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Program Overview

The Utilization Management (UM) Program of Family Health Network (FHN) includes the traditional utilization management functions and processes, but also includes transition of care (TOC) services for members. FHN is committed to comprehensive healthcare management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness, intensity of services, the appropriateness of the provider prescribed treatment plan, and the site of service. Under the contract with the Department of Healthcare and Family Services (HFS), FHN works in partnership with members and providers to promote a streamlined delivery of healthcare services. FHN managed care programs leverages a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education, and proactive preventative care measures to manage cost and improve quality.

The UM Program seeks to:

1. Coordinate the delivery of care that is aligned with evidence-based standards.
2. Promote the efficient utilization of services/resources.
3. Monitor patterns of utilization over time to reduce variations in provider practice and inconsistent use of evidence-based practice guidelines.
4. Improve continuity of care and patient outcomes through effective care management.
5. Enhance physician and patient satisfaction by facilitating access, enhancing awareness of medical necessity and appropriateness of services.

The UM Program includes the review of medical and behavioral health services provided to members in acute care facilities, skilled nursing and rehabilitation facilities, outpatient centers, and the members’ home. It also includes transition of care activities (i.e. discharge planning and post discharge follow up), health education and support for the management of complex and long-term medical problems. The UM/Transition of Care Program also focuses on the evaluation of emergency services.

Prospective, concurrent and retrospective reviews are performed to provide a basis for decision-making. This plan assures that UM decisions are made by qualified licensed healthcare professionals, who have the knowledge and skills to assess clinical information, evaluate working diagnoses and proposed treatment plans. Inter-rater reliability (IRR) reviews are conducted to ensure consistent application of the utilization criteria by FHN UM/Transitional Care Coordinators on a quarterly basis. The Medical Director and other physician reviewers are assessed annually. IRR results are reported to the UM Committee. The FHN Medical Director oversees all UM activities and makes the final determination for denials based on medical necessity. [UM1A; 3] All UM decisions are made in timely manner to minimize any disruption in the provision of healthcare services and to accommodate any clinical urgency.

UM vendors delegated for UM/TOC functions, including those functions related to behavioral healthcare (BH), must align their programs with UM program and practices established by FHN, Illinois State, other accreditation and regulatory agencies. Delegates executing medical and BH UM functions are under the leadership of a Medical and Behavioral Health Medical Director. [UM1A; 1]
Program Goals
FHN’s UM program works in collaboration with network providers to promote the appropriate use of health care resources and influence the continuum of care by achieving improved member outcomes. This includes provision of sufficient services that enable the member to achieve the intended outcomes. The UM program takes a multidisciplinary approach to provide health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, evidence based medical criteria, national medical standards of care, and availability of services within the local delivery system. FHN’s transition of care services are critical to the success and achievement of positive outcomes.

Annually, the FHN UM program goals are reviewed and revised under the guidance of the QM/UM Committee. Overall program goals include:

1. Providing a mechanism to review services rendered to FHN members, ensuring these services take place in the most appropriate setting, based on evidenced based medical standards, and in the most cost-effective manner without compromising quality of care.
2. Measuring the program’s performance to identify gaps in care, network inadequacies, provider availability issues, and other opportunities for improvement.
3. Performing quarterly audits to ensure FHN policies and medical criteria are applied in a consistent manner for medical decision-making.
4. Performing Inter-Rater Reliability (IRR) audits quarterly to ensure consistent application of criteria among utilization review staff.
5. Conducting an annual evaluation of the UM program by collecting and analyzing data from multiple sources; and, implementing appropriate interventions when opportunities for improvement are identified.
6. Monitoring for under- and over-utilization through continuous analysis of various metrics and UM statistics; and, implementing improvement interventions when opportunities are identified.
7. Referring eligible members to case management to assist with their continuity and coordination of care and achievement of members’ optimal health outcomes.
8. Analyzing member and practitioner experience data and complaints, regarding the UM program, to identify opportunities and implement appropriate interventions to continuously improve services.
9. Working with other FHN departments to identify opportunities for collaboration to further organizational goals.
10. Collaborating with practitioners and providers in the active support of FHN members’ rights as defined in the members’ rights and responsibilities statement.
11. Ensuring UM program activities meet state and federal regulatory requirements and requirements of FHN’s accrediting agency.
12. Protecting the confidentiality of members’ protected health information (PHI) and confidential information of practitioners and contracted vendors.
13. Developing, executing, and maintaining processes to achieve and maintain health plan accreditation from the National Committee of Quality Assurance (NCQA).
14. Collaborating with the “Appeals Unit” to effectively and efficiently manage denials and appeals in accordance with state regulations and NCQA guidelines.

Scope
UM program activities interface with all FHN members, practitioners, providers, caregivers, health plan staff, health plan delegates and vendors. The scope of UM activities includes the following:

1. Ensuring quality health care that is medically necessary is delivered at the right time in the right setting;
2. Monitoring the delivery of care for appropriate utilization of resources;
3. Evaluating trends and patterns of utilization of health care services and acting on opportunities to improve resource utilization; and,

4. Directing the delivery of health care services to the appropriate setting through use of the following:
   a. Pre-service authorization of requests for medical and behavioral healthcare; and,
   b. Initial and concurrent review of admissions to acute care facilities, behavioral health facilities, rehabilitation facilities, skilled nursing and long-term care facilities, and referrals for home health care services.

5. Monitoring the delivery of medical and behavioral health services through the following activities:
   a. Retrospective reviews of medical and behavioral health care services;
   b. Review of medical and behavioral health care denials and appeals;
   c. Review of medical, behavioral health, and medical/behavioral health transitions of care to identify opportunities to improve continuity of care for FHN members; and,
   d. Review of provider and member experience ratings, complaints and appeals in regards to UM activities to identify opportunities to improve the UM program.

6. Conducting the following UM activities on an on-going basis to facilitate effective transitions and continuity of care:
   a. Discharge planning; and,
   b. Referrals to Case Management of members identified as eligible for case management and those members that may benefit from case management services.

7. Other activities include:
   a. Providing continuous education and performance feedback to UM staff;
   b. Quality improvement initiatives to improve the efficiency and effectiveness of the UM program; and,
   c. Continuous monitoring of delegates performing UM functions on behalf of FHN.

UM Committee Structure  [UM1A:1 & 3; UM2A:4-5; UM1B; UM1C; UM1D]
The FHN Board of Directors has ultimate authority and accountability of the UM Program.
The QM/UM Committee (The Committee) meets quarterly and serves as a steward of resources by assisting in the coordination of the overall operations of the UM program; recommending the adoption of evidence-based UM criteria, policies and procedures; reviewing and analyzing UM reports; performing the annual evaluation of the UM program; and, participating with long-term planning of the UM program. The Chief Medical Officer will serve as the Chairperson of QM/UM Committee and is ultimately responsible for implementation and management of the UM program. [UM1A; 3]

Committee membership includes:
1. Chair: Chief Medical Officer or designee [UM1B]
2. Voting Membership:
   a. Primary Care/ Administrative Medical Director (1)
   b. Behavioral Health Medical Director – Board Certified Psychiatrist (1) [UM1C]
   c. Internal Medicine (2)
   d. Pediatric (1)
   e. Family Medicine (2)
   f. High volume Specialists (5)
   g. Women’s Health and Obstetrics (2)
   h. Chief Executive Officer or Chief Operating Officer (1)
   i. Chief Compliance Officer (1)
   j. Chief Financial Officer (1)
At least annually, the QM/UM Committee reviews, makes recommendations, and/or approves the following:

1. UM program, plan, goals and objectives;
2. UM policies and procedures;
3. Evidence-based medical decision-making criteria and application process; [UM2A, F5]
4. New or updated state and federal regulations related to UM procedures;
5. Provider and member complaints and other feedback;
6. Provider and member satisfaction survey results;
7. Results of Inter rater reliability audits;
8. Over and under - utilization data;
9. New technology assessments and recommendations;
10. Results of Network access and available studies;
11. Denial and appeal data;
12. Utilization statistics Case Management reports including participation rates;
13. Mortality reports;
15. Results of delegation audits.
16. Delegate UM plan review (annually)
17. Delegate UM statistical reporting (semi-annually)

The Committee makes program recommendations based on the following:

1. Performance on achieving established goals and objectives;
2. Changes in regulatory and/or accreditation requirements;
3. Provider and member feedback; and,
4. Changes to or status of the local delivery system including an analysis of out-of-network (OON) requests; loss of services that were previously available; addition of services that were previously unavailable; adequate availability and access to services required by FHN’s membership. [UM3A;3]

The Committee approves the UM program and votes to submit the approved program to the Board of Directors.

The Committee’s activity is documented in the Committee’s meeting minutes. The meeting minutes include the following:

1. Meeting date and time;
2. Members in attendance;
3. Agenda items discussed including content of the discussion, recommendations, action items, responsible party, due dates for completion; and,
4. Chairman or designee signature.
### Use of UM Data for Quality Improvement Initiatives [UM1A; 1]

Data collected through UM activities may be incorporated in FHN’s QI initiatives when opportunities for improvement are identified. QI initiatives for the improvement of the UM program and activities are included in the annual QI plan and reported to the Committee at designated intervals. New initiatives may be identified throughout the year, but are typically identified as a result of the annual UM program evaluation.

Performance of the UM program is measured through the collection and analysis of several metrics that include the following:

1. Admits per thousand
2. ER visits per thousand
3. Bed days per thousand
4. Average Length of Stay (ALOS)
5. Denial and appeal statistics
6. Results of IRR audits
7. Operational reporting including timeliness of UM decisions and prior authorization reports
8. Results of provider and member satisfaction surveys in regard to UM
9. Monitoring and reporting of the number of member deaths quarterly

### Delegation & Vendor Management [UM14A-F]

The Delegation Oversight Committee monitors delegation activities to ensure that delegated entities maintain compliance with regulatory and contractual obligations and appropriate accreditation requirements. There are four elements of delegation oversight:

1. **Pre-delegation and/or Initial Delegation Assessments:** Prior to initiation of the formal delegation agreement, FHN evaluates the financial viability and capacity of the entity to perform in accordance to expectations, business practices and all applicable state, federal and accreditation requirements. The pre-delegation assessment includes a review of the organizations’ UM programs and related policies and a random sample of UM files, including denial and appeal files. Results of pre-delegation audits are presented to the Delegation Oversight Committee.

2. **Delegation Agreements:** The agreement describes the delegated activities and the responsibilities of FHN and the delegates in regard to these activities; required reports including the content of the reports, frequency of reporting to occur at least semi-annually, and how and to whom the reports are generated to; the method by which FHN will provide the delegate with member experience data, if applicable, and clinical performance data or whether or not the FHN allows the delegate to collect their own data; provisions for PHI if applicable; stipulations regarding sub-delegation by a delegate; a description of the annual oversight process; and, remedies available to FHN if a delegated entity does not fulfill the obligations specified in the delegation agreement, including revocation of the delegation agreement.

3. **Annual Oversight Audits and Corrective Action Plans:** FHN formally reviews the performance of delegated entities annually. The annual delegation oversight audit includes review of delegates’ UM programs and related policies; UM file reviews including denial and appeal files; delegates’ performance against current NCQA standards; and, a review of delegates’ performance in meeting reporting requirements and results of reports. Results of annual oversight audits are presented to the Delegation Oversight Committee.

The Delegation Oversight Committee may:

1. Approve continued delegation,
2. Recommend the implementation of a corrective action plan, or,
3. Suggest termination of the delegation agreement
4. Ongoing Oversight: FHN conducts ongoing oversight of all delegated entities in accordance with established reporting timeframes. This includes review of the material content and performance of the delegated entity on delegated activities as documented in report submissions, e.g., meeting required UM decision timeframes, results of IRR audits, satisfaction with delegates’ UM programs.

The UM division takes an active role in the evaluation of UM delegates through:
1. Regular analysis of required UM statistic reports
2. Periodic auditing of completed events, including denials and appeals
3. Providing feedback of the delegate’s performance issues to the delegate and the Delegation Oversight Committee
4. Annual review of delegate(s) UM Plan/program description, policies, UM decision criteria by the QM/UM Committee
5. Semi-annual review of UM statistics by the QM/UM Committee

(See Appendix A for how FHN delegates UM functions)

The FHN UM division of the Medical Management department is comprised of UM/Transition of Care Coordinators (UM/TCC) and Discharge Planners. The UM/TCC and Discharge Planners are responsible for coordinating the utilization review of medical and behavioral health services for:
1. In-network and out-of-network inpatient admissions;
2. Discharge planning/Transition of Care activities;
3. Post-acute placement; and,
4. Outpatient referrals and services.
The UM/TCC and Discharge planners also make appropriate referrals to case management services.
FHN UM staff share responsibilities with UM delegates for these activities, as described in delegation agreements.
The FHN UM division employs qualified licensed professionals to supervise all medical necessity decisions. Qualified supervisors are licensed registered nurses with an unrestricted license in the state of Illinois, have utilization management experience, accreditation and/or other regulatory requirements for FHN lines of business. UM supervisors:
1. Provide day-to-day supervision of assigned UM staff.
2. Participate in staff training.
3. Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
5. Are available to UM staff on site or by telephone.

Job descriptions specify the level of UM decision-making that can be made by each level of clinical staff. All clinical staff involved in UM decision-making are required to have current, unrestricted State of Illinois licensure.

Denials based on medical necessity are made by FHN’s Medical Director or delegates’ Medical Directors, if this function is delegated. Pharmacists may make denials based on medical necessity for pharmaceutical denials. This function must be described in the job descriptions of individuals making these decisions. All practitioners involved in making denial decisions based on medical necessity are
required to have education, training and/or professional experience in medical or clinical practice and a current clinical license to practice or an administrative license to review UM cases. Non-clinical staff collect information and may utilize explicit criteria to make determinations, when applicable and per FHN policy, e.g. maternity admissions that are auto-approved.

Chief Medical Officer [UM1A; 3]
The Chief Medical Officer is a key member of the Senior Executive team, engaged in defining the overall business strategy and direction of the organization. In addition, this position leads the overall clinical vision for organization and provides clinical direction to the Health Management, Network, Product and Credentialing divisions. This position provides medical oversight, expertise and leadership to ensure the delivery of affordable quality healthcare services.

Other key functions of Chief Medical Officer include:
1. Provides leadership and direction to the Clinical Teams
2. Develops and implements medical policies and procedures
3. Chairs the QM/UM, Credentialing, Professional Peer Review Committees and directs the activities of the Committees toward stated objectives as reflected in the QM and UM plans.
4. Reports the QM/UM, Credentialing, and Professional Peer Review Committee activities to the FHN President, Board of Directors and state agencies in accordance with the requirements specified in the QM and UM Plans.
5. Monitors care and services through continuum among providers: hospitals, skilled nursing facilities and home care to ensure quality, cost efficiency and continuity of care.
6. Provides clinical for all areas and medical expertise for care management.
7. Facilitates conformance to regulatory requirements
8. Monitors practitioner practice patterns and recommend corrective actions.
9. Trains and interacts with network and group providers and medical managers regarding utilization practices, guidelines, pharmacy utilization and effective resource management.
10. Partners with Network Management Department for contract negotiations.
11. Collaborates with Finance in Medical Economics Initiatives.
12. Ensures medical care providers meet standards for acceptable medical care and medical protocols and rules of conduct are followed.
13. Reviews claims, appeals and resolve grievances related to medical quality of care.
14. Participates in regulatory, professional and community activities to provide input and become knowledgeable regarding regulatory, professional and community standards and issues.
15. Responsibilities also include strategy, development and implementation of innovative clinical programs that include collaboration with strategic business partners.

Medical Director [UM1A:3]
Under the direction of the Chief Medical Officer, the Medical Director assists in FHN's clinical services. Manages day to day utilization management, care management and quality improvement activities. Provides clinical expertise needed to effectively resolve clinical and administrative circumstances in the Medical Management Department. Provides expert medical education, consultation and supervision for the clinical staff. Works cooperatively with the FHN staff, providers, vendors and community agencies. Participates in FHN’s Credentialing and Re-credentialing process.

1. Manages the day to day quality improvement, utilization management and care management activities.
2. Assures all internal and vendor medical review activities conforms to company protocols, customer requirements and professional standards.
3. Works closely with other Medical Directors and clinical services staff to attain and/or maintain compliance with company, customer, accreditation and regulatory requirements.
4. Reviews and makes determinations regarding medical necessity.

5. Consults as appropriate with practitioners in determining utilization decisions.
6. Identifies those instances where the competence or conduct of a physician or other health care provider has an adverse effect on the patient care (and/or the goals of FHN) and takes appropriate action.
9. Proven ability to work with cross-functional teams and facilitate the activities of the Interdisciplinary Care Team.
10. Monitor care and services through continuum among hospitals, skilled nursing facilities and home care to ensure quality, cost-efficiency and continuity of care.
11. Provides expert medical education, consultation and supervision for the clinical staff.
12. Review and complete and up to date credentialing and re-credentialing files prior to presentation to the Credentialing Committee.
13. Chairs the QM/UM, Credentialing and Professional Peer Review Committee if delegated by Chief Medical Officer.
14. Demonstrated leadership, ability to build effective teams and structure, decision making, project management and change management skills.
15. Performs other duties as requested or assigned.

**Vice President of Utilization and Transition of Care Management (VP, UM/TOC)**

The VP, UM/TOC reports to the Chief Medical Officer. In collaboration with the Medical Director, the VP, UM/TOC oversees all functions and reporting responsibilities of the Utilization Management Program that includes Transition of Care activities. This includes quarterly reporting of the program's activities to FHN's Executive staff. Other key functions of the VP, UM/TOC include:

1. In collaboration with the Medical Director, serves as an executive sponsor for focused studies and improvement initiatives;
2. Oversees the design of policies and procedures that affect service delivery and standards of care;
3. Approves the staffing plan and resources allocated to integrate UM/Transition of Care programs toward achievement of organizational goals and objectives;
4. Serves as a resource for FHN management and staff; and,
5. Serves as a member of Executive team providing leadership and contribution to interdisciplinary activities within the organization.

**Director of Utilization Management /Transition of Care**

Reporting to the VP, UM/TOC, the Director of Utilization Management/Transition of Care is an Illinois licensed registered nurse who oversees, coordinates and prioritizes the activities of the UM/ Transition of Care staff to achieve the goals and objectives set forth in the HFS Quality Strategy and FHN Quality/Utilization Management program and plans. Other key functions of the Director of Utilization Management/Transition of Care include:

1. In collaboration with the VP, UM/TOC, Medical Director and Chief Medical Officer evaluates and makes makes revisions to the UM program; [UM1A1]
2. Oversees and manages the review of inpatient and outpatient services, discharge planning and transition of care for health plan members;
3. Monitors utilization of healthcare resources;
4. Evaluates barriers and implements collaborative improvement efforts with medical groups and providers;
5. In collaboration with the Medical Director, VP, UM/TOC, and Director of Quality Management (QM), coordinates and prioritizes the activities of the QM/UM Committee. Oversees and manages follow-up on recommended actions; and,
6. Develops and implements policies and procedures in support of FHN UM/TOC goals.

Manager, Utilization Management and Transitions of Care
The Manager of UM/TOC is a licensed registered nurse in the state of Illinois, with specific experience in utilization management, accreditation and/or other regulatory requirements for FHN lines of business. Under the direction of the UM/TOC Director, the Manager of UM/TOC develops, coordinates and manages the administrative and operational activities that are directly associated with the utilization management of medical/BH services provided to FHN members. Key functions include:
1. Managing and supervising the UM/TCC, Discharge Planners and non-clinical staff;
2. Primary supervisor of UM decisions made by the UM/TOC nurse
3. Ensuring that review requests are performed using nationally recognized guidelines, such as InterQual Criteria;
4. Providing leadership in Medical Management programs, operations, projects, policies and procedures to ensure high quality results;
5. Ensuring that authorizations are entered into FHN’s documentation system in a timely fashion and within mandated timeframes; and for,
6. Ensuring the quality and accuracy of UM staff documentation.

Manager, Utilization Management Delegation
The Manager of UM Delegation is a licensed registered nurse in the state of Illinois, and is key in the management and oversight of FHN delegates performing UM functions for medical and behavioral health services. This position provides performance oversight to ensure delegates comply with FHN’s UM policies, regulatory, quality and accreditation requirements. Other key functions of this position include:
1. Supports delegation functions to optimize compliance with accreditation requirements;
2. Works in collaboration with Quality, CM, UM, Network Management and Compliance teams to monitor and evaluate performance of delegates;
3. Supports the delegation of UM processes by performing ongoing monitoring and auditing of delegated entities to ensure that their policies and procedures, documentation, systems, staffing and ability to provide reports are operational and compliant;
4. Collaborates with the Compliance Department to develop and implement audit schedules;
5. Develops, revises and maintains all UM delegation audit tools;
6. Assists in the evaluation of delegates’ UM programs in relation to UM delegation;
7. Facilitates delegates’ improvement initiatives to meet FHN’s accreditation requirements;
8. Maintains accountability for delegates’ outcomes; and,
9. Manages and maintains documents pertaining to oversight activities.

Manager, Utilization Management Accreditation
The Manager of UM Accreditation is a licensed registered nurse who holds a bachelors or master’s degree in a health related field. He or she collaborates with the Vice President and Director of UM/TOC
and FHN leadership teams to establish and implement plans for achieving and maintaining Health Plan accreditation. In collaboration with Quality Management, Case Management, Network Management, Member Services, and Pharmacy teams and FHN practitioners and providers, the UM Accreditation manager monitors FHN’s compliance with accreditation standards. Other key functions include:

1. Manages and leads UM activities required to achieve accreditation;
2. Acts as a collaborative member of the FHN Medical Management leadership team with primary responsibility to oversee and manage mission-critical UM accreditation functions;
3. Maintains primary responsibility for planning and evaluating ongoing UM accreditation requirements with medical groups, delegates and vendors;
4. Leads the communication, education and implementation of initiatives to achieve desired performance results on annual audits and to achieve a state of continuous accreditation readiness; and,
5. Monitors, analyzes, and reports UM performance barriers and works with the multi-disciplinary team to develop and implement interventions to eliminate or decrease barriers.

Utilization Management/Transition of Care Coordinator
The UM/Transition of Care Coordinator (TCC) is a licensed registered nurse in the state of Illinois responsible for making UM decisions and facilitating safe transitions of FHN members between care settings by determining the medical needs of the member. Other key functions include:

1. Conducting daily utilization review and transition of care duties;
2. Assessing members’ clinical status against established guidelines to ensure that members receive appropriate levels of care in appropriate settings and that the length of stay meets the needs of members;
3. Interacting with hospital and delegates’ UM departments;
4. Reviewing and providing oversight of discharge planning activities;
5. Ensuring coordination and continuity of care as members transfer between health plans, facilities, or different levels of care;
6. Referring members for case management and social services per FHN policy when appropriate; and,
7. Working closely with Discharge Planners to coordinate required resources and care post-discharge.

Discharge Planner
The discharge planner holds a Master’s Degree in Social Work, Social Sciences, or Counseling and/or is licensed in clinical social work. Key functions include:

1. Assessing social, financial, and environmental needs and developing goals of care with the interdisciplinary care team, members and/or their families/caregivers and guardians;
2. Collaborating with the UM/TCC to locate available resources for members’ care post discharge;
3. Empowering members’ support systems to take an active role in discharge planning and post-discharge care;
4. Assuring patient education is complete in support of post-acute needs;
5. Serving as a key resource to the interdisciplinary care team by having a working knowledge of community resources including and social service programs;
6. Serving as an advocate for FHN members;
7. Interacting and communicating with hospital discharge planners to ensure continuity of care; and,
8. Communicating regularly with the UM/TCC to identify and maximize discharge planning opportunities.
**Intake Coordinator**

The Intake Coordinator provides non-clinical support for the UM and Transition of Care activities. Key functions include:

1. Using pre-screening referral and service request forms to capture all necessary data elements to support requests;
2. Verifying eligibility and coverage for the requested services;
3. Entering admission notifications, preservice/referral requests into FHN’s documentation system;
4. Transferring UM files to the appropriate UM/TCC nurse;
5. Approving routine service/referral events that require no clinical judgement using explicit criteria per FHN policy (i.e. services that are auto approved such as Maternity admissions); and
6. Assisting with fax communication routing and other clerical functions as assigned.

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**Access to FHN UM Staff [UM3A1-5]**

FHN normal business hours are 8:00 am to 5:00 pm, Monday through Friday, except during scheduled closings for holidays. FHN staff are available eight hours a day during normal business hours for inbound collect and toll-free calls regarding UM issues, which is communicated via the member handbook and provider online manual. Health Integrated is available 24/7 for medical and BH inpatient notifications and pre-service review of elective admissions. During normal business hours, member services staff answers questions by reviewing the system entries. If questions cannot be answered in this manner, the calls are transferred to the UM area for management.

The UM staff are able to receive inbound messages after normal business hours regarding UM issues via voicemail. Outbound communications from staff during normal business hours occur via telephone, fax, secure email and/or voicemail. TTY services are available for deaf and hearing-impaired members. Language assistance is available through bilingual staff and AT&T Translation Services. All communication and language assistance services are free of charge. Members are notified of this in the member handbook.

UM staff returns calls within one business day from receipt of communication. Each staff member has confidential voicemail to receive UM/TCC questions and issues during and after hours. The UM staff identify themselves by name, title and organization name when initiating or returning calls.

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**Member and Provider Communication**

FHN provides regular communications with members and providers to disseminate information about UM and TOC activities. In addition to telephonic, email and fax communications, other communication tools include:

1. Provider Handbook;
2. Provider newsletters;
3. Provider notices;
4. Member Handbook;
5. Certificate of Coverage;
6. FHN’s website;
7. Fax and/or email (upon request); and,
8. Direct contact during office visits by Network Management Representatives.
Necessary Clinical Information: Medical and BH UM Reviews [UM6A-B]

UM/TCC and intake staff receive inpatient and outpatient service requests via phone, fax, delegate portal or medical group FTP websites. To process medical or behavioral health service requests, authorization of services request forms must be completed with relevant information.

To support UM decision making, the UM/TCC and/or Medical Director gather and document relevant clinical information obtained from the attending physician or requesting provider. FHN limits the collection of information to that necessary to certify admissions, procedures, and treatments. Relevant clinical information may include medical history, lab tests, progress notes, operative reports, medical necessity letters, x-ray reports, and information specific to individual members, e.g., age, co-morbidities, complications, treatments, psychosocial situations, and assessments of home care environments, including caregiver resources.

The UM decision-making licensed professional also considers characteristics of the local health care delivery system available to meet members’ needs including: [UM2A3]

1. The availability of skilled nursing facilities or home care in FHN’s service area to support the patient after hospital discharge;
2. The coverage of benefits such as skilled nursing facilities or home care when needed;
3. The ability of local hospital(s) to provide recommended services within the estimated length of stay; and,
4. The availability of ancillary providers to provide recommended services after discharge.
5. Availability of outpatient services that could be utilized to avoid a readmission or future inpatient admission

Medical Necessity Criteria for Medical and Behavioral Health

FHN and its delegates utilize current versions of nationally recognized evidence-based criteria to make UM decisions. These criteria sets encompass medical, surgical, outpatient surgery, behavioral health services including mental health and ASAM criteria for Substance Use Disorders, rehabilitation, home health care (HHC), and skilled nursing facility (SNF) placements. FHN makes UM decisions based on InterQual Level of Care criteria developed by McKesson.

FHN’s QM/UM Committee approves all criteria used to make medical and BH UM decisions including those used by delegated entities annually, or more frequently if new scientific evidence becomes available. FHN and Delegates may employ the reference of internally developed criteria provided they adhere to the following guidelines:

1. All medical and behavioral health criteria used by FHN, FHN delegates and sub-delegates are subject to annual review and approval by the QM/UM Committee.
2. Criteria review and approval is documented in the QM/UM Committee meeting minutes along with relevant research contributing to its approval and concurrence by at least one UM Committee member who is a specialist.
3. (For Delegates): Medical and behavioral health criteria used by FHN’s delegates are submitted to FHN’s QM/UM at least annually as specified in delegation agreements.

InterQual criteria are evidenced based, comprehensive, patient centric and derived from an intense clinical development. Mckesson’s clinical development team comprised of physicians, registered nurses and other healthcare professionals conduct a systematic and rigorous review of credible medical and behavioral health content sources to develop and update clinical review criteria. After appraisal of clinical evidence, and independent review by a panel of over 800 panel experts, McKesson’s releases medical and behavioral health review criteria to ensure its criteria are clinically sound.
The FHN Medical Director may make medical determinations using other nationally accepted and evidence based guideline indexes and literature such as the National Guidelines Clearing House (NGC) when there are no applicable InterQual criteria. NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), US Department of Health and Human Services. Created in collaboration with the American Medical Association and the now America’s Health Insurance Plans, the intention of NGC is to provide access to objective, detailed information on clinical practice guidelines and encourage dissemination, implementation, and use (AHRQ, 2015).

For Substance Use Disorders, in accordance to Illinois State Law under HB1530 Enrolled Public Act 097-0437 Section 5, the Illinois Insurance Code Section 370c.1 (on page 7, number 3) states: "Medical necessity determinations for Substance Use Disorders shall be in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine (ASAM)" (Illinois General Assembly - Full Text of Public Act 097-0437).

For situations where nationally recognized evidence-based criteria are not available, FHN may develop its own guidelines using the best scientific evidence available. The development process of the criteria includes input from appropriate specialists and practitioners that are likely to use the guideline. Documentation of review and approval by the QM/UM Committee must be documented in the meeting minutes. The delegates may adopt additional criteria, clinical pathways, and/or guidelines that have been reviewed by their QM/UM Committee and chosen based on the best available medical evidence. Delegates must describe their process for the development and adoption of guidelines when a national guideline is not available. Discussion of how the additional criteria, clinical pathways, and or guidelines were developed or selected must be identified in delegates’ UM programs as part of the criteria approval process. Guidelines developed by FHN must be reviewed and approved by the QM/UM Committee.

Availability of Criteria [UM2B:1-2]
Annually, FHN informs practitioners, in writing, how they may request and obtain copies of InterQual Level of Care criteria and other criteria used for medical and behavioral healthcare UM decisions. The criteria may be distributed via fax, mail or e-mail, and its distribution is tracked and logged on FHN network drives. Members and providers adverse determination notices also contain information on the availability of review criteria and how they can obtain a copy.

Medical and Behavioral Healthcare Determinations
Only the FHN Medical Director and medical directors or other designated practitioners at delegated entities may deny care or services based on medical necessity. FHN delegates must meet the timeframes and guidelines specified in FHN’s UM program to meet NCQA accreditation requirements. Annually, FHN distributes a statement to all members and to all practitioners, providers, delegates and employees who make UM decisions that affirms the following:

1. All UM decisions are based on the appropriateness of care and service and the existence of coverage;
2. FHN and its UM delegates do not specifically reward practitioners or other individuals for issuing denials of coverage; and,
3. Financial incentives, if offered to UM decision-makers, will not encourage decisions that result in underutilization. [UM4G:1-3]

FHN notifies members of this provision in the member handbook and newsletters and notifies practitioners of this in the provider manual and newsletters. The CEO notifies staff of this provision in emails.
UM Decision and Notification Timeframes [UM5A-D]
FHN, and its UM delegates, make UM decisions and provides notification of the decisions per the following timeframes:
1. Non-urgent preservice: within 10 calendar days of receipt of request;
2. Urgent preservice: within 72 hours of receipt of the request;
3. Urgent concurrent: within 24 hours of receipt of the request; and,
4. Post service: within 30 calendar days of receipt of the request.

Inter-Rater Reliability Testing [UM2C:1-2]
Inter-rater reliability (IRR) testing ensures consistency in the application of nationally recognized medical criteria and is administered to all staff making UM decisions, including physician reviewers. At least annually, if not quarterly, the QM/UM Committee will assess IRR audit results and document its findings in the committee meeting minutes. Inter-rater reliability testing is administered by a licensed professional peer of the individual being tested. FHN utilizes McKesson’s InterQual IRR module, which generates hypothetical test cases to audit the consistency of the application of criteria. After reviewing hypothetical test cases generated by McKesson’s IRR module, all examinees must pass with a score of at least 85%. If an individual does not pass with a score of 85%, he or she will be given additional education in the areas missed and allowed to retake the examination. Further education is on a case-by-case basis. If the application of criteria is not consistent across staff, there is discussion in the QM/UM Committee meetings regarding the files, along with corrective and/or disciplinary actions, if necessary.

Preservice (Prior Authorization) Review
Preservice utilization review is the process by which medical/behavioral healthcare services are assessed for medical appropriateness prior to their delivery using nationally recognized criteria. The UM/TCC staff or delegate UM staff determines member eligibility, benefit coverage and medical appropriateness when making a UM determination. Determinations on non-urgent preservice (or prior authorization) requests are made within 10 calendar days of receipt of the request. Because of the time frame given, this must be a non-urgent pre-service request. If the requests lack clinical information, FHN may extend the non-urgent pre-service decision time frame up to 10 calendar days if the following conditions are met:
1. The organization asks the member or the member’s representative for the specific information necessary to make the decision within the decision time frame; and,
2. The organization gives the member or the member’s authorized representative at least 10 calendar days to provide the information.

The extension period, within which a decision must be made by the organization, begins:
1. On the date when the organization receives the member’s response (even if not all of the information is provided), or
2. At the end of the time period given to the member/member’s representative to supply the information, if no response is received from the member or the member’s authorized representative.

FHN may deny the request if it does not receive the information within the time frame, and the member may appeal the adverse determination.

Initial Admission and Concurrent Reviews
Initial admission and continued stay review decisions are made within twenty-four (24) hours of receipt of the request. Members or their authorized representative may agree to extend the decision-making time frame for urgent concurrent and concurrent requests. FHN may also extend decision time frames under the following conditions:
1. The request to extend urgent concurrent care was not made prior to 24 hours before the
expiration of the prescribed period of time or number of treatments allowing FHN to treat the request as urgent preservice and make a decision within 72 hours; and,
2. The request to approve additional days for urgent concurrent care is related to care that was not previously approved by FHN. FHN documents that it made at least one attempt to obtain the necessary information within 24 hours of the request, but was unable to, and has up to 72 hours to make a decision.

**Post Service (Retrospective) Review**

When medical care or services have been delivered, FHN will perform a post service or retrospective review. FHN may become aware of a post service review request via the Claims Department or directly from the provider. Upon notification, FHN requests relevant clinical information needed to make a determination from practitioners, providers, the member or the member’s authorized representative. FHN completes retrospective reviews within thirty (30) calendar days of receipt of the request; however, members or their authorized representatives may agree to extend the decision-making time frame for post service requests. FHN may also extend decision time frames.

If requests lack clinical information, FHN may extend the post service time frame up to 15 calendar days, under the following conditions:

1. FHN asks the member or the member’s representative for the specific information necessary to make the decision within the decision time frame; and,
2. FHN gives the member or the member’s authorized representative at least 45 calendar days to provide the information.

The extension period, within which a decision must be made by FHN, begins:

1. On the day FHN receives the member’s response (even if all of the information is not provided); or,
2. At the end of the time period given to the member to supply the information, if no response is received from the member or the member’s authorized representative.

FHN may deny the request if it does not receive the information within the time frame, and the member may appeal the denial. FHN members are not held financially responsible for payment of retrospective services and not notified of retrospective decisions.

**Board Certified Consultants/Advisory Panel [UM4F: 1-2]**

FHN contracts with an Independent Review Organization (IRO) to consult with board certified physician specialists to assist the Medical Director and other physician reviewers, including UM delegates’ Medical Directors or designated physician reviewers in making UM decisions that require same or similar specialty review. The referral to and recommendations from board certified consultants are documented, included in the UM file, and tracked for trending and quality purposes.

**Adverse determinations [UM4C-D][UM7A-F]**

All requests for clinical services that do not meet FHN’s or delegates’ medical necessity criteria or are considered experimental/investigational are reviewed by FHN’s Medical Director or other physician reviewers, including UM delegates’ Medical Directors or designated physician reviewers. When a request is denied, FHN notifies the treating practitioner by phone or in the denial notification, about the opportunity to discuss the denial with a reviewer.

Denial files include the clinical information used to make the decision and the following documentation:

1. Dates additional clinical information was requested and received or documentation that requested information was not received;
2. The date the information was forwarded to the physician reviewer to make a determination;
3. Documentation of the physician reviewer’s specific reason for the denial, including criteria used, lack of medical necessity, or lack of sufficient information to approve the request;
4. The physician reviewer’s name and specialty;
5. Date and time the treating practitioner was notified of the opportunity to discuss the denial with a reviewer; and,
6. Copies of all written notifications to members and practitioners.

FHN and its delegates’ written notification of denials includes the following: [UM7B:1-3] [UM7B-C; UM7E-F]
1. The specific reasons for the denial, in easily understandable language;
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based;
3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
4. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal;
5. An explanation of the appeal process, including members' rights to representation and appeal time frames;
6. A description of the expedited appeal process for urgent preservice or urgent concurrent denials; and,
7. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.

Adverse determinations are tracked for quality and UM program analysis.

Appeals Management [ UM1A1; UM8A-C; UM7A-F]

Standard

FHN delegates first and second level appeals for denied inpatient and behavioral health services to Health Integrated. Outpatient appeals are handled by FHN’s Appeals Unit. Appeals management and communications adhere to the following guidelines:
1. Giving members 60 calendar days after notification of the denial to file an appeal, as described in the denial letter;
2. Documenting the substance of the appeal and actions taken;
3. Investigating the substance of the appeal, including all aspects of clinical care that were provided by the member in the additional information and the original denial documentation;
4. Giving members opportunities to submit written comments, documents or other information relative to the appeal as described in the denial letter;
5. Appointing a new practitioner of the same or similar specialty as the treating practitioner to review the appeal, who was not involved in or a subordinate of the clinician making the initial determination, by the appeal coordinator reviewing the original decision;
6. Providing the decision and notification to the member and treating practitioner within 15 business days of receipt of the request for standard appeals;
7. Including in notifications to members the list of titles and qualifications, including specialties, of the individuals who participated in the appeal process;
8. Notifying the member of further appeal rights including the appeal process and notification of the contact information for the HFS State Fair Hearing Process;
9. Providing all documents relevant to the appeal to members upon request, free of charge;
10. Allowing authorized representatives to act on behalf of members with provision of the authorized representative form as described in the denial letter;
11. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner, based on linguistic assessment; and,
12. Providing continued coverage to members pending the outcomes of appeals.

**Expedited Appeals [UM7C:3-4, UM7F: 3-4]**
Members have access to expedited appeals if the proposed or continued services pertain to a medical condition that may seriously jeopardize the life or health of a member; or if the member has received emergency services and remains hospitalized. If the member is hospitalized, the member may continue to receive services with no financial liability until notified of the appeal decision.

FHN has procedures for registering and responding to expedited appeals, which include:

1. Allowance of oral or written initiation of an expedited appeal by the member, his/her authorized representative, provider, facility, or other health care provider acting on behalf of the member;
2. Notification of determination to the member and the treating practitioner as quickly as the medical condition requires, but in no event more than 24 hours after the submission of the appeal request;
3. Initial notification to the treating practitioner of the appeal determination may be given orally followed by electronic or written notification; and,
4. Notification to members that expedited external reviews can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

**External Independent Review**
FHN allows a member to request either a standard or expedited external independent review of adverse appeal decisions within 30 calendar days of receipt of FHN’s appeal decision notice. The member and/or their authorized representative are notified, in writing, whether or not the request meets the external review requirements or if additional information is needed. The member or their authorized representative, has five (5) business days (or twenty-four (24) hours to file an expedited appeal), from the date of receipt of the notification to send additional information. Within five (5) calendar days after receipt of all necessary information, or within two (2) days for an expedited external review, the external independent reviewer will send the member or authorized representative, and FHN a letter with their decision, or provide verbal notification in the case of an expedited external review. The decision of the external independent reviewer is final. Adverse appeal determinations of waiver services may not be reviewed by an external independent entity.

**Discharge Planning & Follow Up After Hospitalization**
Discharge planning is the process by which the Transition of Care staff and Discharge Planners plan for the member’s discharge in collaboration with the health care delivery team and the member/caregivers. Discharge planning begins at the time of the pre-admission certification and/or admission to the hospital and continues through the inpatient confinement. The objectives of discharge planning are:

1. To facilitate timely and appropriate discharge of confined members
2. To evaluate alternative levels of care
3. To provide information about available community resources
4. To support the delivery of quality, cost effective health services; and to direct services to contracted providers

Discharge planning is also conducted by FHN UM/TCC and Discharge Planners in collaboration with delegate (s) UM staff. The UM/TCC and Discharge Planners serve as liaisons to the hospital staff to addresses all post-hospital needs.
Discharge follow-up by telephone is conducted by the UM/TCC or Discharge Planner within 72 hours following discharge. They also make appropriate referrals to Case Management services. The purpose of the post discharge call is to:

1. Re-confirm that all discharge needs are in place (e.g., DME has been delivered, admission to home health is established, etc.),
2. Determine if the member understands post discharge instructions
3. Clarify any questions regarding self-care or other health care questions
4. Verify that physician follow up visit scheduling is understood
5. Determine transportation needs (if any) for follow up visits.

FHN’s delegate, Health Integrated, is responsible for collaborating with FHN UM/TCC staff for discharge planning, initiation, or continuation of Case Management services for medical and behavioral health cases.

Home and Community Based Services Waivers

Home and Community-Based Services (HCBS) Waivers are waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities, brain injury, HIV/AIDS or who are elderly. These members qualify for the level of care provided in an institution but, with special services, may remain in their homes and communities. In the Illinois HFS Contract, references to HCBS Waivers relate only to those HCBS Waivers for which a Service Package under Section 5.2 is then in effect.

FHN delegates all UM and Case Management functions for Waiver recipients to Community Care Alliance of Illinois (CCAI). UM staff screens each service requests to identify waiver recipients. If the member in question is a waiver recipient, the request is forwarded to CCAI for UM decisions and coordination of care.

Family Health Network does not determine eligibility into the Waiver or Nursing Home programs commonly known as Long Term Support Services (LTSS). Eligibility determination is defined by the Department on Aging or the Department of Human Services, Division of Rehabilitative Services.

Emergency Services  [UM11A:1-2]

Family Health Network (FHN) provides coverage for emergency medical conditions. FHN will cover Emergency Room (ER) services that were required to screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably would have believed than an emergency medical condition existed. FHN will also cover ER services where the member was referred to the ER by an authorized representative of FHN, even if it does not turn out to be an emergent situation. An authorized representative includes, but not limited to, a participating practitioner, the member’s primary care physician (PCP), an FHN member services representative, Care Coordinator and/or a Fonemed nurse.

A medical or behavioral health emergency is defined as one with acute symptoms of sufficient severity, including but not limited to severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the lack of immediate medical attention to result in:

1. Serious jeopardy to the person's health (or unborn child's health);
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Members who feel their condition or situation is life threatening are instructed to go to the nearest hospital, call an ambulance or 911. Prior authorization/approval for medical or behavioral health emergency services is not required.
Post-Stabilization Service
Post stabilization services are services related to an emergency medical condition that are provided after the member’s immediate medical problems are stabilized. Emergency services do not require prior authorization. Examples of post-stabilization services that require pre-authorization are outpatient out-of-network services, non-emergent inpatient admissions; non-contracted hospital services and skilled nursing facility admissions. FHN will cover post-stabilization services provided by an affiliated or non-affiliated provider in any of the following situations:

1. FHN authorized the services;
2. Services were administered to maintain the members stabilized condition within one (1) hour after a request to FHN for authorization of further post-stabilization services;
3. FHN does not respond to a request to authorize further post-stabilization services within one (1) hour;
4. FHN could not be contacted; and
5. FHN and the treating provider cannot reach an agreement concerning the members care and an affiliated provider is unavailable for a consultation. In this case, the treating provider is permitted to continue the care of the member until an affiliated provider is reached and either concurs with the treating provider’s plan of care or assumes responsibility for the member’s care.

Out of Network Admissions
Out-of-Network admissions are urgent or emergent admissions to hospitals that are non-contracted with FHN and occur without prior approval. As soon as FHN or its delegates becomes aware of the admission, the UM staff obtains an initial review, patient information and:

1. Monitor of care to determine when the member is stable for transfer or discharge.
2. When stable, facilitate the transfer of the member to an in-network facility
3. Contact the Member concerning the decision to transfer and answer any questions and concerns.
4. Document all member refusals to transfer and refer the case to a physician practitioner for a determination.

Referral Process

Specialists Referrals
Initiation of the referral process requires a written request for all services referred by the PCP, WHCP, or Attending Physician/Specialist including, but not limited to:

1. Diagnostic testing
2. Therapies
3. Specialist evaluation or other consultation services

The decision and notification for specialty referral request are rendered and issued to the member and requesting practitioner(s) within 10 calendar days of receipt of the request, including any requests for additional information. Follow up office visits by a BH specialist following an: Emergent Behavioral Health occurrence and/or the initial Behavioral Health consultation requires prior approval by FHN. FHN delegates BH specialty referral reviews and decision making to Health Integrated.

Standing Referrals
It is the policy of Family Health Network to provide standing referrals to providers to treat a condition that may be chronic or require continuous attention. The standing referral is effective for the period necessary to provide the referred services or for up to one year. It is the policy of FHN to accept a request for specialty services from the members’ PCP or directly from the specialist.
Out of Network Referrals
Members may request a referral to receive services from an out of network provider or vendor when FHN’s provider network is limited. UM staff in collaboration with Case Management services will secure relevant clinical information, discuss letters of medical necessity (when applicable), locate and secure a network provider for the services requested. The review timeframe for out of network services are: 72 hours for the urgent pre-service request and 10 calendar days for the standard preservice request. If services cannot be located in-network, UM staff will facilitate an out of network approval by referring the request to FHN’s Medical Director or physician advisor. When services are determined necessary and appropriate, the VP, UM/TOC or designee notifies FHN’s Network Management Department for the processing of a Single Case Agreement. Written communication of all FHN approved services is provided to the requesting provider and the member.

Second & Third Opinions
FHN member has the right to request a second and third opinion through their PCP, Medical Group or by calling member services. The provider whom the member wishes to consult with for a second or third opinion must be a contracted FHN provider. If a particular specialist is not available in network, FHN will approve the consultation with that out of network specialist for the second and third opinion only.

Continuity of Care
As required by the state of Illinois HFS Contract, FHN ensures continuity of care for prospective, new and current members.

Prospective Member
FHN provides coordination of care assistance to prospective members to continue an ongoing course of treatment, before FHN coverage becomes effective, if:
1. Requested to do so by the prospective member or
2. If FHN has knowledge of the need for such assistance

New Member
FHN ensures continuity of care for new members whose physician is not a contracted provider in FHN’s provider network, but is within FHN’s service area. FHN shall permit the member to continue the ongoing course of treatment with the member’s current physician during the transitional period under the following guidelines:
1. Ninety (90) days from the effective date of enrollment if the member is engaged in an ongoing course of treatment.
2. The member has entered the second or third trimester of pregnancy at the effective date of enrollment including the delivery and the provision of post-partum care.
3. To accept reimbursement from FHN at established rates; Such rates will be at the level of reimbursement applicable to similar providers within the FHN network of services
4. The provider agrees to adhere to FHN’s Quality Management requirements to provide FHN with medical information related to care
5. The provider agrees to adhere to FHN’s policies and procedures regarding referrals and obtaining prior authorization for treatment.

Current Members
FHN ensures continuity of care for its members if a FHN physician leaves FHN’s network for reasons other than:
1. Termination of a contract in situations involving imminent harm to a patient; or
2. Final disciplinary action by State licensing board.

FHN will allow members continued access to their practitioner, in the following situations:

1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic of acute medical condition; or [NET 5B; 1]
2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. [NET 5B; 2]
3. Ninety (90) days from the date of the physician’s termination if the member is engaged in an ongoing course of treatment.
4. The member is in the second and third trimester of pregnancy at the time of provider’s disaffiliation with the health plan. FHN will authorize services for the remaining prenatal care visits, the delivery and the post-partum care.
5. The physician agrees to continue reimbursement from FHN at the rates applicable prior to the start of the transitional period
6. The provider agrees to adhere to FHN’s Quality Management requirements to provide FHN with medical information related to care
7. The provider agrees to adhere to FHN’s policies and procedures regarding referrals and obtaining prior authorization for treatment

FHN will engage the member to develop a safe transition plan to a FHN contracted provider.

Behavioral Health
State Contract Requirements [UM1A; 2 & 4]

FHN seeks to deliver comprehensive, timely and appropriate behavioral health services in compliance with the Illinois State contract with the Department of Healthcare and Family Services. As mandated by HFS, FHN’s behavioral health program aspects include:

1. A Behavioral Health network adequate to serve the Behavioral Healthcare needs of members,
2. Behavioral Health and substance abuse services sufficient enough to provide care within the community in which the members reside
3. Providing assistance in accessing Behavioral Health services, including but not limited to transportation
4. Member’s access to timely Behavioral Health services
5. A member’s Care or Service Plan and provision of appropriate levels of care
6. Coordination of care between providers of medical and Behavioral Health services to assure follow-up and continuity of care
7. Involvement of the PCP in aftercare
8. Assessment of the member’s satisfaction with access to and quality of Behavioral Health services
9. Behavioral healthcare outpatient and inpatient utilization, and follow up.
10. Chemical dependency outpatient and inpatient utilization, and follow up.

Health Integrated & FHN Collaboration for BH

FHN strives to deliver quality of care to members requiring behavioral health services and compliance with HFS program requirements. Although Health Integrated is delegated Behavioral Health UM decision making, FHN’s BH program development and execution is led by the QM/UM Committee’s BH specialist in collaboration with Health Integrated’s Behavioral Health Medical Director. [UM1A:2]
FHN members may seek mental health or substance abuse services from any FHN approved provider without a referral from his or her primary care physician. Members have direct access to behavioral health services and are not required to contact FHN for approval to receive services from in plan behavioral health providers. Follow up visits with behavioral health specialists are subject to the pre-service (prior authorization) review process. In the case of an emergency, members are encouraged to call 911 or consult with their current behavioral health provider.

FHN contracts the PsycHealth Behavioral Health Professionals provider network. Members are instructed to call PsycHealth or FHN Member Services department for assistance in locating behavioral health providers in their area. FHN and Health Integrated work in tandem to manage behavioral health and medical care of members who are affected by behavioral health and medical issues concurrently.

The HFS contract mandates FHN to provide Mobile Crisis Response Services as a part of the covered benefits to members less than 21 years old. Family Health Network accesses SASS providers through PsycHealth, and referrals from the CARES line to deliver Mobile Crisis Response Services to respond to members in crisis. Mobile Crisis Response Services includes a face-to-face screening that:

1. Must be available 365 days a year on a 24-hour basis for all FHN FHP members who are less than 21 years old and are in a behavioral health crisis
2. Is initiated within 90 minutes of referral to CARES for crisis services
3. Uses the Illinois clinical decision tool for face-to-face mobile crisis screening – Childhood Severity of Pediatric Illness (CSPI); This tool is used throughout the duration of the case

Providers must report response time and case disposition to the FHN Case Management department. For child and adolescent psychiatric hospitalizations, the admitting hospital must notify CARES prior to admission into acute inpatient care. CARES will assign a SASS provider, who must conduct an assessment and be involved in the discharge planning of the patient. FHN’s delegate, Health Integrated, begins admission review after the first date of CARES involvement. CARES will engage the SASS program to ensure a crisis response to the member. Contact CARES at (800) 345-9049.

Evaluation of New Technology

New technologies and new applications of existing technologies for medical procedures, behavioral healthcare procedures, pharmaceuticals, and devices are evaluated for inclusion in FHN’s benefits plan when the new technology demonstrates a significant benefit for a particular illness or disease; is scientifically proven to be safe and effective; and there is no equally effective or less costly alternative. The evaluation of a new drug or the new application for an existing drug will be evaluated by CVS Pharmacy and Therapeutics Committee (P&T). CVS is FHN delegated vendor managing the pharmacy benefit.

FHN licenses the new technology assessment tools of Hayes Inc. as primary source of review. The license includes the knowledge center as well as the genetic test evaluation program. Additionally FHN has access to a number of custom reviews from Hayes as needed. FHN Experimental and Investigational coverage determination for new technology is based on the Hayes rating (subject to overall benefit):

- Ratings A and B-covered and considered proven
- Ratings D1 and D2- considered E and I so not covered
• C- generally considered E and I (not covered) with individual case medical consideration by The Medical Director.

To be considered for coverage, the new technology must meet the following guidelines:
1. Improves health outcomes;
2. Beneficial effects outweigh harmful effects on health outcomes;
3. Improves quality of life or ability to function;
4. Increases length of life;
5. Proven to be as beneficial as established alternatives;
6. Improve the net health outcome as much, or more than, established alternatives;
7. Use of the new technology is appropriate in keeping with current medical standards;
8. Proven to be useful outside of investigational settings;
9. Meets government approval to market by appropriate regulatory agencies, as applicable,
10. Supported with information published in peer-reviewed journals;
11. Scientific evidence documents conclusions based on established medical facts; and
12. Opinions and evaluations of professional organizations, panels or technology assessment bodies are based on the scientific quality of the supporting evidence.

Experimental and Investigational Services
FHN requires prior authorization of potentially experimental and investigational services. While these services may not be covered, FHN will classify and track services denied by the FHN Medical Director or physician reviewer for this reason. Adverse determination reports are reviewed by the QM/UM Committee on a quarterly basis.

Transplant Services
FHN will cover transplants under 89 Ill. Admin. Code Section 148.82 using transplant providers certified by the Department of HFS. Covered transplant services include:
1. Inpatient heart, heart/lung, lung (single or double), liver, pancreas or kidney/pancreas transplantation. Inpatient bone marrow transplants, inpatient and outpatient stem cell transplants.
2. Inpatient intestinal (small bowel or liver/small bowel) transplantation for children only. A hospital specializing in inpatient pediatric intestinal (small bowel or liver/small bowel) transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period. (Subsection (d) (1) (H) of 89 Ill. Admin. Code Section 148.82).
3. Other types of transplant procedures may be covered when a hospital has been certified by the Department as a transplant center eligible to perform such transplants. Centers must complete the certification process and provide the necessary documentation of the number of transplant procedures performed and the survival rates.
4. Medically necessary work-up.

Limited Covered Services
Termination of Pregnancy
Termination of pregnancy may be provided only as allowed by applicable State and federal law (42 CFR Part 441, Subpart E.) In any such case, the requirements of such laws must be complied with and HFS Form 2390 must be completed and filed in the member’s medical record. The physician certifies in
writing that the life of the mother would be endangered if the fetus were carried to term or if the pregnancy is the result of an act of rape or incest. To ensure compliance with this statutory regulation, UM staff is required to confirm this form is complete and request that it be submitted with the prior authorization request for services. This form kept in the member’s prior authorization history.

**Sterilization and Contraceptives**
Sterilization services may be provided only as allowed by State and federal law (42 CFR Part 441, Subpart F). Non-therapeutic sterilization must be documented with a completed consent form (HFS Form 2189) which will satisfy federal and state regulations. To ensure compliance with this statutory regulation, UM staff is required to confirm this form is complete and request that it be submitted with the prior authorization request for services.

**Hysterectomy**
Hysterectomy is covered when the procedure is non-elective and medically necessary. The UM review adheres to the following guidelines:

1. The member must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
2. The member must sign and date an acknowledgment or receipt of hysterectomy information form prior to hysterectomy. Informed consent must be obtained regardless of diagnosis or age.
3. The hysterectomy acknowledgement form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.
4. The acknowledgement form is not required if the member was already sterile before the hysterectomy or if the member required a hysterectomy because of a life threatening emergency situation in which the physician determined that a prior acknowledgment was not possible. In these circumstances, a physician statement is required.
5. Hysterectomy shall not be covered if performed solely for the purpose of rendering a member permanently incapable of reproducing.
6. Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

**Vision Benefits**
FHN partners with EyeQuest for administering state mandated vision care benefits and UM review of vision care services. At the members’ or vision care providers’ request, vision service requests resulting in an adverse determination may be reviewed by the FHN Medical Director or delegate Medical Director for coverage by FHN. The decision making process for these services adhere to the preservice review guidelines previously outlined in this document.

**Dental Benefits**
FHN partners with DentaQuest for administering state mandated dental care benefits and UM review of dental services; including services rendered by oral surgeons. At the members’ or dental care providers’ request, dental service requests resulting in an adverse determination may be reviewed by the FHN Medical Director or delegate Medical Director for coverage. The decision making process for these services adhere to the preservice review guidelines previously outlined in this document.
Pharmaceutical Management

The FHN Pharmacy Utilization Management (UM) program is designed to encourage safe and effective drug utilization, help enhance plan members’ health outcomes and promote cost-effective drug benefits plan design. The UM program includes requirements set forth by HFS, the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), the Centers for Medicare and Medicaid Services (CMS) and other applicable regulatory organizations.

The FHN Pharmacy UM program functions under the direction of the Director of Pharmacy who is an Illinois State licensed PharmD, is board certified in Geriatric Pharmacy Management and has completed an accredited residency program in clinical pharmacy practice. The FHN Director of Pharmacy serves as the liaison between FHN and PBM associates on matters of policies and procedures, clinical criteria justifications, and defined roles and responsibilities for prior authorization and coverage determination decisions.

CVS Health, FHN’s contracted pharmacy benefit manager (PBM), is certified by NCQA for Utilization Management. FHN has reviewed the CVS Health program documents, policies and procedures, and regularly performs monitoring and oversight activities that are reported to the Delegated Oversight Committee. All NCQA UM Pharmacy standards are delegated to CVS Health.

The goal of the Pharmacy UM program is to provide a comprehensive pharmacy benefit package that is consistent with standards in care, best practices and regulatory requirements. This goal is accomplished through the following objectives:

1. Providing therapeutically appropriate drug interventions and formulary management for members;
2. Supporting members’ appropriate and timely access to pharmaceuticals prescribed by their practitioners;
3. Monitoring and continuously improving current pharmaceutical UM operations, and ensuring that corrective actions are taken by the appropriate departments when necessary to promote process improvement; and
4. Defining and reporting appropriate measurement standards for pharmaceutical UM activities.

FHN and CCAI adopts CVS Health’s UM Program. The UM program criteria are based on standards of medical practice, current clinical principles and processes of pharmacotherapy, evidence-based drug information, expert opinion from published guidelines and consensus statements, as well as information from other published literature such as those published in drug labeling approved by the U.S. Food and Drug Administration (FDA) and other recognized compendia. Other appropriate resources include randomized clinical trials, pharmacoeconomic studies and outcomes research data. The Pharmacy UM Program will be reviewed at least annually by the FHN Pharmacy Director and Medical Director, and or more frequently when new indications or safety information for the drug or drug class changes. In these situations, the program is updated.

FHN adopts our PBM’s standard Prior Authorization Protocols (PA), Quantity Limits and Step Therapy criteria for our Pharmacy UM programs as the most efficient means for implementing and maintaining clinically current coverage conditions. FHN reserves the right to submit custom criteria to support unique aspects of our plan design. In addition, FHN may select the drugs to include in FHN’s plan design. FHN approves (or modifies) and accepts selected UM criteria before implementation by the PBM. FHN can request the development of custom coverage criteria that are reviewed by the PBM’s medical directors, pharmacists and appropriate clinical personnel.
FHN reviews and approves the PBM’s policies and procedures for pharmaceutical management. These policies and procedures specify the criteria used when adopting pharmaceutical management procedures; the use of clinical evidence for pharmaceutical decisions; the involvement of appropriate practitioners and the distribution of pharmaceutical management procedures. [UM12A:1-4]

FHN annually and after updates, communicates to members and prescribing practitioners, the list of pharmaceuticals, including restrictions and preferences, how to use the pharmaceutical management procedures, an explanation of limits and quotas, the requirement for prescribers to provide information to support exception requests; and the processes for generic substitution, therapeutic interchange and step therapy protocols. [UM12B:1-5]

The PBM monitors potential safety issues and notifies affected members and prescribing practitioners of identified concerns, including Class II and voluntary drug withdrawals from the market for safety reasons within 30 calendar days of FDA notification. The PBM also reviews and adopts an expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. [UM12C:1-2]

FHN reviews and accepts the PBM’s annual review of procedures, the list of pharmaceuticals, appropriate updates as procedural changes arise and updated lists of pharmaceuticals as appropriate. [UM12D:1-4]

FHN reviews and accepts the PBM’s exceptions policies and procedures for making exceptions based on medical necessity, obtaining medical necessity information from prescribing practitioners, using appropriate pharmacists and practitioners to review exception requests, timely handling of requests, and notification of reasons for denials and an explanation of the appeal process when an exception is not approved. [UM12E:1-5]

FHN delegate’s responsibility for denial and appeal of UM decisions to CVS Health. FHN accepts the processes established by CVS Health that gives providers the opportunity to discuss UM denial decisions with a physician or pharmacist. The written notification of pharmacy denial is sent to members and their treating providers. It contains the following information:

1. The specific reasons for the denial, in language that is easy to understand.

2. A reference to the benefit provision guideline, protocol or similar criterion on which the denial decision is based.

3. A statement the members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial was based, upon request. [UM7G, UM7 H:1-3]

CVS Health also provides written notification of pharmacy denials to members and their treating providers regarding appeals rights and the appeal process. The documentation includes the following information: [UM7 I: 1-4]

1. A description of appeal rights, including the member’s right to submit written comments, documents or other information relevant to the appeal.

2. An explanation of the appeal process, including the appeal time frames and the member’s right to representation.

3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials.

4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.
Case Management Services

Program Goals and Scope
The Case Management program provides goal-oriented, individualized, systematic support through ongoing assessment, planning, advocacy, monitoring activities, coordination, and linkage with other health care providers and community resources. The services and activities of the Case Management program are reviewed, monitored, and documented to reflect progress toward individualized goals.

The goal of the program is to assist members who are pregnant, have chronic or complex conditions and co-morbidities, children with special health care needs and all members who express a desire to obtain access to quality care and appropriate services. This is accomplished through coordination of their benefit and health care needs while assisting them to navigate the health care system. The Case Management program aims to ensure that the member achieves the highest level of functioning in the least restrictive setting possible by facilitating the use of available benefits and resources. Support is given to the member to achieve self-stated goals for independence and reviewed in collaboration with the Primary Care Provider (PCP).

Case Management: UM Identification
Members needing Case Management or disease management services are identified at least monthly through a variety of sources including inpatient and outpatient utilization/notification. UM refer members with the following condition triggers to Case Management team for assessment of eligibility for case management services, stratification and member engagement:

1. AIDS
2. Amputation of Major Limbs
3. Asthma
4. Brain Surgeries
5. Burns – 2nd and 3rd degree covering large body areas
6. Behavioral health and/or substance abuse disorders
7. Cerebral Palsy
8. Conditions requiring high cost DME or supplies or needing DME supplies for an extended period (over one month) – e.g. wound care
9. Cystic Fibrosis
10. CVA-Stroke
11. Decubitus ulcers – stage III or IV
12. Dehydration/Malnutrition requiring IV or Enteral Therapy
13. Diabetes
14. Fractures – Multiple
15. Gangrene with wound care
16. Head injury – trauma
17. High-risk obstetrical care
18. Joint replacements
19. Malignancy, terminal stage
20. Muscular Dystrophy
21. Nervous system disorders – e.g. Guillain Barre, ALS, MS
22. Organ Transplants
23. Premature newborns
24. Respiratory/Cardiac Arrest
25. Spinal injury/trauma
26. Tracheostomy
Additionally, members requiring continuity of care assistance and have a condition trigger or is pregnant will be referred to Case Management team. Health Integrated is managing the Case Management for members with behavioral health and substance abuse related disorders. FHN strives to support members throughout the continuum of care and achieve improved outcomes. Full Case Management program details can be found in the Case Management program description.
The Board of Directors for Family Health Network has reviewed and approved the 2016 utilization management program.

_________________________  _________________________
 Full name  Full name

_________________________  _________________________
 Title  Title

_________________________  _________________________
 Signature  Signature

_________________________  _________________________
 Date  Date
Citations:


### Appendix A. Delegation of UM Functions

<table>
<thead>
<tr>
<th>Delegate</th>
<th>Delegated UM Functions</th>
</tr>
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<tbody>
<tr>
<td>Health Integrated</td>
<td>Medical admissions: Urgent and Elective Ambulatory surgeries Behavioral health admissions Outpatient behavioral health services Health Integrated is NCQA certified for UM</td>
</tr>
<tr>
<td>Community Care Alliance of Illinois (CCAI)</td>
<td>Delegation of UM functions to CCAI, a wholly owned subsidiary of FHN, is for a specific FHN membership; members on Home and Community-Based Services (HCBS) waivers (Individuals with disabilities, HIV/AIDS, brain injury, supportive living and the elderly). Inpatient admissions Ambulatory surgeries Outpatient medical services Long Term Support Services (LTSS)</td>
</tr>
<tr>
<td>EyeQuest</td>
<td>Delegation of UM functions in administering mandated, non-medical Medicaid vision care benefits.</td>
</tr>
<tr>
<td>DentaQuest</td>
<td>Delegation of UM functions in administering mandate, non-medical Medicaid s dental care benefits.</td>
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