



Prominence Health Plan Quality and Utilization Management Policy and Procedure

1. Purpose:

Prominence Health Plan's Medicare Advantage Quality and Utilization Management Program (UM) is designed to maximize the effectiveness of services provided to plan members, by advocating access to appropriate, quality and cost effective care.

This UM Plan is applicable to Prominence Health Plan's Medicare Advantage Plan. Utilization Management involves the evaluation and coordination of health care services for a culturally diverse population. The comprehensive Utilization Management Program promotes objective, systematic monitoring and evaluation of appropriate resources throughout the continuum of care. Prominence Health Plan's Utilization Management program is an integral component of the Prominence Health Plan Quality Improvement (QI) Program.

2. Mission:

The mission of the UM Program is to facilitate the delivery of efficient and effective quality health care to its members. It is the goal of Prominence Health Plan's UM Program to coordinate the provision of high quality, safe and cost effective medical services by appropriate providers, utilizing available healthcare benefit resources. Prominence Health Plan is not a provider of care.

Because each of the member's individual health care needs is of primary importance, Prominence Health Plan is committed to:

- Promoting health education and initiating preventive health care measures;
- Maintaining the good health of our members,
- Maximizing the quality of life for those members with chronic illnesses,
- Efficient utilization of healthcare resources.

3. Objectives

Prominence Health Plan has established the following objectives:

- To ensure that members receive timely, medically necessary health care in an appropriate setting for a positive health outcome including the incorporation of culturally competent approaches to care;
- To ensure that services are sufficient in amount, duration and scope to be expected to achieve the purpose for which the services are furnished;
- To promote fair and consistent UM decision making which addresses the needs of individual patients and characteristics of the local delivery system;
- To develop indicators and thresholds for monitoring and evaluating services for continuity of care and over and under-utilization of medical resources, identifying issues, and developing follow-up measures;
- To coordinate referrals for post-hospital medical services to appropriate providers and community support services;
- To identify quality, risk and utilization issues and refer potential issues appropriately;

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- To improve health, wellness and management of chronic diseases and catastrophic conditions through coordination with Prominence Health Plan's Case and Disease Management Programs;
- To identify and change administrative processes which represent barriers to care and implement interventions to remove or minimize these barriers;
- To ensure inter-rater reliability of all individuals performing UM decision-making review;
- To ensure that delegated providers meet all regulatory requirements in the process of providing UM resources;
- To ensure Member and Provider satisfaction with the UM process

4. Care Coordination

Care Coordination is a collaborative process which coordinates monitors and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Care Coordination is performed by non-clinical personnel who possess excellent customer service and telephone skills to engage members in their healthcare needs. Prominence Health Plan care coordination is limited to episodic assistance with transitions of care such as post hospital care, ensuring appropriate use of resources, timely care, and making referrals to Case Management and Disease Management programs. Prominence Health Plan Care Coordination is under the direction of the Health Services Director. All Prominence Health Plan members are eligible for care Coordination assistance at no cost and can self-refer for services at any time. Care Coordination is completely voluntary and members can opt out at any time.

Prominence Health Plan Care Coordinators work with the member, family and other interested parties in collaboration with the member's physician and other allied health care providers to assist in facilitating and coordinating services. In the care management evaluation process, the Care Coordinators will assist in identifying members who may benefit from referrals to Complex Case Management or Disease Management programs.

The Prominence Health Plan Nurse-line will screen calls for any appropriate referral and send the referral to the Care Coordination Staff to do outreach.

Prominence Health Plan Care Coordination staff will assist members in identifying alternative due to a benefit ending.

For example: Prominence Health Plan Care Coordinators would inform a member whose therapy benefit was reaching its maximum, but still needed treatment, of alternative options for coverage that are available through local gyms, or other funded programs.

5. Pre-Certification

Pre-certification is the review and authorization of elective/non-urgent admissions and ambulatory outpatient services which require medical record review for medical necessity; or require determination of provider and location of service but do not require medical record review for medical necessity.



Pre-Certification review is performed by licensed RN's utilizing appropriate criteria in the decision making process. These reviews also determine member eligibility, policy limitations and utilization of participating providers. If the requested service meets medical necessity criteria, eligibility, policy limitation and appropriate provider, the authorization is approved and the requestor is notified by fax, secure portal or phone depending on the classification of the review (standard or expedited). All reviews not meeting any of these requirements are forwarded to the Medical Director for final review and determination. No UM staff (licensed or non-licensed) may render a denial decision on any review. Adverse determinations of services requested are communicated in writing to the member, provider and primary care physician. This communication contains instructions on accessing the appeals and/or grievances processes. All information regarding the authorization is entered into the Prominence Health Plan computer system and is maintained by IT according to the company's data retention protocols.

The following services require Pre-Certification

- Any inpatient, skilled nursing or acute care
- Ambulatory Surgery Center (ASC) services
- Abortions
- Ambulance (for non-emergency transport)
- Chemotherapy
- Clinical Trials (not approved by Medicare)
- Cosmetic procedures
- Dental Services (Medicare-covered)
- DME > \$500 if purchased or \$38.50/mo. if rented
- Enteral Feedings
- Experimental/Investigational procedures
- Genetic testing
- Blood Products
- Home Health
- Hospice Enrollment (notification only)
- Hyperbaric Oxygen Therapy
- Implantable pump/device or stimulator
- Injectable/infusion therapy
- Injections > \$100 billed charged per unit
- Medical Nutrition Education
- MOHS procedure (Dermatology)
- Non-participating providers
- Obstetrical Care
- Orthotics/Prosthetics >\$500 purchase price
- Outpatient hospital (excludes Ultrasounds, X-ray & Labs)
- Pain Management
- Radiation Therapy
- Radiology/Diagnostic Tests: CT, CTA, MRA, MRI, Nuclear Med Cardiac, PET, Pill MUGA,
- Radiation Oncology, Medical Oncology, Virtual Colonoscopy, Endoscopy, 3-D Ultrasound
- Sleep Studies
- Rehabilitation services
- Rehabilitation-Cardiac, Pulmonary, Respiratory

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- Rehabilitation (Chiro, OT, PT,SP) after 10 initial visits
- Sterilizations
- TMJ joint treatment
- Transplants
- Wound Care (Outpatient Hospital only)

6. Criteria

The UM Department utilizes the following criteria as a guide during the review process to determine medical necessity:

- Medicare Coverage Guidelines
- National Coverage Determinations
- Local Coverage Determinations
- State Statutes, Laws and Regulations
- Milliman Care Guidelines
- Hayes Medical Technology
- Policy/Benefit Coverage

Medical Director professional judgment based on review of literature, evidence-based guidelines, other accepted guidelines, etc.

All criteria utilized are objective and based on medical evidence. The criteria are used mainly as a guideline and each decision takes in to account the member's individual needs and an assessment of the local delivery system.

Providers and members may request a copy of criteria used in an organizational determination, at no cost by contacting the UM Department.

7. Clinical Practice Guidelines

Prominence Health Plan has adopted several clinical practice guidelines to assist practitioners and members in making decisions regarding appropriate healthcare. These guidelines and resources are from national and professionally recognized organizations, and are selected based upon the considered needs of the enrolled population. These guidelines are reviewed, updated and approved annually through the Quality Improvement Committee.

Only the Chief Medical Officer or a Medical Director may perform adverse determinations. All decisions are based on appropriateness of care and service and existence of coverage. No member is discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of information.

8. Adverse Determination Process

The Prominence Health Plan does not deny, limit or condition the coverage or furnishing of benefits to individuals eligible to enroll in the plan on the basis of any factor that is related to health status (with certain ESRD exceptions regarding enrollment).

All members and involved providers are notified of the adverse determination in writing (or verbally as required by regulatory guidelines) utilizing CMS approved letter. The letter contains all information needed for the member or provider to access the Appeal or Grievance process, whichever is appropriate.



9. Authorization Time Frames

Pre-Certification requests are completed as quickly as the member's needs dictate, but must be completed within the following timeframes:

- Expedited requests: requests that cannot wait for the standard timeframe of review due to any delay that may cause significant harm to the member. These requests are called or faxed in to Prominence Health Plan by the physician or physician's representative or called into Customer Service by the member and sent to UM via secure web portal. Expedited requests must be completed within 72 hours from the date and time of receipt of the initial request.
- Urgent reviews and concurrent reviews (for patients in a facility) which must be completed within 24 hours of receipt.

Standard requests: requests that do not require being expedited must be completed within 14 calendar days from the initial receipt of the request unless an extension is requested. If an extension is requested Prominence Health Plan must complete the decision within 28 days from the date of receipt of the request. Any request for extension is communicated to the member and provider in writing utilizing a regulatory body approved letter. This letter informs the member and provider of the right to file an expedited grievance if they do not agree with the extension request.

10. Program Structure

The UM Program is comprised of the following functional areas:

- Referral Management
- Pre-Certification
- Concurrent Review (Inpatient and Skilled Nursing Facility)
- Transition of Care
- Complex Case Management
- Care Coordination
- Disease Management
- Social Services (as indicated)

11. Management Structure

The UM Program is overseen by the Chief Medical Officer, Medical Director(s) and the Director of Health Services.

12. UM Data Analysis and Reporting

Monitoring of UM Activity- UM monitors the following activities on a routine basis:

- Inter-rater Reliability – reported annually
- Timeliness of Authorizations, Denials, Expedited reviews – reported monthly and quarterly
- Telephone Accessibility – reported monthly and quarterly
- Results of Internal Compliance Audits – reported monthly



To learn more about our Quality and Utilization Management Program please contact our Care Coordination team at 883-201-0303 (TTY: 711). They are available from 8 am to 5 pm PST and after hours for urgent Utilization Management or Case Management issues.