Purpose

The Upper Peninsula Health Plan (UPHP) uses an integrated approach to 1) coordinate and promote optimal utilization of health care resources 2) make utilization decisions that affect the healthcare of members in a fair, impartial, and consistent manner and 3) assist with transition to alternative care when benefits end, should a member no longer be eligible for UPHP benefits. The UM process has been developed and maintained to comply with 1) the UPHP Medicaid including Children with Special Health Care Services (CSHCS), Healthy Michigan Plan (HMP), and MIChild contract with the State of Michigan per the Michigan Department of Health and Human Services (MDHHS) 2) the Department of Insurance and Financial Services (DIFS) according to Michigan Compiled Law (MCL) and 3) the National Committee for Quality Assurance (NCQA) UM Standards.

The general UM program structure, physician oversight, and integration with the quality improvement program is outlined in the UPHP Quality Assessment and Improvement and Utilization Management (QAI/UM) Program Plan. The UPHP Medical Director is responsible for managing the Utilization Management Program. This policy and procedure explains the clinical criteria and appropriate professionals (including behavioral health practitioners) utilized for UM decisions; communication services for practitioners and members; the assessment of clinical information used to support UM decisions; timeliness in utilization decisions; and documentation and communication of denials in UM decision making. Detailed information regarding the member appeal process is explained in the UPHP member and provider appeal policies.

For information regarding the pharmacy utilization guidelines please refer to policies #300-008 Pharmacy Management and #300-009 Pharmacy Prior Authorization Process.

Policy

UPHP provides healthcare services to members as a plan of covered benefits described in the State of Michigan Medicaid Contract, MDHHS Medicaid Provider Manual, MDHHS fee
schedules, and UPHP member handbooks. Services are to be directed by an in-network primary care provider (PCP) or specialist. These services must be provided within the UPHP network when available and must be medically necessary. Requests for services out-of-network will be reviewed for availability and accessibility in-network. Out-of-network non-emergent/urgent services are not a covered benefit unless reviewed and prior authorized by UPHP.

UPHP will accept Prior Authorization (PA) requests from Out-of-Network (OON) providers under the following circumstances:

1. Emergency Department (ED) follow-up visits to OON Specialists
2. Hospitalization follow-up to OON Specialist
3. OON Provider has current PA on file
4. Prior Authorizations that have been approved by MDHHS for members who were previously on Fee for Service Medicaid until the member is able to safely transition to UPHP in-network providers
5. Newly eligible UPHP members who are in active course of treatment with an OON provider
6. UPHP member has moved out of the UPHP provider area and not disenrolled from UPHP

The plan benefits of emergency services are not reviewed for medical necessity thus are not subject to denial of services based on medical necessity. For additional information regarding emergency services, refer to policy #300-022 Emergency Services.

UPHP members who are pregnant are allowed to select or remain with the obstetrician of their choice, who accepts Medicaid, and will receive all medically necessary prenatal, obstetrical, and standard post-partum follow up care without preauthorization.

UPHP members may receive the following services without prior authorization, from both in-network and out-of-network providers:

- Emergency services (screening and stabilization)
- Family planning services
- Immunizations at local health departments
- Communicable disease detection and treatment at local health departments
- Child and Adolescent Health Centers and Programs (CAHCP) services
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHC)
- Indian Health Services/Tribally-Operated Facility/Urban Indian Clinic for covered services provided to Native American members
- State laboratory services

UPHP allows members to obtain a second opinion from a qualified health professional within the network or arrange for the member to obtain one out-of-network at no cost to the member. Out-of-network requests do require prior authorization and will be reviewed for availability and accessibility in-network.

Services that are covered outside of the UPHP Medicaid benefit and therefore not reviewed for medical necessity include: Dental (except Healthy Michigan Plan and pregnant Medicaid members effective 7/1/2018), custodial nursing home services, inpatient/outpatient partial hospitalization psychiatric services, substance abuse services, and short-term restorative/rehabilitative services in a nursing facility after the 45 day benefit has been exhausted.
Services that are prohibited or excluded under Medicaid are: elective abortions and related services, experimental/investigational drugs, procedures or equipment, elective cosmetic surgery, and services for treatment of infertility.

Definitions

The terminology used in this policy is defined in Appendix A: UM Definitions

Procedure

Section 1: Authorization and Notification Requirements:

The following services require prior authorization from UPHP Clinical Services: Authorization decisions are made upon determination of compliance with appropriate criteria as noted in Section 2: Utilization Criteria. Authorization is required in order to receive payment for services. UPHP does not review retro authorization requests.

1. Out-of-network services:
   a. Elective inpatient admissions
   b. Practitioner services
   c. Facility services
   d. Laboratory services
   e. Durable medical equipment and supplies
2. Medically necessary weight reduction services
3. Medically necessary reconstructive surgery
4. Chiropractic Visits exceeding 18-visit limit per calendar year
5. Durable medical equipment/medical supplies listed on the UPHP Prior Authorization/Notification grid located on the UPHP website
6. Durable medical equipment/medical supplies not meeting Michigan Medicaid guidelines (except for home infusion S codes based on diagnosis)
7. Physical and Occupational therapy exceeding the 144 Units of initial therapy
8. Speech therapy exceeding 36 visits of initial therapy
9. Medical services not meeting the Michigan Medicaid provider manual standards of coverage
10. Outpatient hospital services for dental care requiring anesthesia
11. Genetic and Molecular Testing effective 7/1/2018

Notification is required in order to receive payment for services; however notification does not involve the application of clinical criteria for an authorization decision. Notification is required to trigger necessary care coordination/care management activities on the part of UPHP. Services that require notification to UPHP Clinical Services include but are not limited to:

1. Out-of-Network urgent/emergent inpatient admissions and observation services, including UPHP members who have a global authorization as defined in Appendix A – within one business day of admission
2. Skilled nursing facility/swing bed admissions - within one business day

The process for prior authorization or notification is as follows:

1. Provider verifies:
   a. Member is currently a UPHP member
b. Service request is for a covered benefit  
c. Service request requires prior authorization or notification  

2. Provider submits required documents by fax (preferred) or mail. Requests by phone are taken only in urgent/emergent situations. Required documents include:  
a. Appropriate prior authorization/notification request form. UPHP forms are available by contacting the UPHP UM department or on the UPHP Web site at www.uphp.com  
b. Clinical information to support the request as indicated on the form  

3. UPHP will respond to the request for prior authorization or notification as indicated in Section 5: Timeliness of UM Decisions  

Section 2: Utilization Criteria  

UPHP uses written objective criteria based on sound clinical evidence and specific UM procedures for appropriately applying the criteria. Appropriate practitioners are involved in developing, adopting, and reviewing the criteria as well as the procedures for applying them. This occurs on at least an annual basis as overseen by the UPHP Clinical Advisory Committee (CAC). The CAC meets quarterly and is led by the UPHP Medical Director and consists of at least 6 participating network physicians who broadly represent the composition of the UPHP provider network including behavioral health. To assure clinical expertise in the area being reviewed, specialty consultant knowledge is obtained through local physician experts and, when local expertise is not available, through profession peer review organizations. Specialty consultations are provided in writing and are included in the Criteria Review document submitted to the Committee.  

Resources used to develop UPHP criteria include but are not limited to:  
2. InterQual® Adult and Pediatric Acute Level of Care Criteria  
3. UPHP approved clinical practice guidelines  
4. Specialty consultants  
5. Professional journals and publications  

UPHP adopted criteria includes:  
1. Out-of-Network Referral Criteria  
2. InterQual® Inpatient Acute Level of Care Adult and Pediatric Criteria  
3. Automated Insulin Pump System Criteria  
4. Outpatient Hospital Services for Dental Care Requiring Anesthesia Criteria  
5. Cosmetic versus reconstructive and weight loss surgery criteria:  
   a. Bariatric Surgery  
   b. Reduction Mammaplasty  
   c. Panniculectomy  
6. MDHHS Medicaid provider manual standards of coverage including but not limited to:  
   a. Durable medical equipment  
   b. Inpatient readmission within 15 days  
   c. Skilled nursing facility admission  
   d. Swing bed admission  
   e. Physical, Occupational, and Speech Therapy  
   f. Chiropractic visits  
   g. Genetic and Molecular Testing
Provider education regarding UM criteria and processes occurs through the new practitioner orientation packets, provider manual, provider newsletters, UPHP web site, and provider in-services.

Members and/or practitioners may request a copy of the actual benefit provision, guideline, protocol, or other criteria used in UM determinations, by contacting the UPHP UM Department via the following methods:

1. Verbally via phone at 1-906-225-7774, toll free (reception) 1-888-904-7526 or (automated attendant) 1-800-835-2556
2. Hard copy via mail or fax upon request to 1-906-225-9269 (fax)
3. Download from the UPHP website at www.uphp.com

All UM criteria requests received by the UPHP UM department will be logged in PCM under the category: Utilization, subject: Criteria Request

UM criteria are applied on a case by case basis to incorporate individual needs and to assess the local delivery system for applicable resources or alternatives. UM reviewers must consider at least the following factors when applying criteria to an individual:

1. Age
2. Complications
3. Psychosocial situation
4. Home environment, when applicable
5. Co-morbidities
6. Progress of treatment
7. Access and availability of required services
8. Coverage of benefits

Reviewers must also consider characteristics of the local delivery system available for specific patients, to include:

1. Availability of skilled nursing facilities, sub-acute care facilities or home care in the UPHP service area to support the patient after hospital discharge
2. Availability of inpatient, outpatient, and transitional facilities
3. Local hospitals’ ability to provide all recommended services within the estimated length of stay
4. Availability of outpatient services
5. Availability of highly specialized services, such as transplant facilities or cancer centers

When existing UM guidelines are deemed inappropriate due to any of these above factors, UM reviewers forward the case to the Practitioner Reviewer for review and decision. The Practitioner Reviewer utilizes alternative resources, including information published from peer-reviewed journals, medical associations, government agencies, and authoritative compendia.

The Practitioner Reviewer solicits input from board certified specialty physicians and/or the requesting provider as appropriate. Additional information regarding this process is provided in Section 4: Professionals Making UM Determinations.

UPHP annually evaluates the consistency with which UM reviewers apply criteria in decision making and acts on opportunities for improvement, if applicable. The Clinical Services Manager -UM/designee conducts an inter-rater reliability (IRR) review and analysis, at least annually and as warranted, on all professional staff responsible for making UM determinations.
The annual IRR study consists of conducting a blind review and analysis of hypothetical or sample UM determination file cases using the NCQA 8/30 methodology for each professional staff responsible for making UM determinations, which includes the Medical Director and Clinical Coordinators-UM.

The expected IRR concurrence rate is 80% or greater. If the analysis indicates the concurrence rate is less than 80%, a corrective action plan is formulated and implemented as opportunities for improvement are identified.

After the IRR review and analysis is complete, the Medical Director, Clinical Services Manager-UM, and Clinical Coordinators-UM will review the results and analyze any case which lacked consistent determinations.

Section 3: Access to UM Staff Members and Practitioners

There is a UM staff member available during normal business hours (8:00 a.m. to 5:00 p.m. EST, Monday through Friday, excluding holidays) for provider and/or member UM issues. Referrals and service requests may be submitted by fax: 906-225-9269 (UM department fax), or by phone: 1-800-835-2556 (automated prompt to Clinical Services which forwards caller directly to UM staff) when indicated. Non-urgent requests received by fax or voice mail after normal business hours are considered as received on the day they were submitted. Urgent requests received by fax or voice mail after normal business hours are considered as received on the day they were submitted. Members or providers with questions about the UM process may be referred to Clinical Services UM staff, by other UPHP staff, for discussion of specific cases and/or about the UM process. For language assistance, an interpreter is provided to members upon request to help members with their UM issues. Language assistance is provided to members free of charge.

Tools for incoming and outgoing communication with the UPHP Clinical Services UM department include:

1. Attended incoming phone line (reception) - 906-225-7500
2. Toll-free incoming line (reception) - 1-888-904-7526
3. Automated attendant with prompts - 1-800-835-2556
4. UM department direct line - 906-225-7774
5. Hearing or speech impaired members - Michigan Relay Center (TTY) 711
6. Interpreter Services
7. Dedicated fax line in Clinical Services department - 1-906-225-9269
8. UM staff direct phone lines with confidential voice mail
9. Email address for each individual staff member (upon request)
10. UM staff will accept collect calls

This contact information is published in the UPHP member handbooks, the UPHP Provider Manual, and on the UPHP Web site.

All calls received during normal business hours are returned on the same day. After normal business hours, all calls are forwarded to a UPHP automated voice mail system. Communications received after normal business hours are returned on the next business day and communications received after midnight on Monday-Friday are responded to on the same business day. All forms of communication (phone calls, faxes and/or email) received from providers and/or members receive a response during normal business hours. The exception is UM review determinations which follow appropriate response times as indicated in Section 5:
Timeliness of UM Decisions. When initiating a call or responding to a provider and/or member UM issue by phone, fax and/or email, the UM staff member identifies themselves by first name, title, and organization name. (Example of responding to an incoming phone call: "Upper Peninsula Health Plan, Clinical Services, this is Jane R.N.") If requested by the treating provider, the UPHP Medical Director will be available by phone for physician to physician discussion of UM issues. All physician to physician phone discussions are coordinated through the Clinical Services UM Department.

**Section 4: Professionals Making UM Determinations**

The following are the various levels of reviewers and the decisions permitted at each level using approved explicit criteria as outlined in Section 2 of this policy.

**UM Review and Appeals Coordinator** - non-licensed personnel supervised by appropriately licensed professionals. Staff who are not licensed health professionals may, under the supervision of appropriately licensed health professionals, collect data for preauthorization and concurrent review. They may also have the authority to approve but not to deny the following services for which there are explicit and approved criteria as described in Section 2: Utilization Criteria.

1. OON specialist as direct follow-up to emergency room care
2. Outpatient services requested at an OON facility related to an authorized OON referral
3. New practitioner awaiting credentialing with an approved clean file in accordance with UPHP policy #200-002 Credentialing
4. OON practitioner when member has moved out of the UPHP network area and not yet enrolled in a new plan or has not been disenrolled by UPHP
5. Outpatient dental care requiring anesthesia meeting MDHHS guidelines

The Review and Appeals Coordinator may enter approved authorizations as directed by the Clinical Coordinator-UM staff and may process services that require notification in order to receive payment, as clinical criteria is not applied.

The Review and Appeals Coordinator clarifies with a Clinical Coordinator-UM if uncertainty exists regarding the guidelines for the above requests. **The Review and Appeals Coordinator cannot deny any request for services.**

**Clinical Coordinator** - licensed personnel (non RN) with the authority to approve all of the requests listed within the UM Review and Appeals Coordinator level.

The Clinical Coordinator may enter approved authorizations as directed by the Clinical Coordinator-UM staff and may process services that require notification in order to receive payment, as clinical criteria is not applied.

The Clinical Coordinator clarifies with a Clinical Coordinator-UM if uncertainty exists regarding the guidelines for the above requests. **The Clinical Coordinator cannot deny any request for services.**

**Clinical Coordinator-Utilization Management** - a licensed registered nurse with the authority to approve all of the requests listed within the UM Review and Appeals Coordinator and Clinical Coordinator levels as well as:

1. OON services
2. Durable medical equipment
3. Medically necessary reconstructive surgery
4. Medically necessary weight reduction services
5. Inpatient readmissions within 15 days (Post Service Review)
6. Physical, Occupational, and Speech Therapy services
7. Chiropractic visits exceeding 18-visit limit
8. Outpatient hospital services for dental care requiring anesthesia
9. Medical services/supplies not meeting the Michigan Medicaid provider manual standards of coverage

The Clinical Coordinator-UM cannot deny any request for services. Any request not meeting criteria is referred to the Practitioner Reviewer for decision.

Clinical Services Manager-Utilization Management- a licensed registered nurse with a Bachelor’s degree in nursing or health-related area; or a master’s degree in a related discipline. The Clinical Services Manager-UM oversees the Clinical Coordinators-UM, Clinical Coordinators and UM Review and Appeals Coordinators ensuring that UM staff complies with UPHP policies and procedures, NCQA UM standards, and MDHHS requirements. In addition, the Clinical Services Manager-UM provides day to day supervision of UM staff, participates in staff training, and monitors consistent application of criteria and documentation for accuracy. The Clinical Service Manager-UM has the authority to approve all requests listed within the Clinical Coordinator-UM level. In addition, the Clinical Services Manager is able to review and deny non-medical necessity requests. The Clinical Services Manager-UM cannot deny medical necessity requests.

Practitioner Reviewer – professional with education, training or professional experience in medical or clinical practice possessing current licensure without restriction may review medical necessity requests for health care services under the UPHP medical benefit including but not limited to:
1. Services listed within the above Utilization Management roles
2. Cosmetic versus reconstructive and weight loss surgical procedures
3. Referrals that do not meet UPHP CAC approved utilization management guidelines
4. Referrals in which consideration of individual needs and the local delivery system is required
5. OON services
6. All medical necessity and benefit determinations as defined in Appendix A

The Practitioner Reviewer is the only UM professional able to deny medical necessity service requests.

UPHP utilizes board certified practitioners from appropriate specialty areas (physicians, psychiatrists, doctoral level psychologists, chiropractors, dentists, pharmacists) and/or the requesting provider to assist in making the practitioner reviewer determinations as appropriate. The in-network specialists list is maintained in the UPHP Provider Directory. For assistance in medical necessity reviews when no in-network specialist is available, UPHP contracts with an Independent Review Organization for independent review services.

For prior authorization decisions related to CSHCS members, UPHP may consult with the Office of Medical Affairs Medical Consultants to determine pediatric sub specialists, hospitals and ancillary providers available and appropriate to render services to CHSCS members and to assist in determining appropriate durable medical equipment for CSHCS members.
UPHP provides CSHCS enrollees and families the opportunity to provide input on UPHP policies and procedures that influence access to medical services or member services. These opportunities include but not limited to: grievances and appeals, UPHP CSHCS forums, and UPHP Management Committee meetings.

All UM practitioner review decisions are documented in Plexis Claims Manager, including:

1. Date requests are received
2. All UM reviewer identification, including the electronic signature/identifier, on the notation of denial in the file
3. All UM reviewer decision documentation
4. Date, time, method of communication and to whom the determination was communicated
5. All follow-up information

For specific procedures related to review of medical necessity of pharmacy benefits, refer to UPHP policy #300-009 Pharmacy Prior Authorization Process.

For all medical necessity and non-medical necessity denials, UPHP utilizes the MDHHS approved Notice of Adverse Benefit Determination. This notice of denial is sent to members and their treating practitioners. It contains the following information:

1. The specific reasons for the denial, in easily understandable language
2. A reference to the benefit provision, guideline, protocol, or criterion on which the denial decision is based
3. A statement that the member can obtain upon request, free of charge, a copy of the actual benefit provision, guideline, protocol, or criterion on which the denial decision was based.
4. How to appeal denial decisions.

For information pertaining to member appeal rights and process, refer to UPHP policy #300-024 Member Appeals Related to Utilization Management Adverse Determinations.

For service denials that are terminated, suspended, or a reduction of previously authorized services, UPHP mails the Adverse Benefit Determination Notices within 10 days before the date of action except when:

- UPHP has factual information confirming the death of a member
- The member submits a signed written statement that:
  - He/she no longer requests the services or;
  - The member gives information that requires termination or reduction of services and indicates he/she understands that service termination or reduction will result.
- The member has been admitted into an institution where he/she is ineligible under the plan for further services.
- The member’s whereabouts are unknown and the post office returns UPHP’s mail directed to the member indicating no forwarding address.
- UPHP verified with MDHHS that the member has been accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth.
- A change in the level of medical care is prescribed by the member’s provider.
- The notice involves an adverse benefit determination with regard to preadmission requirements.

UPHP may shorten the period of advanced notice to five days before the date of action if:
• UPHP has facts indicating that action should be taken because of probable fraud by the member; and
• The facts have been verified, if possible, through secondary sources.

If the treating practitioner does not agree with the UM determination, he/she may request a phone conference with the practitioner making the determination. This request may be made via phone by calling UPHP Utilization Management at 906-225-7774 or toll-free at 1-888-904-7526 or in writing to:

Upper Peninsula Health Plan
Attn: Utilization Management
853 West Washington Street
Marquette, MI 49855

A mutual time is scheduled upon receipt of the practitioner’s request.

UPHP distributes a statement to all of its members and to all practitioners, providers, and employees who make UM decisions affirming that: Utilization management decision making is based on appropriateness of care and service and existence of coverage. UPHP does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. UPHP does not provide financial incentives to utilization management decision makers that result in under-utilization. All UM staff making UM decisions sign the UPHP Confidentiality and Affirmative Statement Form upon hire which placed in their employee file.

Section 5: Timeliness of UM Decisions

Requests are received on the date and time:
• UPHP stamps a document received by regular mail
• Delivery service that has the ability to track when a shipment is delivered (i.e. US Postal Service, UPS, FedEx) indicates
• A faxed document is successfully transmitted to UPHP, as indicated on the fax transmission report
• A verbal request made by telephone with a customer service representative or UM staff as documented in PCM
• A message is left on UPHP’s voicemail after normal business hours as indicated on the voicemail
• Request is received through the UPHP website “Contact Us” feature as documented on the email

The processing timeframe begins when UPHP receives a request from the member or member’s authorized representative (i.e. provider). Written notification of the decision is considered delivered on the date (and time if applicable) when UPHP has deposited the notice in the courier drop box. Please refer to UPHP Standard Operating Procedure #500-2006 Mail Process. For urgent/expedited requests, verbal notification will be attempted up to three times to reach the member/authorized representative documenting each attempt in the PCM case file notes, with the last attempt noted in the oral notification field in PCM.

For approval and denial written notifications, UPHP adheres to MDHHS, DIFS, and NCQA standards for timeliness of UM decision notification as outlined below:
<table>
<thead>
<tr>
<th>Request Type</th>
<th>Notification Time Frame*</th>
<th>Member Notification</th>
<th>Provider Notification</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent/Expedited concurrent</td>
<td>72 hours</td>
<td>X</td>
<td>X</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Urgent/Expedited preservice</td>
<td>72 hours</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nonurgent/Standard preservice</td>
<td>14 calendar days</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Postservice</td>
<td>14 calendar days</td>
<td>X- issue denial only if member is at financial risk</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

*Table indicates from time of receipt of request to written notification of decision

**Urgent/Expedited Requests**

If an expedited request is made or supported by a physician or other prescriber who indicates applying the standard timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, UPHP will process the request as urgent/expedited.

**Extensions**

Time frames may be extended up to 14 calendar days before the end of the time frame if:

- The member, authorized representative, or provider requests the extension; or
- UPHP justifies (to MDHHS upon request) a need for additional information and how the extension is in the member’s interest. UPHP will notify the member in writing of UPHP’s intent to extend the timeframe.

If a decision is not made within the specified timeframes, UPHP will issue an adverse benefit determination notice.

**Section 6: Clinical Information**

Documentation of relevant clinical information is gathered consistently to support UM decision making and is maintained in the UM review files. Information required for UM decision making may include, but is not limited to:

1. Pertinent medical records to substantiate medical necessity
2. Inpatient: history and physical, admission and discharge summaries, pertinent test results
3. Outpatient: progress notes of treating physician or professional, pertinent test results, written consultant recommendations
4. Evidence of consultation with treating practitioner when applicable

Clinical information utilized to support UM decision making may include, but is not limited to: office and hospital records, history of presenting problem, clinical exam, diagnostic testing results, treatment plans and progress notes, psychosocial history, consultations or evaluations from other health care providers, photographs, operative reports, pathological reports, and rehabilitation reports. Additional clinical information may also be used such as a printed copy of
criteria related to the request, service or procedure benefit information, local delivery system information, member characteristics as well as other information about the member and responsible family members.

Relevant clinical information is sent by the requesting practitioner in accordance with the UPHP Clinical Services Prior Authorization Request Form instructions. UM staff obtains missing information by contacting the provider in accordance with the time frames in Section 5: Timeliness of UM Decisions.

**Section 7: Post Service Review**

UPHP reserves the right to retrospectively review any medical services, where the member is not at financial risk, for medical necessity and appropriateness of care.

**Section 8: Transition to Other Care**

When members are receiving approved services but their benefit coverage is to end while they are still in need of medically necessary care, UPHP Clinical Coordinators-UM in collaboration with UPHP Clinical Coordinators-Care Management will assist with the member’s transition to other care, if necessary, when benefits end.

Members who may need this service are identified through member and provider requests and/or through review of utilization and care management information. The Clinical Coordinator-UM is responsible to identify available resources within the member’s community and discusses alternative care and resources available with the member and/or provider.

If the transition to other care is necessitated as a result of a UM denial, written notification of available alternative resources is contained within the denial letter.

**Section 9: Utilization Management File Audits**

All UPHP UM decisions are audited weekly by the Clinical Services Manager-UM or designee to monitor timeliness and ensure correct data entry into PCM. All denials are reviewed for compliance by the Clinical Services Manager-UM or designee prior to sending related provider and/or member correspondence.

The UPHP Pharmacist audits and maintains pharmacy UM files.

**Attachments:**

1. Appendix A: Utilization Management Definitions
2. UPHP Agreement for Medical Peer Review Services
3. UPHP Confidentiality and Affirmative Statement Form

Exception to this policy may be made with the approval of the Chief Executive Officer or an authorized designee.

/// END OF POLICY & PROCEDURE ///
# Appendix A

## Upper Peninsula Health Plan

### Utilization Management Definitions

<table>
<thead>
<tr>
<th>accessibility</th>
<th>The extent to which a patient can obtain available services at the time they are needed. Such service refers to both phone access and ease of scheduling an appointment, if applicable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>active course of treatment</td>
<td>Treatment in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.</td>
</tr>
</tbody>
</table>
| appeal | A request, oral or written, for review of:  
- The denial or limited authorization of a requested service, including the type or level of service;  
- The reduction, suspension or termination of a previously authorized service;  
- The denial, in whole or part, of payment for a properly authorized and covered service;  
- The failure to provide services in a timely manner, as defined by the state;  
- The failure to act within the established timeframes for grievance and appeal disposition; or  
- The denial to exercise the right to obtain services outside of the network. |
| availability | The extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership. |
| benefit | Services or supplies for which the health plan agrees to provide coverage. |
| benefit determination | Decision on a request for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan. |
| clinical appropriateness | Based on judgement of a health care practitioner, applicability of a requested service to a member’s case in terms of type, frequency, extent, site and duration. |
| concurrent request | A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. |
| continuity of care | A process for assuring that care is delivered seamlessly across a multitude of delivery sites and throughout the course of the disease process. |
| continuity of clinical care | The provision of care by the same set of clinicians to a member over time or, if the same clinicians are not available over time, a mechanism to promptly provide appropriate clinical information to the clinicians who continue to provide the same type and level of care. |
| coordination of clinical care | The mechanisms ensuring that a member and clinicians have access to and take into consideration all required information on the member’s conditions and treatments, to ensure that the member receives appropriate health care services. |
| criteria | Systematically developed, objective and quantifiable statements used to assess the appropriateness of specific health care decisions, services and outcomes. |
| denial | Non-authorization, reduction, or termination decision of care or service based on either medical necessity or benefit coverage. |
### Upper Peninsula Health Plan
#### Utilization Management Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>evidence-based guidelines</td>
<td>Clinical practice guidelines that are known to be effective in improving health outcome. The effectiveness is determined by scientific evidence, professional standards, or in the absence of professional standards, expert opinion.</td>
</tr>
<tr>
<td>global authorization</td>
<td>Authorization that allows UPHP members to receive services from multiple providers within a health system utilizing one prior authorization. These authorizations are for members with complex health conditions needing multiple providers and outpatient services within a health system. A Global Authorization does not cover inpatient admissions.</td>
</tr>
<tr>
<td>licensed independent practitioner</td>
<td>An individual permitted by law to provide individual or patient care services without direction or supervision within the scope of the individual’s licensure or certification and in accordance with individually granted clinical privileges.</td>
</tr>
<tr>
<td>medical necessity</td>
<td>Refers to services or supplies for diagnosing, evaluating, treating or preventing an injury, illness, condition or disease, based on evidenced-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standards of care. Determination of medical necessity is based on specific criteria.</td>
</tr>
<tr>
<td>medical necessity review</td>
<td>A process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member’s circumstances, relative to appropriate clinical criteria and the organization’s policies.</td>
</tr>
<tr>
<td>nonurgent request</td>
<td>A request for medical care or services in which the application of the time periods for making a decision does not jeopardize the life or health of the member or the member’s ability to regain maximum function and would not subject the member to severe pain.</td>
</tr>
<tr>
<td>notification</td>
<td>Does not involve the application of clinical criteria for an authorization decision. Notification is required to trigger necessary care coordination/care management activities on the part of UPHP.</td>
</tr>
<tr>
<td>over-utilization</td>
<td>Providing clinical services that are not clearly indicated or providing services in either excessive amounts or in a higher-level setting than is required.</td>
</tr>
<tr>
<td>postservice request</td>
<td>A request for coverage of medical care or services that have been received (e.g., retrospective review).</td>
</tr>
<tr>
<td>preservice request</td>
<td>A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.</td>
</tr>
<tr>
<td>term</td>
<td>definition</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>primary care provider (PCP)</td>
<td>An individual, such as a physician or other qualified practitioner, who provides primary care services (including family practice, general practice, internal medicine, and pediatrics) and manages routine health care needs. For women, an obstetrician/gynecologist may be considered a PCP.</td>
</tr>
<tr>
<td>prior authorization</td>
<td>Pre-service decisions made upon determination of compliance with appropriate criteria</td>
</tr>
<tr>
<td>treatment</td>
<td>The provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.</td>
</tr>
<tr>
<td>under-utilization</td>
<td>Failure to provide appropriate or indicated services, or provision of an inadequate quantity or lower level of services than required. See medical necessity.</td>
</tr>
</tbody>
</table>
| urgent request | A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:  
  - Could seriously jeopardize the life and health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgement, or  
  - Could seriously jeopardize the life, health or safety of the member or others, due to the member’s psychological state, or  
  - In the opinion of a practitioner with knowledge of the member’s medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. |
| utilization management (UM) | The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to the clinician or patient, in cooperation with other parties, to ensure appropriate use of resources. |
| utilization review | A formal evaluation (prospective, concurrent or retrospective) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans. |
Appendix B

Agreement for Medical Peer Review Services

This agreement is made and entered into this ____ day of ___________, 200__, by and between Upper Peninsula Health Plan (UPHP) and _________________________________, a physician on the UPHP provider panel and board certified in ________________________________.

UPHP agrees to reimburse _______________________ in the amount of $________ per hour for performing peer review on the enclosed case. The required forms to be completed for this review are enclosed with the medical record(s).

This review is protected from disclosure pursuant to the provisions of MCL 333.20175, MCL 333.21513, MCL 333.21515, MCL 331.531, MCL 331.533, MCL 330.1143a and other applicable state and federal laws. Unauthorized disclosure or duplication is absolutely prohibited.

Case ID: _______________ Review Completion Date Required: _________________________

UPHP Confidentiality and Affirmative Statement signed:  Date: ______________

UPHP Confidentiality and Affirmative Statement attached to be signed by physician reviewer

I agree to the above conditions. Authorized UPHP Representative:

______________________________ ____________________________________

Physician Reviewer                          Signature

______________________________ ____________________________________

Title                          Date

Date                          Date

To be completed by Physician Reviewer:

Time Spent on Review: ____________ hours ____________ minutes

Please return this with the medical record(s) and review determination.

For office use only:

Received by UPHP (date): _____________________

To UPHP Finance Department for payment (date and initials): _______________________________
Upper Peninsula Health Plan Confidentiality and Affirmative Statement

Confidentiality Statement
As a representative of the Upper Peninsula Health Plan, I may have access to confidential information pertaining to patients, physicians, hospitals or other individuals. It is my responsibility to maintain in confidence this information at all times. Any unauthorized disclosure of confidential information will result in disciplinary action that may include immediate termination from my position.

Affirmative Statement
Utilization management decision making is based on appropriateness of care and service and existence of coverage. UPHP does not reward practitioners and other individuals conducting utilization review for issuing denials of coverage or service care. UPHP does not provide financial incentives for utilization management decision makers that result in under-utilization.

I hereby understand and agree to comply with the above statements.

UPHP Representative Signature: ________________________________

Printed Name: ________________________________________________

UPHP Position: ________________________________________________

Date: ____________________

At a minimum, this document must be signed by the UPHP Chief Executive Officer, Medical and Clinical Directors, and licensed utilization management staff.