

***Health Net of Oregon  
Utilization Management  
Program  
2009***

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- The Health Net of Oregon Vice President of Health Care Services has reviewed and approved this program description.

\_\_\_\_\_ Date \_\_\_\_\_  
Renee D. Claborn, RN  
*Vice President, Health Care Services*

- The Health Net of Oregon Medical Director has reviewed and approved this program description.

\_\_\_\_\_ Date \_\_\_\_\_  
David Krier, MD  
*Medical Director*

## ***Committee Approval***

- The Health Net of Oregon Utilization Management Committee has reviewed and approved this program description.

\_\_\_\_\_ Date: December 2008  
Renee Claborn, VP Health Services, RN  
*Committee Chairman*

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*Utilization Management Program*

*Effective: 10/96      Revised: December 8, 2003, November 23, 2004, November 18, 2005, December 11, 2006, May 9, 2008 December 5, 2008*

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***Revisions must be submitted to the HNOR Health Services Department.***

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**REVIEW/REVISION HISTORY**

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# ***Section 1***

# ***Introduction***

## ***Introduction***

The Health Net of Oregon (HNOR) Board of Directors has established the HNOR Quality Improvement (QI) Program, which includes the Utilization Management Program.

Health Net's Quality Improvement Program (QI Program) provides an integrative structure that links knowledge and processes together throughout the organization to assess and improve quality and safety of clinical care and quality of services provided to members. Each department is accountable for reviewing procedures, systems, quality, cost and outcomes related to their areas of responsibility to ensure that they meet regulatory requirements, achieve business objectives, add value to members and providers and take action to maintain and/or improve performance, as needed. It is an evolving program that is responsive to the changing needs of Health Net's members and standards established by the medical community and regulatory agencies.

The HNOR Utilization Management Program (Program), under the Oversight of the QI Committee, applies to both Medicare Advantage and Commercial members and defines responsibility and oversight for the development, implementation, monitoring, and continuous quality improvement of all healthcare initiatives.

The Program is multi-dimensional and operates to direct and monitor the use and quality of health care services provided to its members. The Program includes pre-service, concurrent, and retrospective review and evaluation of the utilization of services provided to members. The Program requires cooperative participation of HNOR, participating practitioners, delegates, hospitals, and other providers to ensure it is timely, effective, and medically sound. The Program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence of HNOR management or concerns for the plan's fiscal performance. The model is patient centric and empowers the member with knowledge that allows them to become more active participants in health care decisions.

The Utilization Management Description summarizes the utilization management policy, procedures and process, and the use of utilization management standards.

# ***Section 2***

# ***Description of Program***

# **Description of Programs**

## **Utilization Management**

### **Introduction**

The Utilization Management Program (Program) is designed to optimally manage healthcare resources to maximize the cost effectiveness and quality of the care provided to its members. It is designed to promote fair, safe and consistent utilization management decision-making. The Program is under the clinical supervision of the Medical Director, an Oregon and Washington licensed physician, who provides support to the development and implementation of the program. The Program is updated as necessary and is evaluated and approved annually by the HNOR Utilization Management Committee and HNOR Quality Improvement Manager. The Quality Improvement (QI) Program Description, developed and implemented by the QI Manager and Medical Director(s) includes information on the Utilization Management Program. The Quality Improvement Program Description, QI Work Plan and the annual QI Evaluation are reviewed and approved by the HNOR QI Committee.

### **Purpose**

The purpose of the Utilization Management Program is to provide a comprehensive, integrated process that ensures that HNOR members receive timely, safe and appropriate medical care in the most efficient and cost-effective manner. The Program also provides the process and structure whereby Health Services staff and the Delegation Oversight Committee provide oversight for delegated utilization activities provided by HNOR practitioners, providers and/or third party administrators. The Program interfaces with the quality management system to facilitate the achievement of its goals and objectives.

### **Objectives**

The objectives of the HNOR Utilization Management Program are:

1. Provide members with equitable access to care across the network.

2. Ensure that qualified health professionals using appropriate clinical information and evidence-based criteria sets make appropriate utilization management decisions.
3. Establish and adhere to standards for the timeliness of utilization management decision-making.
4. Ensure that the reasons for each denial are clearly documented and communicated to members and practitioners.
5. Through participation in the National and Regional Pharmacy and Therapeutics Committees establish processes to ensure that the HNOR Drug Formulary is based on member's need, sound pharmacological advances driven by clinical evidence and is reviewed and updated at specific intervals.
6. Establish processes to monitor and oversee utilization of high-risk and high-cost procedures and services.
7. Use written guidelines and criteria based on evidence-based clinical information and develop and implement procedures for applying this criteria in an appropriate manner to ensure that current technology and scientific evidence is used in the utilization review decision.
8. Establish and/or adopt processes and tools for authorization, case/disease management, discharge planning and other utilization management functions to improve efficiency, continuity of care and standardization of application.
9. Monitor utilization (over and under) of selected services against benchmarks.
10. Establish processes to collect and periodically monitor data, implement interventions, and measure results of the interventions for effective strategies to achieve appropriate utilization.
11. Identify and intervene when quality of care issues are identified. Establish and/or adopt policies/procedures and reporting systems for quality of care management and to track and trend quality of care issues.
12. Establish a process for annual review of pre-service list for effectiveness and appropriateness of requirements. Make the recommendations for significant changes to the requirements to the HNOR Executive Management Team for final determination.
13. Consider the feasibility and desirability of exempting certain Participating Physicians from certain administrative requirements based on criteria such as physician's delivery of quality and cost effective medical care, accuracy and appropriateness of claims' submissions.
14. Comply with all applicable federal and state laws, regulation and accreditation requirements

15. Maintain responsibility for delegated utilization management activities by ensuring appropriate oversight of delegated entities.

## **Delegation**

Health Net of Oregon (HNOR) delegates utilization management activities to other organizations that meet HNOR's standards. HNOR retains accountability for all delegated activities and has a thorough process in place to systematically monitor a delegate's ability to perform delegated functions. Delegation occurs only after an evaluation of capacity, past-performance and administrative ability prior to delegation. The functions that may be delegated are pre-service, concurrent review, discharge planning and case/disease management. The functions to be delegated are evaluated pre-contractually and at least annually thereafter. If a delegate fails to perform any aspect of a delegated function, a Corrective Action Plan (CAP) may be implemented. If a CAP is initiated the delegate must identify specific actions intended to improve performance standards and obtain HNOR's approval of the plan. If the delegate fails to improve performance within the agreed upon timeframes, HNOR has the ability to modify or rescind delegation.

Additionally, HNOR's delegates are obligated to provide oversight and documented evidence of monitoring the utilization review process for medical appropriateness whenever this process is performed by a sub-delegated or sub-contracted provider and/or review organization.

## **Scope of Utilization Management Program**

The Utilization Management Program includes all Health Net of Oregon Commercial and Medicare Advantage PPO products and members. The scope of the HNOR Utilization Management Program includes direct referrals, pre-service, concurrent review, discharge planning, case/disease management, and retrospective review of inpatient and selected outpatient services. The scope of services also includes but is not limited to:

- Pharmaceutical Management through Health Net's Pharmaceutical Management Program
- Care of Institutionalized Members
- Ambulatory and Inpatient surgery
- Home Health Care
- Mental Health and Chemical Dependency Services
- Ambulatory Care

- Durable Medical Equipment/Corrective Appliances
- New Technology Assessment

### **Direct Referrals**

Health Net of Oregon (HNOR) does not require authorization of referrals to specialists. A direct referral occurs when the member's Primary Care Physician (PCP) refers the member directly to a specialist for consultation and evaluation without pre-service or prior review by HNOR. Members may also self-refer directly to a specialist. Direct referrals enhance the member's ability to directly access specialists such as dermatologists, podiatrists, ophthalmologists or obstetricians and gynecologists.

### **Pre-service Decisions**

HNOR maintains a list of drugs, devices, procedures, and other medical services that require pre-service authorization. HNOR periodically reviews this list in accordance with a nationally developed methodology to determine the appropriateness for inclusion in those services requiring authorization and potential deletion of services from the requirements. The required regulatory approval for pre-service requirement changes are obtained and providers are notified appropriately of any changes.

Pre-service decisions are determined by HNOR's Utilization Management staff for non-delegated Commercial and Medicare Advantage PPO members.

Pre-service decisions include both the initial determination of requests for urgent and non-urgent services and requests for continuation of services. Pre-service decisions are required for multiple services including inpatient admissions, referrals to ambulatory surgery, home health care, durable medical equipment and home infusion. The purpose of obtaining a pre-service decision is to prospectively evaluate proposed services to determine if they are medically necessary, covered by the member's benefit plan, provided by a contracted practitioner or provider, where appropriate or possible, and provided in the most appropriate setting.

The practitioner mails, telephones, faxes or submits electronically via the web, pre-service requests directly to the HNOR Pre-service Unit. The unit is staffed with registered nurses and intake coordinators who document the authorization information in the medical management data system. Requests for Pre-service decisions may be required to include:

1. Member demographics
2. History and clinical findings
3. Diagnosis with ICD-9 code
4. Procedure with CPT code

5. Reason for PA request
6. Results of pertinent or applicable evaluation and tests already performed
7. Any lab, X-ray, or other reports pertinent to the request
8. Pertinent medical information to facilitate the authorization decision

### **Qualifications of Decision Makers**

All requests requiring a determination of medical necessity and/or whether a service is experimental or investigational are reviewed by a licensed clinical associate for medical appropriateness utilizing *InterQual® Criteria*, Medicare Guidelines, Hayes, Health Net, Inc. Medical Advisory Committee Policies, or other standardized evidence based medicine sources.

The registered nurse clinical associates have the authority to approve all situations that meet the medical review criteria. Potential denials or questionable cases that can not be approved by the registered nurses are referred to an HNOR Medical Director for review. An appropriately licensed HNOR Medical Director is responsible for making all denial determinations based on medical necessity and experimental/investigational decisions. An Oregon licensed physician is specifically responsible for any denials for medical necessity and/or experimental for commercial members on Oregon licensed plans. A Washington licensed physician is specifically responsible for these denials for commercial members on Washington licensed plans.

Board-certified specialty physicians (appropriately licensed for Oregon or Washington as described in prior paragraph) are utilized when appropriate as needed to make medically appropriate determinations for their respective specialty areas.

The HNOR Medical Directors and/or nursing staff make all utilization management decisions based on appropriateness of care and service and are not financially incentivized to approve or deny care in any way.

### **Timeframes for Making Utilization Review Decisions**

Routine commercial medical necessity determinations are made within 2 business days of request. HNOR has qualified health professionals available 7 days a week to provide same day response (within 24 hours) to inquiries regarding certification of continued stay. Continued stay is certified until a response is given. Determinations may be delayed when inadequate medical history or clinical information is available. However, HNOR notifies the provider of any additional information that is needed to make a determination within the time frames outlined above.

The Center for Medicare and Medicaid Services (CMS) mandates that pre-medical necessity determinations be made within 14 days of receipt and that expedited or fast determinations be

made within 72 hours of receipt. HNOR strives to meet the same standards for Medicare determinations as those established for commercial plan members.

If the Medical Director denies a request for treatment or services as not medically necessary or as experimental/investigational, HNOR notifies the member and provider(s) of their denial and appeal rights. For commercial members, determination letters advising what services are authorized, not authorized or partially authorized are sent to the member and provider(s).

### **Binding Authorizations – Commercial Members**

Except in the case of misrepresentation relevant to a request for pre-service, a pre-service determination is binding as follows:

- Thirty days for medical necessity and benefits (commercial plans);
- For eligibility, the lesser of five business days or the period during which the member's coverage is in effect when HNOR determines the member's coverage will terminate sooner than five business days following the day the authorization is issued and the authorization specifies the termination date of the authorization (commercial plans).

### **Inpatient Facility Authorization and Concurrent Review**

HNOR Nurses and Medical Directors conduct telephonic and/or onsite concurrent review of patients admitted to hospitals, rehabilitation units, or skilled nursing facilities. Delegates are responsible for delegated membership and HNOR's staff is responsible for non-delegated membership.

This review occurs within 1 working day of the day of admission or within 1 working day of notification of admission and continues throughout the patient's stay (See Timeframes for Making Utilization Management Decisions). The review monitors medical necessity, levels of care, discharge planning and evaluates alternatives to inpatient care. HNOR registered nurse clinical associates utilize *InterQual*® to assess the appropriate level of care and length of stay. The frequency of concurrent reviews of authorization requests will be based on the severity or complexity of the patient's condition or on the necessary treatment and discharge planning activity. The determination of medical appropriateness includes consideration of the individual patient's needs, as well as the requirements of the local delivery system such as in remote sections of the state. Board-certified physician specialists are utilized in making medical determinations as needed.

HNOR non-clinical associates support inpatient authorization review by receiving and documenting notifications. They may also approve some services based on clearly established guidelines and criteria. Reviews of requests that do not meet guidelines or criteria for certification are referred to the HNOR Medical Director. During the concurrent review process, nurses identify potential case management cases and members with chronic conditions and refer such cases to Case/Disease management programs for evaluation and/or intervention. The

Medical Directors collaborate with Care Managers and Case Managers to review cases and are available to review potential medically necessary denials or questionable cases through out the review process. HNOR physicians contact the attending physician(s) when additional information is needed and/or to discuss opportunities to improve the delivery of care. Medical Directors are available to discuss cases with the member's attending physicians as needed.

### **Discharge Planning**

Care Managers, Case Managers and Medical Directors facilitate discharge planning to promote continuity and coordination of care in conjunction with the practitioner, member, and family to assure a timely and safe discharge. Discharge planning begins within 24 hours of the member's admission whenever possible. The Care Manager and/or Case Manager is responsible for coordinating and approving referrals for home health care, durable medical equipment and/or transfer to a lower level of care (e.g., skilled nursing facility or acute rehabilitation). The criteria used for evaluating and guiding timely discharge planning is *InterQual*®. Discharge planning includes, but is not limited to:

- Assessment of continuity of care needs to include benefits eligibility; assessment of member's support system to determine necessary services;
- Development of a plan of care based on short-term medical/psychosocial needs;
- Coordination and implementation of services requested in the plan of care;

### **Second Medical Opinion**

HNOR and its Delegates provide timely second opinions for medical health conditions when requested by the member or the provider. Pre-service review is not required for a referral to a participating specialist for second medical opinion. If a participating provider is not available, HNOR will authorize a second opinion through a non-participating provider. The member is responsible for applicable copayments or co-insurance, but HNOR does not impose a charge that is greater than the cost the member would otherwise pay for an initial medical opinion from the second provider.

### **Retrospective Review**

HNOR and delegates perform retrospective review of medical records when services rendered or inpatient hospitalization have not been authorized and the provider is non-participating, and/or participating provider requests a retrospective review due to extenuating circumstances. The member is held harmless when a service is denied for lack of authorization when the services have been obtained from a participating provider. An HNOR Medical Director, and/or a registered nurse, using *InterQual*® Criteria, Medicare Guidelines, Hayes, and Health Net, Inc. Medical Advisory Committee Position Statements, conducts these reviews for medical necessity and payment adjudication recommendations. The purpose of retrospective review is to evaluate the request for payment against documented evidence that the member received the services and

that services meet the criteria for medical necessity and were provided within the context of the member's HNOR contract. Retrospective review determinations are processed within twenty-one (21) calendar days of obtaining all necessary information.

### **Medical Information Support System**

HNOR utilizes automated systems that document all information related to utilization management and case/disease management activities.

The system allows the user to enter, audit and view authorization, concurrent review and case/disease management information. Information is imported directly from HNOR's membership, eligibility and claims system which records, retains and displays information; controls and monitors the correctness and logic of authorization data; produces utilization statistical reports; generates authorization letters; and permits inquiry into the member/provider authorization and claims payment history.

### **Coordination with the Quality Improvement Program**

The Utilization Management Program is a component of Health Net of Oregon's QI Program.

### **Provider Participation**

HNOR contracts with primary and multi-specialty group practices, individual providers, hospitals and ancillary service providers to deliver quality, cost effective medical services to members and their dependents. For HMO lines of business, selection of a Primary Care Physician (PCP) and establishment of a relationship with that physician is the foundation for members obtaining appropriate health care services. PCPs include Internists, Family Practitioners, General Practitioners, Pediatricians, Nurse Practitioners and Women's Health Care Providers (WHCP).

HNOR Medical Directors are available to discuss provider concerns regarding issues that impact member care.

Through participation in the Professional Review Committee (PRC), and Pharmacy and Therapeutics Committee, providers have an opportunity to provide input regarding HNOR, Inc. and HNOR guidelines and policies, quality of care oversight and credentialing.

### **Access / Availability to Health Care Services**

An ongoing review of the Health Plan's network is conducted to ensure the availability and access to all needed levels of care. The review includes an analysis of the scope of the network physicians, including Primary Care Physicians, specialists, facilities and ancillary services in relationship to members' needs. Site and medical record reviews are also conducted to ensure

that access to care and services, appointment standards, and the confidentiality of member records are met. Recruitment will take place in areas where unmet needs are identified.

## **Continuity of Care**

Health Net implements mechanisms to monitor, evaluate and facilitate continuity, coordination, and transition of care among its members. These activities include, but are not limited to:

- The administration of case/disease management for complex cases that require the use of multiple health resources. Case Managers act as facilitators, resource finders and coordinators responsible for bridging communication, problem solving with practitioners and assisting members and their families to facilitate implementation of a smooth and coordinated plan of care.
- Coordination of care for HMO members whose treatment is in progress at the time of transfer to Health Net coverage, transfer to a new health plan, contracted provider group closures or contract terminations. Case Managers act as patient advocates and liaisons to assist new and existing members so they receive continuous health care services until they are safely transitioned to a Health Net network provider or non-network Health Net provider if appropriate.
- Continuity of care allows HMO members to temporarily continue receiving services from their out-of-plan provider if they are involved in an active course of treatment. This may include second trimester pregnancy; scheduled surgery and post-operative follow up. It may also include certain medical conditions, when the member is receiving ongoing care at the time a Medical Service Contract is terminated. Some examples of the types of medical conditions that may be considered include cancer, HIV/AIDS, hemophilia, transplant, or congestive heart failure.
- Continuity and coordination of care between general medical practitioners and behavioral health specialists is ensured via member-approved communication between contracted providers, behavioral health practitioners and behavioral health facilities. Practitioner compliance with this process is monitored by the Quality Improvement Department.
- Transition of care process.

If HNOR first learns the identity of an enrollee affected by provider contract termination after the termination date of the contract or after notice was given to the other affected enrollees, then HNOR gives notice to the enrollee no later than the 10<sup>th</sup> day after learning that enrollee's identity.

The enrollee may receive care until the later of:

- (a) The 45<sup>th</sup> day after birth; or

(b) As long as the enrollee continues under an active course of treatment, but not later than the 120<sup>th</sup> day after the date HNOR notified the enrollee of the termination of the contractual relationship with the provider.

### **Ensuring Appropriate Utilization**

HNOR monitors over and under utilization. Monthly and quarterly reports include data on primary care, specialist, ancillary, inpatient, outpatient, emergency room, and pharmacy encounters, and selected procedures by line of business and on an aggregate basis. Utilization Management data is analyzed for adverse trends (over or under utilization) for intervention when appropriate.

### **Development & Implementation of Utilization Management Guidelines for Determinations**

HNOR utilizes nationally recognized guidelines in making medical necessity and experimental/investigational determinations, and in monitoring the quality of care provided to HNOR Commercial and Medicare plan members.

InterQual Intensity of Service/Severity of Illness ® Criteria are used as guidelines for pre-service, pre-admission, and continued certification of stay review determinations. Evidence Based Medicine guidelines are available to review the quality and effectiveness of care. Medicare guidelines are used as a guideline in making determinations for durable medical equipment and home health.

InterQual Intensity of Service/Severity of Illness ® Criteria, Medicare Coverage Manuals and Local Medicare Carrier Policies are the primary tools used for initial benefit determination and pre-service (pre-service) for the HNOR Advantage Plan. InterQual Intensity of Service/Severity of Illness ® Criteria are used as guidelines for unscheduled admissions and continued certification of stay review determinations.

The Hayes Technology Directory is used as a guideline in reviewing new technology. The guidelines include confirmation that the appropriate regulatory body (e.g., Food and Drug Administration) has assessed the new technology in cases where that assessment is required by law, clinical literature, review of current medical journals or other sources. All decisions involving new technology are forwarded to the Medical Director for review. The Medical Director utilizes information from these guidelines and other appropriate evidence based medicine sources in making his/her determinations.

In cases, where the technology has not been evaluated, the Medical Director refers the request to the HN, Inc. Medical Advisory Committee (MAC). The MAC comprises physicians representing a broad spectrum of medical specialties, as well as the HN, Inc. Medical Policy Medical Director and registered nurses. A HNOR Medical Director is also a member of this committee. The committee meets at least monthly to establish policies when guidelines for a particular service are not addressed by approved Health Net, Inc. guidelines.

## **Consistency of Application of Utilization Decision Criteria**

HNOR evaluates consistency of application of decision criteria through:

1. A supervisor's periodic review of determinations;
2. Twice-weekly UM rounds attended by UM staff members and Medical Director to evaluate determinations and problem cases; and
3. Periodic testing of reviewer determinations against criteria.

## **Use of Clinical Information for Utilization Review Decisions**

Efforts are made to obtain all pertinent clinical information, including consultation with the treating physician(s).

## **Denials**

HNOR registered nurses review requests for pre-service, unscheduled admissions, continued certification of stay, and retrospective clinical review process. When criteria for pre-service initial unscheduled admission or continued stay are not met or are questionable, the case is referred to an HNOR Medical Director. The Medical Director may contact the requesting physician by telephone to discuss the case and/or may consult with a board certified specialist before making determination of medical necessity. A psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist reviews any denial of behavioral health care that is based on medical necessity.

An Oregon or Washington licensed Medical Director makes all denial decisions for Oregon and Washington members respectively, stating the actual reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all Oregon and Washington regulatory and CMS guidelines.

## **Notification of Determination**

For members on Oregon commercial plans, determination letters advising what services are authorized, not authorized or partially authorized are sent to the member and provider(s).

## **Grievances and Appeals**

Commercial Members:

Members or providers who appeal a decision by HNOR to deny pre-service or benefits for service(s) as not medically necessary or experimental, receive acknowledgment of their appeal within seven days of receipt for OR or five days for WA members. The case is then forwarded to a medical consultant or peer review committee for review. HNOR currently contracts with an

independent medical review organization for external specialty reviews. This organization is accredited by the American Accreditation of Health Care Commission (also known as URAC).

A decision is made within thirty days of the receiving notification of the appeal for OR members or fourteen days for WA members. Members or providers who appeal the decision made by an independent medical reviewer will enter the Grievance and Appeal Process as a Level 2 Appeal.

Applicable standard for timeliness do not apply when:

- The period of time is too long to accommodate the clinical urgency of the situation;
- The member or provider does not reasonably cooperate; or
- Circumstances beyond the control of a party prevent complying with the standard, but only if notice of inability to comply is given promptly.

All grievance and/or appeals filed by a Health Net Options Plus Plan (Medicare Advantage PPO) member are processed in compliance with the CMS mandated Grievance and Appeals policies and procedures.

Medicare Advantage Plan Members:

Appeals and grievances filed by Health Net Medicare Advantage Plan members or their authorized representatives are processed according to requirements of the Centers for Medicare and Medicaid Services (CMS). Letters acknowledging receipt of non-expedited cases are issued within five business-days. Standard grievances and pre-service appeals are processed within thirty days while post-service appeals are processed within sixty days. Cases qualifying as expedited grievances are processed within 24 hours and appeals meeting expedited criteria are processed within seventy-two hours.

Anytime Health Net does not issue an appeal determination that is entirely favorable to the member, the case is forwarded to CMS' reconsideration contractor, Center for Health Dispute Resolution (CHDR). Depending on CHDR review outcomes and dollar amounts under dispute, members may also have rights to a review by an Administrative Law Judge, Departmental Appeals Board or Federal Court Judge.

## **External Review**

Upon exhaustion of the Health Plan's appeal process or after the Health Plan has exceeded regulated timelines for appeals, the member may request an external review if the member finds the Health Plan's decision to be unfavorable. The Health Plan provides external review through an independent review organization (IRO) contracted with the Director of the Department of Consumer and Business Services to provide external review in compliance with regulatory requirements. A request for IRO assignment by the Oregon Insurance Division (OID) is submitted within 2 business days of the date that the Health Plan receives the review request from

the member. All required documents are submitted to the IRO within 6 business days of receipt of written notice of the OID's assignment. Expedited standards are also implemented for external review of clinically urgent cases. The Health Plan promptly implements the determination made by the certified independent review organization and pays the certified independent review organization's charges for the review.

### **Confidentiality**

1. The utilization process deals with sensitive information about members and providers.
2. Medical records or other materials used for utilization/care management shall be considered strictly confidential and retained in a secure environment
3. Health Net fully complies with the Health Insurance Portability and Accountability Act (HIPAA), which regulates the privacy of protected health information (PHI). Health Net strictly prohibits any unlawful and unauthorized access to, use or disclosure of member or provider information. Members are informed of these rights through the distribution of the Notice of Privacy Practices.

### **Conflict of Interest**

HNOR associates are required to adhere to the HNOR, Inc. policies and procedures for conflict of interest. The Code of Business Conduct policy defines and outlines the individual's responsibilities for complying.

### **Emergency Services**

Emergency admissions and emergency room services do not require pre-service reviews.

Information on the coverage of emergency services is provided in both health benefit materials and the member handbook.

### **Communication Services**

Upon request, HNOR provides UM program information to enrollees, prospective enrollees or network providers. Such information is provided in a timely manner and in accordance with regulatory requirements.

Information on HNOR policies, and authorization guidelines and requirements are communicated to providers through the HNOR Provider Policy Manual, physician newsletters, provider mailings, and HNOR's website. The Provider Directory, also available on HNOR's website, provides information on network providers and designated specialists.

HNOR health benefit plan materials include information on any requirements for referrals, authorization, external review, and appeals and grievances. All guidelines used in making



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decisions regarding utilization review and authorization are available to providers and members upon request. The HNOR Member Handbook and HNOR Medicare Advantage Evidence of Coverage, provided to enrollees covered under HNOR plans, include a summary of how HNOR makes decisions regarding utilization review and pre-service determinations that affect coverage or payment.

## Case Management and Health Coaching and Condition Specific Management

Case management focuses on strategies to identify members with chronic and catastrophic disease conditions and assist the member and his/her provider in managing the member's health care needs. Case management promotes appropriate coordination of benefits, alternative resources and funding for members with complex care needs.

Health Net also offers members Health Net Decision Power, which is a program that provides members with Health Coaching and care support information. Health Coaches can provide the following for members:

- Education and support to help patients work with their practitioners to make better-informed decisions about significant medical events such as surgery and chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease and congestive heart failure
- On-line resources are available to members through Health Net's website links to both Decision Power programs and WebMD.
- Clear and concise evidence-based information to help members understand their available treatment options, taking into consideration the member's own preferences and values
- Continued support for members during the decision-making process
- Answers to general health and prevention questions
- Printed materials and videotapes, when appropriate, on many common conditions and information regarding the audio reference line

Health Coaching involves:

Chronic Condition Management: Support across all disease states and support for complex medical conditions (e.g., diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease, and asthma)

Symptom Management: Support for general health information, prevention and triage services

Additional member benefits:

Scheduled follow-up calls as appropriate

Members may speak with the same Health Coach during subsequent inbound or outbound phone call

# ***Section 3***

# ***Pharmacy***

## Pharmacy

All HNOR pharmacy benefit plans use a formulary called the Preferred Drug List (PDL). This list indicates the drugs covered under a benefit plan. Some plans have coverage for medications not listed on the PDL that are not specific exclusions of the plan benefits.

The Director of Pharmacy, a registered pharmacist, working with the Medical Director and Vice President of Health Care Services, oversees the clinical components of the HNOR Pharmacy Program. The HN National Pharmacy and Therapeutics (P&T) Committee develops recommended guidelines and criteria for HNOR Pharmacy Programs. The P&T Committee also reviews the quality, effectiveness and safety of new medications, therapeutic classes on the formulary, and conversion programs. The Director of Pharmacy and the Medical Director are participating members of the National P&T Committee.

The regional P&T Committee provides feedback to the National P&T Committee. Committee membership includes a HNOR Medical Director, Director of Pharmacy, and practicing network physicians from different specialty areas, and community pharmacists. The regional P&T committee reports to the Quality Improvement Committee that reports to the Health Plan Board of Directors. The committee meets at a minimum on a quarterly basis. Responsibilities include review of the quality, effectiveness and safety of new medications, therapeutic classes and conversion programs, as well as review and adoption of National P&T guidelines.

HNOR has adopted HN, Inc. guidelines to determine whether medications will be added to the HNOR PDL, the level of benefit, and any limits that will apply to a specific medication. The guidelines also establish a standardized method for requesting, and determining how and when to add medications to the PDL at the request of a provider or committee member.

A summary of PDL provisions is included in the HNOR Provider Policy Manual. The PDL is also available to members and providers on the HNOR website. New members receive a copy of the PDL with their member materials at the time of enrollment. Updates are available on the HNOR website or can be sent to the member upon request.

In addition to PDL activities, the Director of Pharmacy and Medical Director conduct retrospective drug utilization review and drug use evaluation studies to assess both the quantity and quality of medication use. Information from these studies is used to educate providers and members about issues such as inappropriate use of antibiotics and low use of generic medications, as well as best practices for the pharmacological treatment of a particular illness.

HN Pharmaceutical Services (HNPS), a subsidiary of HN Inc., processes requests for pre-services and formulary exceptions. The HNPS Director of Pharmacy, a registered pharmacist, reviews all denials. The HNOR Medical Director reviews all appeals for services not meeting HNPS guidelines, and medical necessity and experimental/investigational determinations.

# ***Section 4***

# ***Utilization Management Committee***

## ***Utilization Management Committee***

The HNOR Utilization Management Committee is responsible for the oversight of the HNOR utilization processes and Program Objectives. It ensures that HNOR members receive all necessary and appropriate care that is consistent with nationally recognized standards, in a timely manner, and across the continuum of care. The Utilization Management Committee reports to the HNOR Quality Improvement Committee quarterly and is responsible for implementation of the Utilization Management Programs. The committee is chaired by a Medical Director or his/her designee under his/her direction. Committee members include the Vice-President of Health Care Services, Manager, Quality Improvement, a HNOR Medical Director, the Director of Pharmacy, Manager, Health Services for Medicare Advantage, Manager Care Management Commercial, the Quality of Care Review Nurse and the Manager of Retrospective Review.

# ***Section 5***

# ***Organizational Structure and Resources***

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# Organizational Structure and Resources

The Health Net of Oregon Board of Directors (Board) has ultimate authority and responsibility for the oversight of the Health Net of Oregon Quality Improvement Program. The Utilization Management Program is a component of the QI Program. The Board has delegated the authority and responsibility for the development and implementation of the QI Program to the Health Net Quality Improvement Committee. The Board provides oversight to the QI Program through reviewing and approving annual revisions to the QI Program Description and Work Plan and provides direction, as needed, based on a review of program updates and annual QI Program Evaluation. Quality improvement activities are reported to the governing body.

The Vice President of Health Care Services, a registered nurse, and the Medical Director(s) are responsible for ongoing appropriate clinical relevance and focus of the Utilization Management Program. The Medical Director(s) provide expert clinical support to HNOR's Utilization and Case Management staff. Final review and approval of the Utilization Management Program is the responsibility of HNOR's Quality Improvement Committee and the Board of Directors.

## Resources

### Board of Directors

The Board or Directors is responsible for oversight of the Quality Improvement Program. The Utilization Management Program is a component of the Quality Improvement Program.

#### Board of Director Functions

- Establish strategic direction for the Quality Improvement Program;
- Review reports from the Health Net of Oregon Quality Improvement Committee, delineating actions taken and improvements made;
- Ensure the Quality Improvement Program and Work Plan are implemented effectively and result in improvements in care and service;
- Provide feedback to the Health Net of Oregon Quality Improvement Committee, as appropriate following each review; and
- Assess and recommend resources, as needed, to implement Quality Improvement activities.

HNOR also has full time associates dedicated to the Utilization Management Program.

## **Plan President**

Health Net of Oregon's Plan President (President) is delegated the authority by the HN President to provide the overall direction, development and monitor the progress of the Health Net of Oregon Quality Improvement Program which includes the Utilization Management Program. The President, or his/her designee, chairs the QIC.

## **Vice President of Health Care Services**

The Vice President of Health Care Services reports to the HNOR Plan President. He/she collaborates with the health plan Medical Director's to administer and coordinate the implementation of corporate medical policy and the UM Program.

The Vice President of Health Care Services and the Medical Director(s) assists the Plan President by providing input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care.

The Vice President of Health Care Services is responsible for assuring the Utilization and Quality Management Program updates are reported to the Board of Directors. He/she is responsible for assuring any directives from the Board of Directors regarding the UM Program and UM Program activities are communicated to internal stakeholders.

The Vice President of Health Care Services is responsible for executing the Utilization Management Program, which includes but is not limited to, pre-service, inpatient concurrent review, retrospective review and case/disease management. This individual is responsible for the organization-wide development, integration, implementation, assessment and measurement of utilization management improvement activities in order to improve the quality of care and services provided to the membership. Committee participation includes active membership on the HNOR Executive Management Team, Quality Improvement Committee, Utilization Management Committee, Delegation Oversight Committee, Health Care Cost Utilization team, National Nursing Leadership Committee and other committees as needed.

The Vice President of Health Care Services is responsible for all Health Services operations. He/she directs staff, develops and implements activities of utilization/case/disease management, establishes, implements and monitors departmental goals, and productivity standards, and is responsible for the direct management and supervision of all Health Services staff. The VP coordinates activities and collaborates with the Medical Director.

## **Medical Director**

The Medical Director is responsible and accountable for ensuring appropriate clinical relevance and focus of the Utilization Management Program for pre-service, concurrent review, retrospective review and case/disease management. The Medical Director interfaces with



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individual practitioners and facilities on a day-to-day basis, to ensure the performance of the provider community meets established HNOR standards.

### **Director of Pharmacy**

The Director of Pharmacy is responsible and accountable for the oversight of prescription medication utilization as well as development of utilization guidelines and pre-service.

### **Quality Improvement Manager**

The Quality Improvement Manager is responsible for the management of the following functions: grievances and appeals, delegation oversight, health improvement and disease management programs. The Quality Improvement Manager is responsible for the structural components of the QI Program and develops reports for submission to the Board. The Quality Improvement Manager, chairs the Delegation Oversight Committee.

### **Manager of Medical Management, Commercial**

The Manager of Medical Management (Manager) is responsible for the oversight of the day-to-day operations effectiveness and regulatory compliance of the case and care management units.

The Manager of Care Management reviews data for tracking and trending patterns of utilization and case management and identifies adverse over and or under utilization trends. The Manager collaborates with the Medical Director and Vice President of Health Care Services in developing interventions to address trends.

### **Manager of Medical Management, Medicare Advantage PPO**

The Manager of Medical Management (Manager), Medicare Advantage PPO is responsible for the oversight of day-to-day operations, effectiveness and regulatory compliance program development of the Medicare Advantage Medical Management unit.

The Manager reviews data for tracking and trending patterns of utilization and case management and identifies adverse over and or under utilization trends. The Manager collaborates with the Medical Director and Vice President of Health Care Services in developing interventions to address trends.

### **Supervisor of Care Management**

The Supervisor of Care Management provides supervision of the Care Managers and assists with all departmental regulatory and certification requirements. The Supervisor of Care Management participates in the daily operations of the department and evaluates utilization/care management caseloads and care plans and ensures continuity of care.

The Supervisor collaborates with the Medical Director in activities related to the utilization process.

The Supervisor is responsible for day-to-day operations of the department, including evaluation of utilization caseload and providing ongoing assessment and training of Care Management staff.

### **Care Manager**

The Care Manager, a Registered Nurse, conducts effective utilization review activities to ensure appropriate, cost-effective, coordinated care, while maintaining quality of care and quality of service. The Utilization Management Nurse conducts pre-service, concurrent and retrospective review of ambulatory, hospital and emergency services using clinically valid criteria.

The Care Manager initiates and directs discharge planning, focusing on potential transfers to appropriate alternate levels of care such as skilled nursing facilities and home health care. Pertinent information is documented into the electronic medical management system on a daily basis, including detailed clinical information and authorizations. The Care Manager also performs extra-contractual negotiations for out-of-area and in-area non-contracted admissions and physician services.

In conjunction with the Medical Director and Case Managers, the Care Manager reviews hospital admissions for appropriate utilization of resources, timeliness of treatment and quality of care.

### **Case Manager**

The Case Manager acts as a resource coordinator for providers, members and families. The Case Manager collaborates with the practitioners and is responsible for monitoring and managing the utilization of health care resources for HNOR members in the most cost-effective manner by identifying, planning and coordinating and the care of those members that require care management.

The Case Manager pro-actively identifies candidates for care and/or disease management from either internal or external referral sources. High-risk/high-volume cases are actively managed throughout the continuum of the member's health care needs or until a care plan is no longer required.

### **Manager of Authorization Services**

The Manager of Authorization Services is responsible for oversight of the day-to-day operations, effectiveness and regulatory compliance of the Pre-service programs. He/she reviews data for tracking and trending and development of policies and procedures for authorization management. The Manager collaborates with the Vice President of Health Care Services in activities related improving the effectiveness of the authorization process and requirements.

### **Supervisor of Pre-service**

The Supervisor of Pre-service provides supervision of the Utilization Management Coordinators, manages cross-unit and cross-functional medical management projects and assists with all departmental regulatory and certification requirements. The Supervisor participates in the daily operations of the department and manages production activities and reporting.

The Supervisor reviews and reports data for tracking and trending patterns and assists with the identification and development of policies and procedures for authorization.

The Supervisor is responsible for day-to-day operations of the department, including evaluation of workload and providing ongoing assessment and training of staff.

### **Utilization Management Coordinator**

The Utilization Management Coordinator (UMC) receives information, verifies eligibility/benefits, and enters inpatient and outpatient authorizations into the electronic medical management system and routes cases to the appropriate nurse for continued management.

The UMC provides non-clinical support for the utilization management activities of the department. He/she utilizes carefully defined guidelines to approve services when appropriate, but must refer cases without clearly defined guidelines to a registered nurse or the Medical Director.

### **Case Management/Disease Management Assistant Senior**

The Case Management/Disease Management (CM/DM) Assistant Senior provides assistance to the nurses in the CM/DM departments that enable the review of clinical information to be processed according to Health Net policies and procedures. The Assistant Senior assists in training of CM/DM assistant positions and orientation process. CM/DM Sr. will utilize specific guidelines, policies and procedures. Assist members of Health Net's medical management team in the process of identifying members appropriate for case management and or disease management programs/services. The CM/DM also serves as liaison with external case management/disease management vendors.

### **Case Management/Disease Management Assistant**

The Case Management/Disease Management Assistant provides assistance to the nurses in the CM/DM departments that enable the review of clinical information to be processed according to Health Net policies and procedures. The Assistant assists members of Health Net's medical management team in the process of identifying members appropriate for case management and or disease management programs/services.

### **Manager, Medical Claims Review**

The Medical Claims Review Manager, a certified coder, is responsible for over-sight of all Medical Claims Review activities. He/she assures compliance with correct adjudication for compliance with corporate policies and procedures and other applicable regulatory guidelines.

He/she participates in regional/national workgroups to establish consistent guidelines for medical claims review and claims editing.

### **Care Manager for Claims Review**

A Care Manager, a registered nurse, provides clinical review supports for the medical claims review process. The Care Manager receives information, verifies eligibility/benefits, enters inpatient and outpatient authorizations into the electronic medical management system, provides retrospective clinical review of services for retrospective authorization and routes cases to the Medical Director for final determination of potential medical necessity and experimental investigational denials. He/she follows the same policies and guidelines for retrospective review as those described under Section 2 of this description.

### **Post Utilization Review Coordinator**

The Post Utilization Review Coordinator, a experienced coding expert, receives information, verifies eligibility/benefits, enters inpatient and outpatient authorizations into the electronic medical management system, resolves routine and complex pre- and post-payment claims issues and determines correct adjudication for compliance with corporate policies and procedures and other applicable regulatory guidelines. He/she forwards clinical reviews to the appropriate level of clinical reviewer when clinical review is required.

### **Physician Consultants**

Physician Consultants are available for the review of individual cases and provide medical review consultation. HNOR Medical Directors and/or other clinical staff may use any of the consultants representing the major specialties. All external consultants are board certified by one of the American Boards of Medical Specialties (ABMS).

# ***Section 6***

# ***Delegation Oversight***

## ***Delegation Oversight***

Health Net may delegate to an organization the authority and responsibility to carry out utilization management. Quality improvement functions are not delegated and Health Net reviews the Delegates' internal quality improvement and Utilization Management (UM) programs and documents to ensure that state and federal regulatory requirements are met. A pre-delegation review is conducted by Health Net prior to delegating UM functions to an organization. Entities who do not meet Health Net's criteria must complete a satisfactory corrective action plan before services will be delegated.

Health Net retains accountability for delegated activities and conducts assessments and reviews reports and policies and procedures to assure established standards and regulatory requirements are met. Health Net also retains the grievance and appeals functions as a way to monitor the quality of care and services provided to Health Net members. A corrective action plan must be successfully completed by those Delegates who do not meet established quality standards. Delegation oversight documents are maintained in hard copy and/or electronically, when possible.

# ***Section 7***

# ***Program Evaluation***

## ***Program Evaluation***

Annually, the Vice President of Health Care Services and/or his/her designee present the Utilization Management Program Evaluation to the Utilization Management Committee for review and final approval. The Utilization Management Committee reports to the HNOR Quality Improvement Committee quarterly and is responsible for implementation of the Utilization Management Program (Program).

The annual evaluation of the Program provides structure for the determination of program effectiveness and the impact of the Program on members, practitioners and providers. The process identifies program strengths and limitations, improvement opportunities and unfinished business, in addition to assessing demographics and effectiveness of the program's initiatives. The evaluation has indicators for over- and under-utilization, timeliness of decision making, access to care issues, clinical criteria utilization and disease management.

The Utilization Management Program evaluates and monitors the effectiveness and efficiency in achieving HNOR's Utilization Management mission by continuously utilizing evidence-based monitoring and measurement of clinical and service performance indicators, quality of care and quality of service issues, member complaints and timeliness of services delivered to HNOR members. Identification of causal effects, design and implementation of improvement opportunities and re-measurement of initiatives ensures a continuous cycle of evidence-based monitoring of care and delivery systems.

The annual evaluation identifies problems and/or concerns that may limit a member's equitable access to health care and provides recommendations for improvement. The Utilization Management Program Description is reviewed and updated annually.

### **Utilization Management Program Work Plan**

An annual Utilization Management Program work plan is a component of the Quality Improvement Work Plan (Work Plan), defines the Program's goals and objectives, and planned activities and projects to be accomplished for the year. The Work Plan identifies the Health Services staff and/or committee responsible for completing the activities and establishes the time frame for when the activities or projects are to be completed. The Work Plan also provides a structure for measuring progress towards achieving program objectives through regularly scheduled updates and a review of the document at quarterly Quality Improvement Committee (QIC) meetings. The QI Work Plan is developed annually and is approved by the QIC and Board.

# ***Section 8***

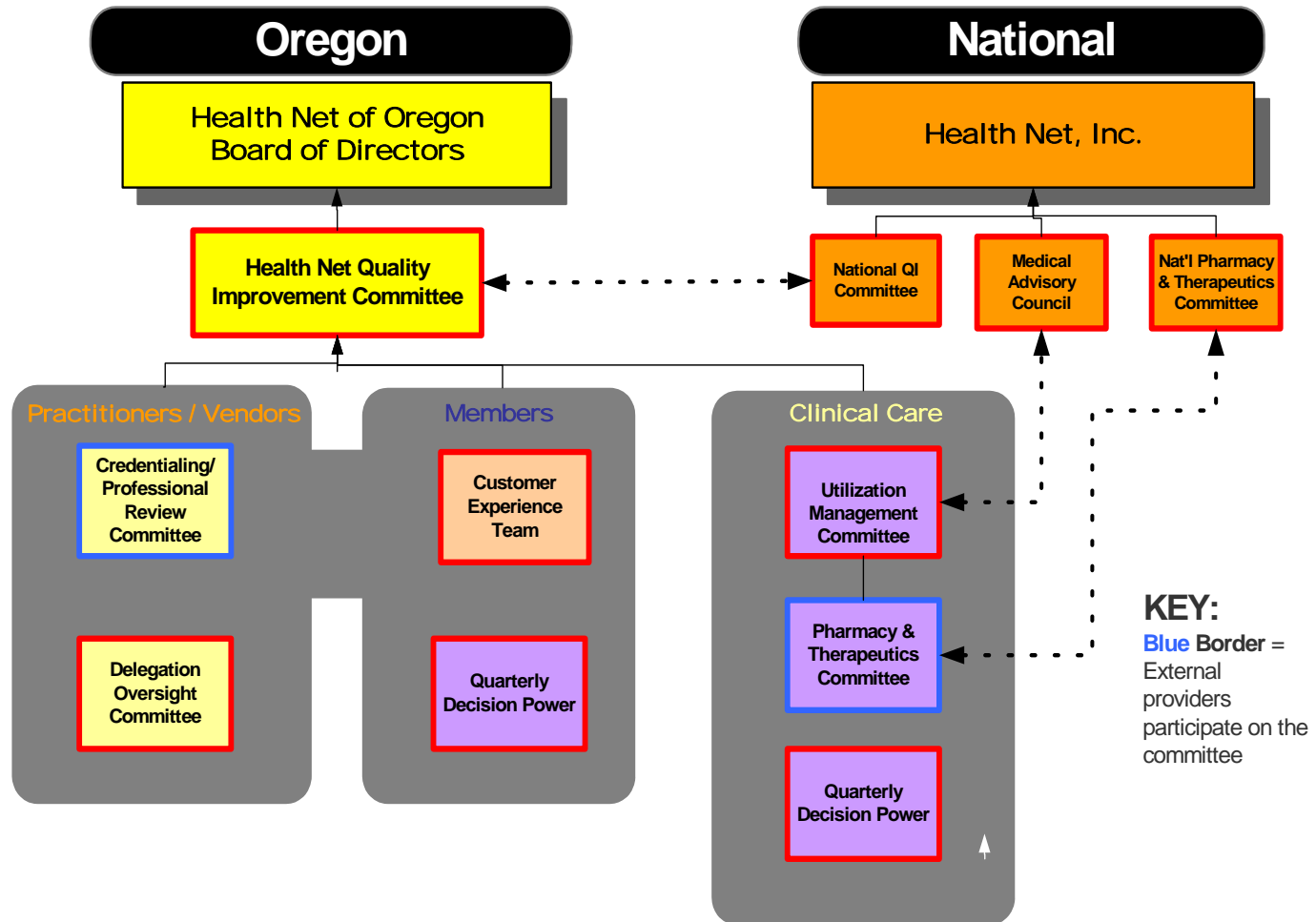
# ***Appendices***

## ***Appendices***

### ***Appendix I: Organizational Structure and Resources***

- HNOR Quality Improvement Committee Structure
  - HNOR Health Services Department Organizational Chart
  - Health Net Pharmaceutical Services (HNPS) NW Region Organizational Chart
  - HNOR Delegated Activities
-

## 2009 Health Net of Oregon Quality Improvement Committee Structure with National Committees\*



\* Each Committee covers all lines of business



President Health  
Plan Division

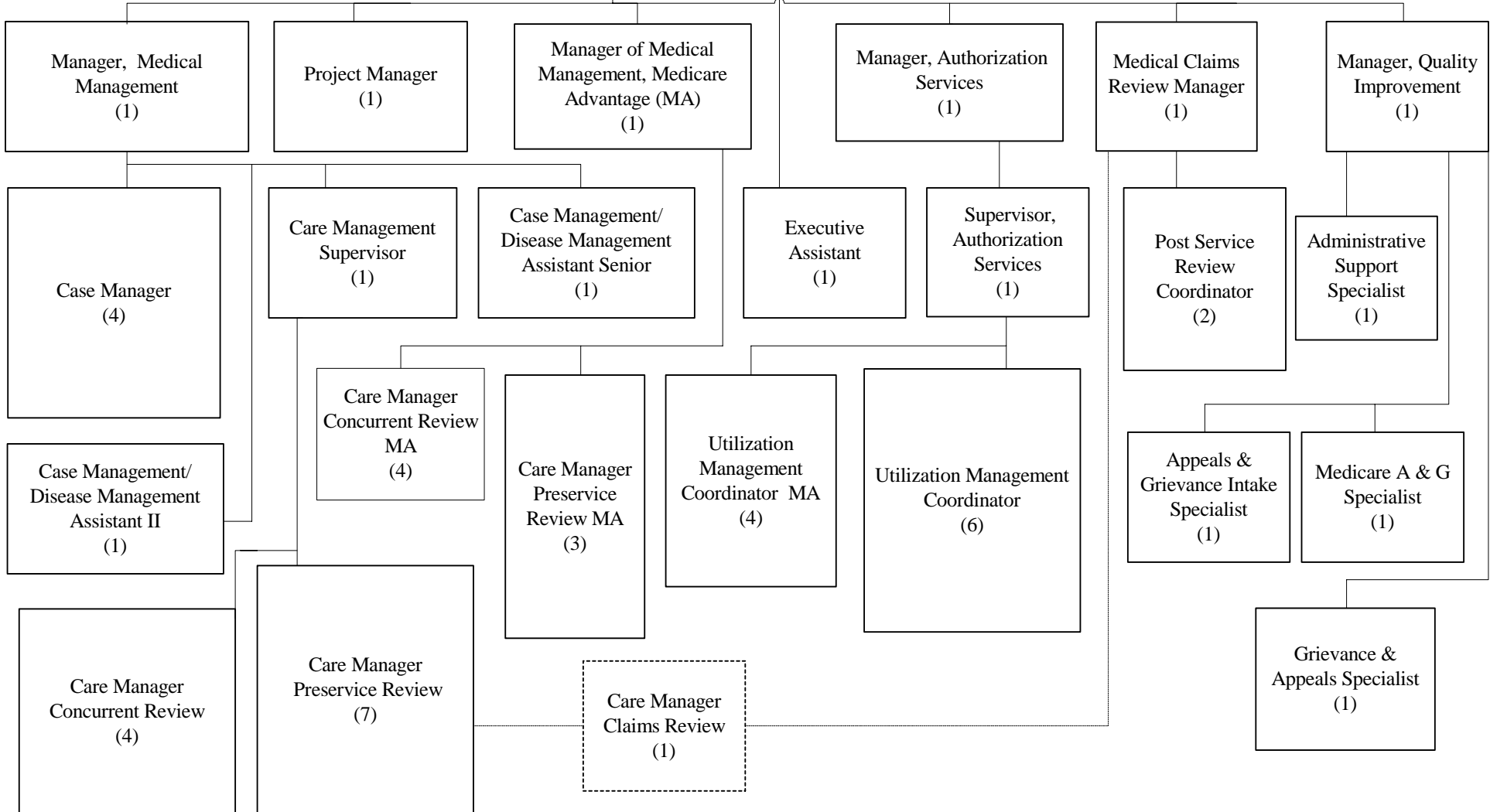
President, Health  
Net Oregon

# Health Net Health Plan of Oregon Health Services Department

Dec '08 Appendix 1

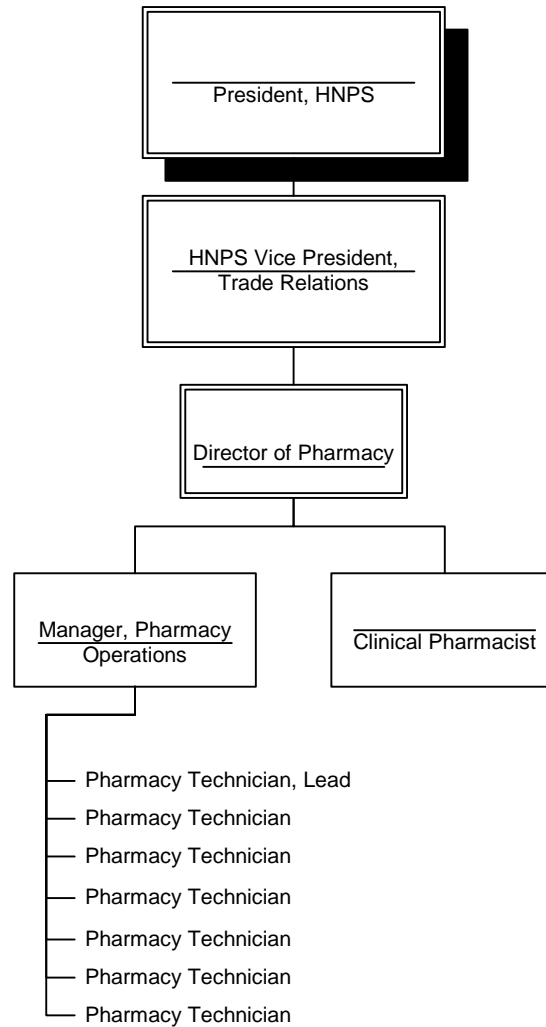
Vice President of Health  
Care Services

Medical Director  
(1)



# Pharmacy Organization Chart

Health Net, Health Plan of Oregon



## **Health Net of Oregon Delegated Utilization Management Functions**

Initial Date: August 2002

Reviewed and Revised: October 2002; December 2004, May 2008

<b>Vendor Name</b>	<b>Functions Performed</b>	<b>Frequency of Onsite / Review Month</b>
Managed Health Networks	Utilization Management	Annually / November
American Specialty Health Network	Utilization Management	Annually / December