Purpose

Upper Peninsula Health Plan (UPHP) uses an integrated approach to insure access to Medicare-covered services consistent with Medicare requirements and to coordinate and promote optimal utilization of health care resources, make utilization decisions that affect the healthcare of beneficiaries in a fair, impartial, and consistent manner, and assist with transition to alternative care when benefits end, should a beneficiary no longer be eligible for UPHP Medicare benefits. The Utilization Management (UM) process has been developed and maintained to comply with the UPHP contract with the Centers for Medicare & Medicaid Services (CMS), The Office of the Inspector General (OIG), the Department of Insurance and Financial Services (DIFS) according to Michigan Compiled Law (MCL) Chapters 330, 331, 333, 500, and 550, and the National Committee for Quality Assurance (NCQA) UM Standards.

The general UPHP Medicare 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. This policy and procedure explains the clinical criteria and appropriate professionals (including behavioral health practitioners) utilized for UM decisions; communication services for practitioners and beneficiaries; 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 beneficiary appeal process is explained in UPHP policy #600-324 Beneficiary Appeals Related to Utilization Management Adverse Determinations-Medicare. Detailed information regarding the provider appeal process is explained in the UPHP policy #600-320 Medicare Provider Appeals.

Policy

UPHP provides healthcare services to beneficiaries as a plan of Medicare-covered benefits described in the UPHP Evidence of Coverage (EOC) document and as outlined by the Centers for Medicare and Medicaid Services (CMS). Services are to be directed by an in-plan Primary Care Provider (PCP) or specialist. These services must be provided within the UPHP Medicare network when available and must be medically necessary. Requests for services out-of-plan will be reviewed for availability in-plan. Out-of-plan 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-Plan (OOP) providers under the following circumstances:

1. Emergency Department (ED) follow-up visits to OOP Specialists
2. Hospitalization follow-up to OOP Specialist
3. OOP Provider has a current PA on file
4. Newly eligible UPHP members who are in active course of treatment with OOP provider
5. 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.

Definitions

*(See 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. Specific details on all UPHP Medicare criteria are included in Section 2 of this policy.

1. Out-of-plan services:
   a. Practitioner services
   b. Facility services – inpatient and outpatient
   c. Durable medical equipment and supplies
2. Medically necessary weight reduction services
3. Medically necessary reconstructive surgery
4. Durable medical equipment/medical supplies listed in Appendix C
5. Durable medical equipment/medical supplies not meeting CMS guidelines
6. Hearing aids
7. Home Health Services- effective 1/1/2017

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/case management activities on the part of UPHP. Services that require notification to UPHP Clinical Services include but are not limited to:

1. In-plan elective inpatient admissions – *prior to admission*
2. In-plan and out-of-plan urgent/emergent inpatient admissions – *within one business day of admission*
3. In-plan and out-of-plan urgent/emergent observation admissions – *within one business day of admission*
4. Transplant services – *prior to service*
5. Reversal of bariatric surgeries – *prior to service*
6. Skilled nursing facility admissions- *within one business day of admission*
7. Swing bed admissions- *within one business day of admission*

The process for prior authorization or notification is as follows:

1. Provider verifies:
   a. Beneficiary is currently a UPHP Medicare member
b. Service request is for a UPHP Medicare covered benefit

c. Service request requires prior authorization or notification

2. Provider submits in writing by fax (preferred), phone or mail:
   a. Appropriate prior authorization/notification request form. UPHP forms are available from Customer Service or 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/notification as indicated in attached Appendix B: UM Review Decision Time Table

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 UPPH 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 Medicare criteria include but are not limited to:

1. CMS Medicare Managed Care Manual guidelines
2. InterQual® Inpatient 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-Plan Referral Criteria
2. InterQual® Inpatient Adult and Pediatric Acute Level of Care Criteria
3. CMS criteria:
   a. Bariatric Surgery for the Treatment of Obesity
   b. Cosmetic and Reconstructive Surgery
   c. Durable medical equipment
   d. Inpatient readmission within 30 days
   e. Skilled nursing facility admission
   f. Swing bed admission
4. UPHP Medicare Utilization Management Criteria for Medical Necessity of Hearing Aids
5. InterQual® Home Care Criteria

Provider education regarding UM criteria and processes occurs through the new practitioner orientation packets, provider manual, provider newsletters, UPHP web site, and provider inservices.

Beneficiaries and/or practitioners may request a copy of the actual benefit provision, guideline, protocol, or other criteria used in UM determinations, by any of the following methods:
1. Verbally via phone to UPHP Customer Service toll free at (877) 349-9324
2. Hard copy via mail or fax upon request to 1-906-225-7720 (fax)
3. Download from the UPHP Web site at www.UPHP.com

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. Results of Health Risk Assessment (HRA)
2. Beneficiary’s Individualized Care Plan
3. Age
4. Complications
5. Psychosocial situation
6. Home environment, when applicable
7. Co-morbidities
8. Progress of treatment
9. Access and availability of required services
10. Coverage of benefits

Reviewers are also encouraged to seek input from the beneficiary’s interdisciplinary care team when making utilization decisions. Additionally they 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 Medicare 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 specialists in the area
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 as appropriate. Further details are available in Section 4 of this policy.

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 Review (IRR) 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 a consistent number of cases (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 go over any cases where there were inconsistent decisions.

Section 3: Access to UM Staff Beneficiaries and Practitioners

There is a UM staff member available during normal business hours (8:00 a.m. to 5:00 p.m. ET, Monday through Friday, excluding holidays) for provider and/or beneficiary UM issues. A call center operates outside of normal business hours and holidays until 9:00 p.m. ET and can accept standard and expedited requests for coverage determinations/redeterminations. After 9:00 p.m. calls are forwarded to confidential voice mail that is checked regularly. Referrals and service requests may be submitted by fax: 906-225-9269 (UM department fax – preferred method), or by phone: 1-877-349-9324. Non-urgent requests received by fax or phone after normal business hours are considered as received on the next business day. Urgent requests received by fax or voice phone after normal business hours are considered as received on the day they were submitted. Beneficiaries 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 free of charge upon request to help members with their UM issues.

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

1. Toll-free incoming line - 1-877-349-9324
2. Hearing or speech impaired members - Michigan Relay Center (TTY) 711
3. Dedicated fax line in Clinical Services department - 1-906-225-9269
4. UM staff direct phone lines with confidential voice mail
5. Email address for each individual staff member (upon request)
6. UM staff will accept collect calls

This contact information is published in the UPHP Medicare Evidence of Coverage document, UPHP Medicare Provider Manual, and 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, or email, received from providers or beneficiaries receive a response during normal business hours. The exception is UM review determinations which follow appropriate response times as indicated in the attached Appendix B: UM Review Decision Time Table. When initiating a call or responding to a provider or beneficiary UM issue by phone, fax or email, the UM staff identifies themselves by first name, title, and organization name. For example when 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 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.

**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. Section 2 of this policy provides further information on how to obtain these criteria.

1. Out-of-plan (OOP) specialist as direct follow-up to emergency room care
2. Outpatient services requested at an OOP facility related to an authorized OOP referral
3. New practitioner awaiting credentialing with an approved clean file in accordance with the appropriate UPHP policy
4. OOP practitioner when beneficiary has moved out of the UPHP Medicare network area and not yet enrolled in a new plan or has been disenrolled from UPHP.

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

1. OOP services
2. Durable medical equipment
3. Hearing aids
4. Medically necessary reconstructive surgery
5. Medically necessary weight reduction services
6. Skilled nursing facility admissions
7. Swing bed admissions
8. Inpatient readmission within 30 days (Post Service Review)
9. Home Health

*The UM Clinical Coordinator cannot deny any request for services.* Any request not meeting criteria is referred to the Practitioner Reviewer for decision. The UM Clinical Coordinator may issue an administrative denial when UPHP UM filing procedures were not followed (late notification, retro-authorization requests).

**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 and Review and Appeals Coordinator ensuring that UM staff complies with UPHP policies and procedures, NCQA UM standards, and CMS requirements. The Clinical Service Manager-UM has the authority to approve all requests listed within the Clinical Coordinator-UM level and administer administrative denials. In addition, the Clinical Services Manager is able to review and deny benefit determination 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 and benefit requests for health care services under the UPHP medical benefit including but not limited to:

1. Cosmetic versus reconstructive and weight loss surgical procedures
2. Referrals that do not meet UPHP CAC approved utilization management guidelines
3. Referrals in which consideration of individual needs and the local delivery system is required
4. 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) to assist in making the practitioner reviewer determinations as appropriate. The in-plan specialists list is maintained in the UPHP Provider Directory. For assistance in medical necessity reviews when no in-plan specialist is available, UPHP contracts with an Independent Review Organization for independent review services.

All UM practitioner review decisions are documented in the UM determination database, including:

1. Date requests are received
2. All UM reviewer identification, including the handwritten signature, initials or 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 all medical necessity and benefit determination denials, UPHP provides a written notification to beneficiaries and their treating practitioner via the Integrated Denial Notice (CMS-10003) as required by CMS. The notice is specific to each individual case and written in a manner the beneficiary can understand in easily understandable language. This notice contains:

1. The specific reasons for the denial that takes into account the enrollee’s presenting medical condition, disabilities, and special language requirement, if any.
2. A reference to the benefit provision, guideline, protocol, or criterion on which the denial decision is based.
3. Information regarding the enrollee’s right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee’s behalf
4. A description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeal process
5. The beneficiary’s right to submit additional evidence in writing or in person.

For information pertaining to beneficiary appeal rights and process, refer to UPHP Medicare policy #600-324 Beneficiary Appeals Related to Utilization Management Adverse Determinations.

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 @ 906-225-7500/toll-free 1-888-904-7526 or in
writing to: UPHP, Utilization Management, 853 W. Washington, Marquette, MI 49855. A mutual time is scheduled upon receipt of the practitioner’s request.

UPHP distributes a statement to all of its beneficiaries 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 for utilization management decision makers that result in under-utilization.

Section 5: Timelines of UM decisions

UPHP Medicare adheres to CMS, OIG, DIFS, and NCQA standards for timeliness of UM decision making as outlined in attached Appendix B: UM Review Decision Time Table

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. Results of the beneficiary’s Health Risk Assessment (HRA)
3. Beneficiary’s Individualized Care Plan (ICP)
4. Inpatient: history and physical, admission and discharge summaries, pertinent test results
5. Outpatient: progress notes of treating physician or professional, pertinent test results, written consultant recommendations
6. Evidence of consultation with the Interdisciplinary Care Team (ICT) when applicable
7. 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. Missing information is obtained by the UM staff by contacting the provider in accordance with NCQA and CMS timelines indicated in Appendix B.

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 in accordance with UPHP policy #600-320 Medicare Provider Appeals.

Section 8: Transition to Other Care
For beneficiaries who are receiving approved services but their benefit coverage is to end while they still need medically necessary care, UPHP UM coordinators assist with the beneficiary’s transition to other care (including Part D drugs), if necessary, when benefits end.

Beneficiaries who may need this service are identified through beneficiary and provider requests and/or through review of utilization and case management information. The UM coordinator is responsible to identify available resources within the beneficiary’s community and discusses alternative care and resources available with the beneficiary 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 notification.

**Section 9: Utilization Management File Audits**

All practitioner UM review decision files are audited, by UM program staff when the review is completed and each file must contain a completed and signed file audit. All denial and appeal cases are audited for compliance with standards by the Clinical Services Manager-UM or designee prior to sending related provider and beneficiary correspondence.

**Attachments:**

1. Appendix A: Utilization Management Definitions
2. Appendix B: UM Review Decision Time Table
3. Appendix C: UPHP DME Prior Authorization List
4. UPHP Agreement for Medical Peer Review Services
5. 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 ∥
<table>
<thead>
<tr>
<th><strong>Appendix A</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Upper Peninsula Health Plan Plus</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Utilization Management Definitions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>accessibility</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>active course of treatment</strong></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>
<tr>
<td><strong>administrative denial</strong></td>
<td>Denial due to not following UPHP UM procedures such as late notification or asking for authorization on services that have already been rendered (retro-authorization).</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 a beneficiary’s benefit plan or that exceed the limitations or restrictions stated in the benefits plan. |
| **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 beneficiary 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 beneficiary and clinicians have access to and take into consideration all required information on the beneficiary’s conditions and treatments, to ensure that the beneficiary 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. |
### Appendix A

#### 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>Health Risk Assessment (HRA)</td>
<td>A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease.</td>
</tr>
<tr>
<td>Individualized Care Plan (ICP)</td>
<td>A document developed for each UPHP Plus member by a UPHP Clinical Coordinator, documents the medical, psychosocial and functional interventions based on the health risk assessment. The care plan will reflect a coordination of services to improved transition of care across healthcare settings and providers, appropriate utilization and cost-effective service delivery.</td>
</tr>
<tr>
<td>Interdisciplinary Care Team (ICT)</td>
<td>A group of individuals participating in a coordinated effort to benefit the beneficiary and assist in achieving the goals of the care plan. The purpose of the ICT is to foster coordinated, structured, access to health and preventive health services. Examples of members of the ICT may be any of the following: physicians, mid-level provider (e.g. physician’s assistant), social worker, registered nurse, behavioral health specialist, caregiver, pastoral specialist, and/or pharmacist.</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 determinations</td>
<td>Decisions on specific covered medical benefits defined by UPHP Evidence of Coverage, and/or decisions about care or services that could be considered either covered or not covered, depending of the circumstances.</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>post-service</td>
<td>Assessing appropriateness of medical services on a case-by-case or aggregate basis after services have been provided. In most cases the beneficiary is not held at financial risk.</td>
</tr>
<tr>
<td>pre-service review</td>
<td>A case or service that the organization must approve, in whole or in part, in advance of the beneficiary obtaining medical care or services.</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>
</tbody>
</table>
## Upper Peninsula Health Plan
### Utilization Management Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<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>
<tr>
<td>utilization management (UM)</td>
<td>The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.</td>
</tr>
<tr>
<td>utilization review</td>
<td>A formal evaluation (prospective, concurrent or retrospective) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.</td>
</tr>
</tbody>
</table>
Appendix B

Upper Peninsula Health Plan
UM Review Decision Time Table

Table indicates time from receipt of request to notification of decision. Timelines meet all NCQA Timeliness of UM Decisions Standard requirements and CMS UM regulations. (For appeal decision time frames see UPHP Policy #600-324 Beneficiary Appeals Related to Utilization Management Adverse Determinations)

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Time Frame</th>
<th>Notification of Decision</th>
<th>Decision Time Extensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.  Pre-service</td>
<td></td>
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<td></td>
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</tbody>
</table>
| Non-urgent                   | 14 calendar days   | Approval: verbal, electronic, or written to practitioner | 14 additional calendar days for:
|                              |                    | Denial: written notice to beneficiary with copy to practitioner | • delay due to matters beyond the control of UPHP
| Urgent/Expedited             | 72 hours           | Approval: verbal, electronic, or written to practitioner | • lack of necessary information and UPHP can justify the need of information in the beneficiary’s interest.
|                              |                    | Denial: verbal to practitioner and beneficiary - with written notice within 3 days after verbal | • beneficiary voluntarily agrees
|                              |                    |                                                    | 48 hours if due to lack of necessary information (Within 24 hours of receipt of the request, UPHP will notify the requestor and specify information needed and time period to provide the information. The 48 hour extension begins when information is received or at the end of the specified time period.) |
| B.  Concurrent               | 24 hours           | Approval: verbal to practitioner*                 | 72 hours if:
| Urgent/Expedited             |                    | Denial: verbal to practitioner*                    | • request to extend is received <24 hours before expiration of concurrent care
|                              |                    | - with written notice within 3 days               | • request is for services related to care not previously approved and UPHP is unable to obtain needed clinical information within 24 hours of receipt of request (UPHP must document making at least one attempt to obtain needed information)
|                              |                    | *notice to member also only if at financial risk  | • member voluntarily agrees to extension
| C.  Post Service             | 30 calendar days   | Written notice to beneficiary and practitioner    | Same as Pre-service Non-urgent                                                             |
| Beneficiary (at financial risk) | up to 90 calendar days | Written notice to practitioner and/or notification via Explanation of Payment (EOP) |                                                                                             |
| Provider (beneficiary not at financial risk) |                    |                                                    |                                                                                             |

1. The time of receipt is when UPHP receives the request in accordance with its reasonable filing procedures.
   a. If a practitioner or beneficiary fails to follow UPHP procedures for requesting a pre-service decision, UPHP will notify the requestor of the failure and the proper procedures to follow.
   i. For non-urgent pre-service decisions UPHP will notify the requestor within 5 calendar days.
   ii. For urgent pre-service decisions UPHP will notify the requestor within 24 hours.
   iii. Notification will be verbal with written notification upon request.

2. UPHP must notify the beneficiary or beneficiary’s authorized representative of the specific information required within the decision timeframe for the request and gives the beneficiary or beneficiary’s authorized representative at least 45 days to provide the information for non-urgent decisions.

3. NCQA definition: Urgent care is any request for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations:

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600-305
13-17
a. could seriously jeopardize the life or health of the beneficiary or the beneficiary's ability to regain maximum function based on a prudent layperson's judgment, or
b. in the opinion of a practitioner, with knowledge of the beneficiary’s medical condition, would subject the beneficiary to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
Appendix C

Upper Peninsula Health Plan
Durable Medical Equipment/Medical Supplies
Prior Authorization List

, UPHP Advantage and UPHP MI Health Link

✔ Orthotics and Prosthetic Devices (L codes)-PA required on items ≥$1000.00 per Medicare fee schedule
✔ Powered air floatation bed
✔ Powered pressure-reducing air mattress
✔ Non powered advanced pressure reducing overlay for mattress
✔ Powered air overlay for mattress
✔ Non-powered advanced pressure reducing mattress
✔ Miscellaneous Durable Medical Equipment codes
✔ Negative Pressure Wound Therapy
✔ Wearable Cardioverter-Defibrillators
✔ Bi-PAP/CPAP-
✔ Power Wheelchairs/Accessories
✔ Lightweight wheelchair
✔ Hospital bed semi-electric w/mattress
✔ Pneumatic Compression
✔ Osteogenic Bone Stimulator
✔ TENS Unit
✔ Ventilator

effective Jan1_2017
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 (print name)_______________________ 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

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): ____________________________

600-305

16-17
Upper Peninsula Health Plan Confidentiality & 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.