PrimeWest Health does not triage behavioral health or mental health service provision. PrimeWest Health members may see any contracted provider within the PrimeWest Health network for a covered benefit. Effective January 1, 2026, outpatient mental health treatment or SUD treatment is excluded from service authorization requirements for contracted and non-contracted providers.
4. 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 as an expedited authorization decision in accordance with 42 CFR 438.210.

F. Review determinations

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. 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. 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. 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 to consult with the requesting health care provider, if needed, in accordance with 42 CFR 438.210, prior to a final decision being made.
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, by fax to a verified number or electronic mail to a secure electronic mailbox within one working day of the determination being made. 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 42 CFR 438.404(c)(3) referring to 438.210(d)(1) and MN Stat. sec. 62M.05, for standard review determinations, utilization review determinations are communicated to the practitioner, the member, and the claims administrator within five 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 48 hours, which must include one business day, of receipt of the request. Requests for covered outpatient drugs are evaluated in time to comply with Title 42 United States Code (USC) Section 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.
7. 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.
8. 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.
9. Practitioner can request UM criteria that is utilized within the UM program at any time. To obtain a copy of UM criteria, practitioners may visit the PrimeWest Health website or call **1-866-431-0803** (toll free) to request the criteria. The criteria are provided by fax or email or via the PrimeWest Health website.
10. 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. 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.

11. 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. 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. The request must include all information necessary for PrimeWest Health to conduct its review of the Appeal.
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 reviews and 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 dental services and chiropractic services, a reviewer licensed and/or board-certified in that specialty 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.
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, Director of Pharmacy Management, 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 Behavioral Health 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 Behavioral Health 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: Utilization Management Staff-Clinical and Non-Clinical.
2. To comply with NCQA standards UM 4 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, Assistant Medical Director, Behavioral Health Medical Director, Director of Pharmacy Management, Dental Medical Director, Dental Reviewers, Licensed Alcohol and Drug Counselor, Licensed Independent Clinical Social Worker, 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. 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 webinar attendance for InterQual updates.

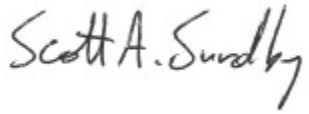
3. All UM decisions are based on appropriateness of care and service and existence of coverage. No individuals who perform utilization review for PrimeWest Health receive any financial incentives based on the number of denials of certifications made by such individuals in accordance with MN Stat. sec.72A.20, subd. 33.
    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, 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 NCQA UM 3, 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 (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. Communications received after midnight Monday – Friday are responded to the same business day.

J. Updates to UM Plan Based on 2024 UM Annual Program Evaluation

1. Implement a dental category in the Service Authorization portlet.
    a. This was put on hold in 2024 in order to dedicate resources to projects with higher priorities.
2. Prepare for 2027 interoperability rules and automation of Service Authorizations.
3. Add additional InterQual modules to help with genetic testing reviews and delete modules that are no longer applicable.
4. Continue to monitor overutilization of psychotherapy visits.
5. Continue to monitor E/M outliers.
6. Continue reviewing Service Authorization list to see if there are services that are always approved. Removal of these services can help prevent delays in members getting needed services.
7. Continue automating and streamlining online Service Authorization requests and continue working on phase two of the portlet, which includes upgrades and automation.
8. Continue IRR testing with all UM staff to ensure criteria are being applied consistently.
9. Continue risk adjustment reviews and continue modifying our risk score accuracy potential report to capture targeted charts for review.
10. Present quarterly UM data at Public Health and Human Services meetings to monitor admissions, ER use, acute inpatient average length of stay (ALOS), SUD inpatient discharges, and mental health inpatient ALOS. PrimeWest Health will continue to work with county partners to identify any potential inappropriate ER use or other outliers and, once identified, further develop initiatives to address any issues.
11. Implement text messaging (utilizing the Mutare platform) to members who have not seen their primary care provider within the past year.
12. Monitor disparities in race and ethnicity data to help identify areas of concern and to help PrimeWest Health develop additional interventions to address any identified over- or underutilization of services.
13. Create additional PrimeWest Health criteria not available in InterQual Connect related to the interoperability rule for 2025.
14. Work with PrimeWest Health's Data and Reporting team to combine all daily monitoring reports into a single report.

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: **Date:** 3/5/2026

Scott Sundby, MD
Chief Senior Medical Director

Board Approval: **Date:** 3/5/2026

Gary Hendrickx, Chair
PrimeWest Health Joint Powers Board of Directors