



Department of Consumer & Business Services

Insurance Division — 2

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Utilization Review  
Annual Summary

Utilization review annual summary for 2003.

Due on **June 30** for previous calendar year.

All health benefit insurers that provide utilization review or have utilization review provided on their behalf shall file an annual summary describing all utilization-review policies and utilization-review monitoring activities, including delegated functions. ORS 743.807, OAR 836-053-1130

1. Company name: Clear Choice Health Plans a dba of Central Oregon Independent Health Services Filing date: 5/28/04
2. Company address: 2650 NE Courtney Dr.  
City, state, ZIP: Bend, OR 97701
3. Company Web site: www.clearchoicehp.com
4. Name, e-mail address, and phone number of the person completing this form:  
Pamela Johnson: VP Regulatory Affairs, pjohnson@coihs.com 541 330-4960
5. Name, title, and department of manager responsible for oversight of utilization review:  
Diana Hergenrader RN Manager of Medical Affairs, dhergenrader

For the following information, enter the URL, or the name of the publication in which it appears:

6. Time frame for making utilization review decisions:  
Target: 48 hours / 2 days Actual (average): less than 2 days  
URL, or the publication title, date, and page: Pre-Authorization Policy attached
7. Specify minimum qualifications for those who make first-level utilization-review decisions:  
Registered Nurse, Pharmacist or Physical Therapist  
URL, or the publication title, date, and page: Job Description attached
8. Specify minimum qualifications for those who make second-level utilization-review decisions:  
Registered Nurse or MD (Medical Director or Medical Management Committee)  
URL, or the publication title, date, and page: Job description attached.
9. Do providers participate in making utilization-review decisions?  
 No  Yes At which level(s)? 2<sup>nd</sup> level or higher  
URL, or the publication title, date, and page: Medical Management Committee Policy attached
10. Indicate the sources of clinical information the company researches for utilization-review decisions:  
Standards set by the Quality Assurance/UM Committee, Medline, Medicare Coverage decisions and private resources from Stn Anthony's Press  
URL, or the publication title, date, and page: see attached Practice Guidelines Policy



11. List company's steps in developing utilization-review criteria:

**See Attached Practice Guidelines Policy**

URL, or the publication title, date, and page: \_\_\_\_\_

12. What action or event causes utilization-review criteria to be revised?

**Changes in Medical and/or Medicare Standards, benefit changes, provider review for community standard of care, community standards, Advances or changes in technology**

URL, or the publication title, date, and page: \_\_\_\_\_

13. How does the company inform enrollees about changes in utilization-review criteria?

**Member Handbook**

URL, or the publication title, date, and page: \_\_\_\_\_

14. How does the company inform providers about changes in utilization-review criteria?

**Provider manual, web page, newsletter, direct physician contact if appropriate**

URL, or the publication title, date, and page: \_\_\_\_\_

15. Is there a procedure for monitoring in-house utilization-review criteria?

No  Yes Specify: **Quality Improvement and Internal Audit**

URL, or the publication title, date, and page: \_\_\_\_\_

16. Does the company delegate any utilization-review activities to outside resources?

No  Yes Specify: \_\_\_\_\_

URL, or the publication title, date, and page: \_\_\_\_\_

17. Are there procedures for monitoring utilization-review activities delegated to outside resources?

No  Yes Specify: \_\_\_\_\_

URL, or the publication title, date, and page: \_\_\_\_\_