Upper Peninsula Health Plan (UPHP) uses an integrated approach to ensure access to Medicare and Medicaid covered services consistent with Medicare and Medicaid 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 and or Medicaid 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), Michigan Department of Health and Human Services (MDHHS), and the National Committee for Quality Assurance (NCQA) UM Standards.

The general UPHP 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 #800-324 MI Health Link Appeals Related to Utilization Management Adverse Determinations.

Policy

UPHP provides healthcare services as outlined by CMS and MDHHS to MI Health Link members as a plan of Medicare and Medicaid-covered benefits described in the UPHP Evidence of Coverage (EOC) documentand the UPHP MI Health Link Provider Manual. Services are to be directed by an in-plan 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-plan will be reviewed for availability in-plan. Out-of-plan non-emergent/urgent services are not a covered benefit unless reviewed and authorized by UPHP. UPHP will accept Prior Authorization (PA) requests from Out-of-Plan (OOP) providers for the following circumstances:
1. Emergency Department (ED) follow up visits to OOP Specialists
2. OOP Provider has current PA on file
3. Continuity of Care—see Policy #800-023 Continuity of Care.

The plan benefits for emergency services are not reviewed for medical necessity thus are not subject to denial of services based on medical necessity.

UPHP defines medically necessary services as services that are:

1. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. §1395y.
2. For Medicaid services: Services that are medically (clinically) appropriate, necessary to meet needs, consistent with the person’s diagnosis, symptomatology and functional impairments, the most cost-effective option in the least restrictive environment, and consistent with clinical standards of care. Medical necessity includes those services and supports designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in his or her community.
3. Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the three way contract; the benefits will maintain coverage to at least the extent provided by Medicare and Michigan Medicaid as outlined in both state and federal rules. UPHP will be required to abide by the more generous of the applicable Medicare and Michigan Medicaid standards.

The member has the right to self-refer to in-network services. Please refer to UPHP and Pre-paid Inpatient Health Plan (PIHP) contract for self-referral of behavioral health therapies. UPHP allows for beneficiaries to have a second opinion from an in-plan provider at no cost to the beneficiary. UPHP allows members to have a second opinion from an out-of-plan provider at no cost as long as the member has seen an in-plan provider and Prior Authorization is obtained prior to seeing the out-of-plan provider. Items and services unavailable in-plan are made available to members following the UPHP out-of-plan referral criteria and when prior authorization is obtained.

**UPHP contracts with the PIHP to provide Behavioral Health Inpatient and Outpatient Services. UPHP delegates to the PIHP behavioral health service authorization with authorization requirements specified in the UPHP and PIHP contract. Provider questions and requests related to behavioral health authorizations, policies, and procedures are addressed by the PIHP.**

Prior Authorization is not required for the following services: emergency and post-stabilization services (which include emergency behavioral health care); urgent care; family planning services; and out-of-area renal dialysis services.
For specific UM procedures related to review of medical necessity of pharmacy benefits and the pharmacy prior authorization process, refer to UPHP policy #800-404.

Definitions

(See Appendix A: UM Definitions)

Procedure

Section 1: Authorization and Notification Requirements:

The following services and items require prior authorization from UPHP Clinical Services: Authorization decisions are made upon determination of compliance with appropriate criteria. Specific details on all UPHP 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
   a. 
5. Medical services/supplies not meeting CMS/MDHHS guidelines
6. Home Health Services-effective 1/1/17

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 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. Member is currently a UPHP member
b. Service or item request is for a UPHP Medicare and/or Medicaid covered benefit
c. Service or item 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

Provider and Interdisciplinary Care Team (ICT) education regarding items and services requiring
prior authorization and the procedure for obtaining prior authorization occurs through the new
practitioner orientation packets, provider manual, provider newsletters, UPHP web site
information, and the annual provider in-service. Providers and the ICT also receive verbal
education from care management staff as needed.

**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 criteria include but are not limited to:
1. CMS Medicare Managed Care Manual guidelines
2. MDHHS Provider Manual
3. InterQual® Inpatient Adult and Pediatric Acute Level of Care Criteria
4. UPHP approved clinical practice guidelines
5. Specialty consultants
6. 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. InterQual® Home Care Criteria

Provider and ICT education regarding UM criteria and processes occurs through the new practitioner orientation packets, provider manual, provider newsletters, UPHP web site information, and the annual provider in-service.

Members 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 from the member’s Level 1 and/or Level 2 assessment
2. Nursing Facility Level of Care Determination (NFLOCD)
3. Member’s Individual Integrated Care and Supports Plan (IICSP)
4. Input from member’s Clinical Coordinator- Care Manager
5. Age
6. Complications
7. Psychosocial situation
8. Home environment
9. Co-morbidities
10. Progress of treatment
11. Access and availability of required services
12. Coverage of benefits
13. Consulting with the requesting provider

Reviewers are also encouraged to seek input from the member’s Integrated Care Team (ICT) 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 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.

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, UM Clinical Manager, and Clinical Coordinators-UM will review the results and go over the 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 member 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. 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 help members free of charge 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. Interpreter Services
4. Dedicated fax line in Clinical Services department - 1-906-225-9269
5. UM staff direct phone lines with confidential voice mail
6. Email address for each individual staff member (upon request)
7. UM staff will accept collect calls

This contact information is published in the UPHP Evidence of Coverage document, UPHP MI Health Link Provider Manual, and the UPHP Web site.
UPHP has a physician and behavioral health provider available 24 hours a day for timely authorization of medically necessary items and services and coordinate transfer of stabilized members in the emergency department if necessary.

UPHP will ensure that a PIHP provider is available 24 hours a day, seven days a week for timely authorization of medically necessary items and services and to coordinate transfer of stabilized members in the emergency department, if necessary.

Currently UPHP does not require authorization or apply medical criteria to services that would require immediate response such as in-plan and out-of-plan urgent/emergent observation admission, transplant services, skilled nursing facility admissions, or swing bed admissions. UPHP does require notification of these services as described in Section 1 of this policy.

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 follows appropriate response times as indicated in attached Appendix B: UM Review Decision Time Table. When initiating a call or responding to a provider and/or member UM issue by phone, fax and/or email, the UM staff 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 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 network area and not yet enrolled in a new plan or has been disenrolled by 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. Medically necessary reconstructive surgery
4. Medically necessary weight reduction services
5. Skilled nursing facility admissions
6. Swing bed admissions
7. Inpatient readmission within 30 days (Post Service Review)
8. Home Health

*The Clinical Coordinator-UM 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 such as late notification or 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, MDHHS 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 CMS guidelines or Medicaid Provider manual standards of coverage
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. 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

The Practitioner Reviewer is the only professional allowed to deny a request for medical necessity services which includes the reduction in the amount, duration, or scope of an item or service less than requested. This Reviewer is a health care professional with appropriate clinical expertise in treating the indicated medical condition, performing the procedure or providing the treatment.

For all medical necessity and benefit determination denials, UPHP provides an Integrated Notice of Denial of Medical Coverage as required by CMS and MDHHS. The notice is specific to each individual case and written in a manner the member can understand. Interpreter services and TTY/TDD toll free services are available to assist members with communication barriers to discuss decision with UM staff. This notice contains:

1. The specific reasons for the denial that takes into account the member’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 member’s right to a standard or expedited appeal and the right to appoint a representative to file an appeal on the member’s behalf
4. A description of both the standard and expedited appeal processes and time frames, including conditions for obtaining an expedited appeal, and the other elements of the appeal process; and
5. The member’s right to submit additional evidence in writing or in person.

For information pertaining to member appeal rights and process, refer to UPHP policy #800-324 MI Health Link 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 at 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.

For approved decisions made by the Practitioner Reviewer, Clinical Coordinator-UM, and/or Reviews and Appeal Coordinator, the approval will be documented on the Prior Authorization form and sent back to the provider who made the request for prior authorization. Members contacting UPHP requesting information regarding UM decisions will receive a response in a manner the member can understand such as interpreter services and TTY/TDD toll free services.

UPHP distributes a statement to all of its beneficiaries and to all practitioners, providers, and employees who make UM decisions affirming that UM decision making is based only on appropriateness of care and service and existence of coverage; UPHP does not specifically reward practitioners or other individuals for issuing denials of coverage or service care; and the financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Section 5: Timelines of UM decisions

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

Provider and Interdisciplinary Care Team (ICT) education regarding time-frame requirements for prior authorization occurs through the new practitioner orientation packets, provider manual, provider newsletters, UPHP web site information, and the annual provider in-service. Providers and the ICT also receive verbal education from care management staff as needed.

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 Level 1 or Level 2 assessment and or NFLOCD
3. Member’s Individual Integrated Care and Supports Plan (IICSP)
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 Integrated Care Team or UPHP Clinical Coordinator-Care Manager 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, MDHHS, and CMS timelines indicated in Appendix B.

**Section 7: MI Health Link Personal Care Services**

Personal care service determinations are made by completing a face to face personal care assessment utilizing a tool provided by MDHHS. The assessment is completed by a licensed registered nurse or social worker. The member’s clinical coordinator-care manager who is either a licensed registered nurse or social worker has the ability to approve, reduce, deny, or terminate services based on the personal care assessment tool results, guidelines in the MDHHS Medicaid Provider Manual MI Health Link Chapter State Plan Personal Care Services, and/or information listed in Section 6 of this policy.

**Section 8: MI Health Link Nursing Facility Level of Care Determinations**

For MI Health Link members who are requesting custodial care services in a long term care facility or MI Health Link Waiver services, UPHP will complete a MDHHS Nursing Facility Level of Care Determination (NFLOCD) and submit this information to MDHHS. MDHHS staff make all final determinations and is responsible for sending out the Integrated Denial Notice for denials.

**Section 8: Transition to Other Care**

For members who are receiving approved services and items but their benefit coverage is to end while they still need medically necessary care, UPHP Clinical Coordinators-UM assist with the beneficiary’s transition to other care (including Part D drugs), 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 Coordinator 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 notification.

**Section 9: Utilization Management File Audits**

All practitioner UM review decision files are audited when the review is completed by the UM program staff 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.

**Section 10: Utilization Reporting**

UPHP utilizes various dashboard reports to monitor member under and over-utilization of supplies and services. Several UPHP departments are involved in this process including: Information Technology, Clinical, Finance, Compliance and Government Programs. Formal Data Analysis meetings are held at least quarterly to review clinical and claims data for under or over utilization of services or supplies. The Compliance Officer serves as the chairperson for this Committee.

**Attachments:**

1. Appendix A: Utilization Management Definitions
2. Appendix B: UM Review Decision Time Table
3. Appendix C: UPHP DME Prior Authorization List

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

// END OF POLICY & PROCEDURE \

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**Appendix A**

**Upper Peninsula Health Plan Plus**  
**Utilization Management Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>accessibility</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>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>
<tr>
<td>administrative denial</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>
<tr>
<td>appeal</td>
<td>A request, oral or written, for review of an adverse action taken by UPHP and/or PIHP regarding a coverage or payment determination.</td>
</tr>
<tr>
<td>availability</td>
<td>The extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership.</td>
</tr>
<tr>
<td>benefit</td>
<td>A valued or desired outcome; an advantage.</td>
</tr>
<tr>
<td>benefit determination</td>
<td>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.</td>
</tr>
<tr>
<td>continuity of care</td>
<td>A process for assuring that care is delivered seamlessly across a multitude of delivery sites and throughout the course of the disease process.</td>
</tr>
<tr>
<td>continuity of clinical care</td>
<td>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.</td>
</tr>
<tr>
<td>coordination of clinical care</td>
<td>The mechanisms ensuring that a member and clinicians have access to and take into consideration all required information on the beneficiary’s conditions and treatments, to ensure that the member receives appropriate health care services.</td>
</tr>
<tr>
<td>criteria</td>
<td>Systematically developed, objective and quantifiable statements used to assess the appropriateness of specific health care decisions, services and outcomes.</td>
</tr>
<tr>
<td>denial</td>
<td>Non-authorization, reduction or termination decision of care or service based on either medical necessity or benefit coverage.</td>
</tr>
</tbody>
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## 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 see multiple providers in a health system utilizing one prior authorization. These authorizations are for members who have complex health conditions and need to see multiple providers and outpatient services in a health system. Global Authorizations do not cover inpatient admissions.</td>
</tr>
<tr>
<td>Individual Integrated Care and Supports Plan (IICSP)</td>
<td>The plan of care developed by a member, the member’s UPHP Clinical Coordinator- Care Manager and the member’s Integrated Care Team which incorporates the following elements: assessment results; summary of the member’s health; the member’s preferences of care, supports and services; the member’s prioritized list of concerns, goals and objectives, and strengths; specific services including amount, scope, and duration, providers and benefits; the plan for addressing concerns or goals; the person (s) responsible for specific interventions, monitoring, and reassessment; and the due date for the intervention and reassessment. The IICSP is also referred to as person-centered plan or plan of care. The IICSP will be maintained in the Integrated Care Bridge Record.</td>
</tr>
<tr>
<td>Integrated Care Team (ICT)</td>
<td>A team including the member, member’s chosen allies or legal representative, Primary Care Physician, UPHP Clinical Coordinator-Care Manager, LTSS Coordinator or PIHP Supports Coordinator (as applicable) and others as needed. The ICT works with the member to develop, implement, and maintain the IICSP and to coordinate the delivery of services and benefits as needed for each member.</td>
</tr>
<tr>
<td>Level I Assessment</td>
<td>A broad assessment tool that will be used to assess the member’s current health and functional needs within 45 calendar days of enrollment. This assessment will serve as the basis for further assessment needs that may include LTSS, BH, and I/DD.</td>
</tr>
<tr>
<td>Level II Assessment</td>
<td>Based on the findings from the Level I Assessment, for members identified with BH, I/DD, LTSS or complex medical needs, UPHP will collaborate with the regional PIHP or the regional LTSS providers to conduct the Level II Assessment based on the member’s needs.</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 determination</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>Term</td>
<td>Definition</td>
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</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>Pre-paid Inpatient Health Plan (PIHP)</td>
<td>PIHPs manage the Medicaid specialty services under the 1915(b)(c) Waiver Program, consistent with the requirements of 42 C.F.R. Part 401. This benefit plan covers mental health and substance abuse services for people eligible for Medicaid who have a need for behavioral health, intellectual/developmental disabilities services and supports, or substance use services.</td>
</tr>
<tr>
<td>pos 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>preservice 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 practitioner (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>
<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 the 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, MDCH, and CMS UM regulations. (For appeal decision time frames see UPHP Policy #800-324 MI Health Link 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>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-urgent</td>
<td>14 calendar days</td>
<td>Approval: verbal, electronic, or written to practitioner</td>
<td>14 additional calendar days for ²:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denial: written notice to beneficiary with copy to practitioner</td>
<td>• delay due to matters beyond the control of UPHP Plus</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• lack of necessary information and UPHP can justify the need of information is in the member’s interest.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Member voluntarily agrees</td>
</tr>
<tr>
<td>Urgent/Expedited</td>
<td>72 hours</td>
<td>Approval: verbal, electronic, or written to practitioner</td>
<td>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.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denial: verbal to practitioner and beneficiary - with written notice within 3 days after verbal</td>
<td></td>
</tr>
<tr>
<td>B. Concurrent</td>
<td>24 hours</td>
<td>Approval: verbal to practitioner*</td>
<td>72 hours if:</td>
</tr>
<tr>
<td>Urgent/Expedited</td>
<td></td>
<td>Denial: verbal to practitioner*</td>
<td>• request to extend is received &lt;24 hours before expiration of concurrent care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- with written notice within 3 days</td>
<td>• 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)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*notice to member also only if at financial risk</td>
<td>• member voluntarily agrees to extension</td>
</tr>
<tr>
<td>C. Post Service</td>
<td>30 calendar days</td>
<td>Written notice to member and practitioner</td>
<td>Same as Pre-service Non-urgent</td>
</tr>
<tr>
<td>Beneficiary (at financial risk)</td>
<td>up to 90 calendar days</td>
<td>Written notice to practitioner and/or notification via Explanation of Payment (EOP)</td>
<td></td>
</tr>
<tr>
<td>Provider (beneficiary not at financial risk)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. The time of receipt is when UPHP receives the request in accordance with its reasonable filing procedures.
   a. If a practitioner or member 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.

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2. UPHP must notify the member or member’s authorized representative of the specific information required within the decision timeframe for the request and gives the member or member’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:
   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 or Medicaid 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