UTILIZATION MANAGEMENT PROGRAM

2025

VENTURA COUNTY HEALTH CARE PLAN

UTILIZATION MANAGEMENT

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UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Program Scope

The scope of Ventura County Health Care Plan's ("VCHCP" or the "Plan") Utilization Management (UM) Program activities includes timely direct referrals, pre-authorizations, concurrent review, discharge planning, appropriate referral to case management and long-term catastrophic case management, and Perinatal Support Services, delivered at the appropriate level of care and in a timely manner by delegated and non-delegated practitioners.

Mission

The mission of the UM Program is to assure the delivery of medically necessary, quality patient care through the consistent provision or management of health care services in a coordinated, comprehensive, fair, consistent, and culturally competent manner without discrimination based on the health status of our members.

Purpose and Scope of the Utilization Management Program

The UM Program is designed to ensure that medically appropriate services are provided to all members of the Plan through a comprehensive framework that assures the provision of high quality, cost effective, medically appropriate healthcare services in compliance with the patient benefit coverage and in accordance with regulatory and accreditation requirements. The utilization management structures and processes are clearly defined, and responsibility is assigned to appropriately trained individuals. The program description includes the scope of the program and the processes and resources used in making determinations based on plan benefits and medical appropriateness. The Medical Director of the Plan acts as the Medical Director of the UM Program.

The UM Program of the Plan is charged to ensure that:

1. VCHCP staff utilize, as applicable, established current criteria for approving, modifying, deferring, or denying requested services (e.g., Milliman Care Guidelines, UpToDate, National Guideline Clearinghouse). In addition, the individual needs/member's circumstances are considered whenever a UM decision/medical necessity review is made. Member's circumstances are considered with involvement of providers in the development and adoption of specific/appropriate clinical criteria and VCHCP's policies used to establish medical necessity which is clearly documented.
2. Clinical Guidelines, standards, and criteria set by regulatory, and any accrediting agencies are adhered to as appropriate for the Plan. Decisions are based upon evidence-based criteria and consistent with professionally recognized standards of care.
3. All medical services are delivered at appropriate levels of care and are appropriate for the needs of the individual member, i.e., not over-utilized or under-utilized.
4. There is separation of medical decisions from fiscal and administrative management to assure that medical decisions will not be unduly influenced by fiscal and administrative management.
5. Authorized care matches the benefits defined in the member's Evidence of Coverage ("EOC").
6. Services are provided by VCHCP contracted providers, (e.g., network physicians and

hospitals), unless otherwise authorized by the Plan. For the purposes of this document, "provider" refers to individuals and organizations that provide care to Plan members.

7. All contracted health care practitioners are aware of procedures and services which require prior authorization and are aware of the timeframe necessary to obtain prior authorization for these services.
8. Establishment of a specialty referral system to track and monitor referrals requiring prior authorization to include authorized, denied, deferred, or modified referrals, and the timeliness of referrals. Providers are informed of the prior authorization and referral process.
9. Costs of services are monitored, evaluated, and determined to be appropriate.
10. The utilization management team of physicians, licensed staff, and unlicensed staff are trained and qualified to assess the clinical information which is used to make utilization management decisions and provide the service within their respective scope of practice. Appropriately licensed health professionals supervise all review decisions.
11. Provides procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.
12. Written UM Plan, UM protocols and program evaluation are approved annually by VCHCP UM Committee and reported to the VCHCP Quality Assurance Committee ("QAC") and the Governing Body through the Oversight Committee. The VCHCP Oversight Committee is known as the VCHCP "Standing Committee".
13. The UM Program is integrated with the Quality Assurance (QA) Program to ensure continuous quality improvement.
14. The Governing Body, through the Standing Committee, and the Quality Assurance Committee have oversight responsibilities for the UM Program.
15. An annual evaluation of the UM Program is prepared and includes a description of the accomplishments of the Plan, work plan, program evaluations, policies, and procedures. It shall also include reporting on the Plan's operation using statistical data and other information regarding the care delivered to members and any suggested revisions. The Quality Assurance Committee (QAC) will be responsible for approving the updated UM program.
16. The process for handling appeals and making appeals determination is in the Utilization Management Policy for Appeals.

Goals of the Utilization Management Program

The UM Program goals are to:

1. Provide access to the most appropriate and cost-effective healthcare services
2. Ensure that authorized services are covered under the member's health plan benefits
3. Develop protocols to determine services which are consistent with professionally recognized standards of care, as determined by physicians and other providers in the medical community, and in areas served by the Plan
4. Perform peer review in conjunction with the Quality Assurance Program of the Plan

5. Coordinate thorough and timely investigations and responses to member and provider grievances about utilization issues
6. Initiate necessary procedural revisions to prevent the recurrence of problematic utilization issues
7. Facilitate communication and develop positive relationships between members and providers, as well as among the Primary Care Physicians (PCPs), specialists and the Plan
8. Monitor and evaluate healthcare services provided through VCHCP's network by tracking and trending data
9. Monitor, evaluate and improve continuity and coordination of care
10. Identify specific services that are over-utilized or under-utilized, and develop appropriate responses to these findings
11. Provide utilization management data for the provider re-credentialing process
12. Continuously improve the UM Program
13. Ensure cohesive interdepartmental and UM processes
14. Identify potential quality of care/quality of service issues which may require further review by the Quality Assurance Program of the Plan

Utilization Management Protocols

1. In making determinations of benefit coverage and/or medical necessity, the Plan uses written utilization review criteria, developed in consideration of Plan-specific provider and member demographics. See Medical Policy Development document for details.

2. The criteria are evaluated, updated as appropriate and approved annually by the UM Committee. Documentation of approval by the UM Committee can be found in the minutes of the UM Committee. UM Committee minutes and activities are presented to the Plan's QAC for final review and approval.
3. The Medical Director of the Plan is responsible for the implementation of the UM Program and oversees the criteria development and adoption process.
4. All criteria, policies and procedures of the Plan are made available, upon request, to all participating providers. See Notifications section of this document and the associated Disclosure of UM processes document. This is the responsibility of the Utilization Management Department.
5. At least annually, personnel involved with UM decision-making are evaluated for consistency and accuracy of the application of criteria. This is the responsibility of the Director of Health Services. See Medical Policy development document.
6. All needed emergency services are arranged for or facilitated, including appropriate coverage of costs.
7. Initial emergency services, defined as those which are necessary to screen and stabilize the patient, do not require prior authorization, and are paid in cases where a person reasonably believed that the absence of immediate medical attention (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), would result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

8. Emergency services are also covered if an authorized representative, acting for the Plan, authorized the provision of these services.

9. There are processes to ensure that VCHCP's Preferred Drug List ("PDL") is based on sound clinical evidence. The PDL is developed with input from appropriate and actively practicing providers, working through the Pharmacy and Therapeutics Committee of the Plan. The PDL is reviewed annually and a printed copy is available to participating providers and pharmacists upon request. See the Prescription Medication Benefit Program Description for details.

10. Documentation for case review and authorization, modification or denial of services demonstrates efforts made to obtain all pertinent clinical information to support the UM decision-making process at all levels.

    Plan actions taken on requested services may include approvals, modifications, and denials. Written notifications of Plan actions are sent to members and providers within a timeframe that is consistent with the type of requests and regulatory and any accreditation requirements. Denial letters will include the reason for the denial and the specific UM criteria, or benefits interpretation used in making the determination. Appeal information is included in all denial notifications. See the TAR Authorization Process document and the UM Policy for Appeals document for details.

11. VCHCP has policies and procedures for the referral/authorization process and associated time frames.

12. Appropriately licensed health care professionals supervise all UM review decisions. A licensed physician reviews any denial that is based on medical necessity. Board-certified physician consultants from appropriate specialty areas assist in making medically appropriate determinations when necessary.

13. Monitoring of UM data is performed to detect potential under- and over-utilization. Data are monitored across practices and provider sites of PCPs and specialists. Appropriate interventions are implemented whenever under- or over-utilization is identified. Interventions are measured to determine their effectiveness, and further strategies may be implemented to achieve appropriate utilization.

14. Determinations for care or service are made according to VCHCP approved timeframes. See TAR Authorization Process and Timeline Standards document for details.
    a. Determinations are monitored to ensure compliance with approved timeliness standards.
    b. If the standards are not met, VCHCP will take action to improve performance based on the recommendations from the UM and/or QA Committees.

15. Member and provider appeals, and grievances are investigated promptly. A written response is submitted to the concerned party within the time frame designated by Plan policy, based on statutory or regulatory requirements as appropriate. See Grievances and Appeals document for details.

16. There are mechanisms to evaluate the effects of the UM program and process using

member and provider satisfaction data, staff interviews and/or other appropriate methods.

a. VCHCP gathers information at least yearly from members via CAHPS (Consumer Assessment of Healthcare Providers and Systems) program which uses member satisfaction surveys.
b. The Plan is using an outside vendor to conduct the annual provider satisfaction survey which includes provider satisfaction with the UM process of service and referral approval.
c. Identified sources of dissatisfaction are addressed. When opportunities for improvement are identified, VCHCP makes appropriate interventions to change the process.

17. Utilization tracking and trending data are submitted on a regular basis to the UM Committee.

The data are analyzed by the UM Committee to determine opportunities for improvement. The UM Committee makes recommendations for necessary interventions based on the findings. After intervention strategies, have been implemented, re-evaluation is done with the results reviewed by the UM Committee.

18. The UM Program includes continuous quality improvement processes which are coordinated with Quality Assurance Program activities as appropriate. The interface of the UM Program with the Quality Assurance Program is described beginning on page 18 of this UM Program Description. Quality-related issues are referred to the Quality Assurance Committee. The UM and QM Committees work together to resolve any cross-related issues or problems.

19. The Utilization Management Program includes the effective processing of prospective, concurrent, and retrospective review determinations by qualified medical professionals. The areas of review will include:

a. Emergency and urgent care
b. Inpatient hospitalizations
c. Outpatient surgeries and selected services
d. Rehabilitative services
e. Selected ancillary services
f. Home health services & Durable Medical Equipment (DME)
g. Selected pharmaceutical services
h. Selected physician office services
i. Out-of-network services
j. Selected psychiatric services (currently delegated)

20. When indicated, the case management program provides for the clinical and administrative identification, coordination, and evaluation of the services delivered to a member who requires close management of his/her care. The case management program ensures continuity and coordination of care to improve the health status of members who are at risk for additional health care problems and complications. Appropriate health education programs may be offered to members.

21. The Utilization Management Program Description, Work Plan (which may be incorporated into the QA Work Plan), policies and procedures, goals for the coming year, and program evaluation are reviewed, approved, and updated as necessary, at least annually, by the UM Committee, and by the QAC.

22. The following Affirmative Statement is posted in the UM department and includes the following associates: medical and clinical directors, physicians, UM directors and managers, licensed UM staff including management personnel who supervise clinical staff and any associate in any working capacity that may come in contact with members during their care continuum:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- Financial incentives for UM decision makers do not encourage decisions that may result in underutilization.
- VCHCP does not use incentives to encourage barriers to care and service.
- VCHC does not make hiring, promotion or termination decisions based upon the likelihood or perceived likelihood that an individual will support or tend to support the denial of benefits.

The Affirmative Statement is emailed to all staff members and physicians. It is widely distributed via a newsletter mailed to all members, via the Physician's operation manual sent to all practitioners and via a letter mailed to all facilities/providers. It is also available on the Plan website.

Organizational Structure and Responsibility

1. Structure:

VCHCP's organizational chart reflects the utilization management personnel and committee reporting structures. Staff positions and committee descriptions explain associated responsibilities, duties, and reporting relationships. The staff ratios are consistent with the organization's needs and are accommodated by the departmental budget. Performance objectives are included in the staff evaluations. Interdepartmental coordination of the utilization of care and services is clearly delineated in the description of each department.

2. Responsibilities:

Governing Body (Ventura County Board of Supervisors, through the Standing Committee)

Responsibilities of the Governing Body include the development and maintenance of the UM program. The responsibility for creating and implementing the UM program's infrastructure is delegated to the UM Committee.

Through the QA Committee review process and directly, the Standing Committee oversees the Utilization Management Program activities, and receives reports from the UM Committee quarterly. Documented summaries of utilization statistics and focus study results are reviewed.

All policy, procedure and program changes are submitted for the approval of the Standing Committee.

The Standing Committee may delegate additional responsibilities to the UM Committee as needed.

Health Plan Administrator

Responsibilities of the Health Plan Administrator include overseeing the organization and management of the Utilization Management Program with a focus on the program's financial viability, the allocation of resources and staffing and the interdepartmental effectiveness of the program.

Medical Director

The governance of the Medical Director is critical to the Program's effectiveness. The following is an excerpt from the Medical Director Job description that defines the qualifications and responsibilities for this position:

Medical Director

Qualifications:

1. Doctor of Medicine or Osteopathy
2. Current, unrestricted license to practice medicine in the State of California
3. Member of the medical staff of the Ventura County Medical Center
4. Board Certification
5. Three (3) years or more of medical practice experience

Responsibilities:

1. Development and implementation of the Utilization Management Program
2. Provides the direction, guidance, and control for the medical components of VCHCP's services
3. Develops and interprets medical policies
4. Coordinates and communicates with the Health Care Agency Director, Insurance Administrator, UM, and QA Staff
5. Oversees credentialing and peer review
6. Participates in the Plan's oversight committee, the Standing Committee, and presents the utilization and quality reports and concerns from the Health Plan
7. Implements disciplinary actions for participating providers
8. Oversees the outpatient and inpatient referrals, ensuring consistent medical necessity decision making and timely reviews of grievances and appeals
9. Reviews Potential Quality Issues (PQIs)
10. Provides clinical supervision and consultation to utilization management nurses and staff
11. Makes utilization review/coverage determinations including denials, modifications, closed treatment requests and appeals
12. Participates in the recruitment, and selection of VCHCP providers
13. Represents the Plan in a liaison role with other agencies, practitioners, and facilities
14. Consults with Plan Providers when requested or when contacted by the provider
15. Works with other Plan administrators to ensure that Protected Health Information is secure
16. References and follows the utilization guidelines and policies adopted by the Health

Plan

17. Consults with specialist providers when necessary and appropriate to make a decision on a requested treatment or medical service
18. Participates in inter-rater review audits

Note: The Medical Director may have additional responsibilities defined in the Independent Contractor Contract

Associate Medical Director/Physician Reviewer/Senior Level Physician

The following is an excerpt from the Associate Medical Director Job description that defines the qualifications and responsibilities for this position:

Qualifications:
1. Doctor of Medicine or Osteopathy
2. Current, unrestricted license to practice medicine in the State of California
3. Member of the medical staff of the Ventura County Medical Center
4. Board Certification
5. Three (3) years or more of medical practice experience

Responsibilities:
1. Provides clinical supervision and consultation to utilization management nurses and staff
2. Makes utilization review/coverage determinations including denials, modifications, closed treatment requests and appeals
3. Participates in the peer review process
4. At the request of the Plan Medical Director, attends Utilization Management Committee and Quality Assurance Committee Meetings
5. Consults with Plan Providers when requested or when contacted by the provider
6. Safeguards Protected Health Information
7. References and follows the utilization guidelines and policies adopted by the Health Plan
8. Consults with specialist providers when necessary and appropriate to make a decision on a requested treatment or medical service
9. Participates in inter-rater review audits
10. Assists in the formulation of new policies and guidelines when necessary

Note: the professionals included in this policy may have additional responsibilities defined in their Independent Contractor Contracts

Director of Health Services

Qualifications include a bachelor's degree in business, public health or health administration or a

closely related field and must possess and maintain a valid California Nursing License. Responsibilities include the oversight, execution, supervision, and evaluation of the Utilization Management Program in coordination with the Medical Director and UM/QA Manager. Identification of trends through the analysis of UM data and coordination with the Quality Management program is a focus to continuously improve the care and services provided to the membership of VCHCP.

UM/CM Manager

Qualifications include a B.S. or A.S. In nursing, business, healthcare administration or closely related field as well as 3-5 years' experience. Must possess and maintain valid California nursing licensure.

Responsibilities include the operational execution of Utilization Management Program and Case Management Programs under the direction of the Medical Director/Director of Health Services, concurrent review, and other UM decision activities. The UM/CM Manager is responsible for managing the UM/CM Staff which may include the following positions:

1. Utilization Review Coordinator/ UM Nurse/RN-duties include computer input and daily review of TARs and approvals for medical necessity, denials based on benefit coverage only.
2. UM Clerk-duties include answering phone calls to the UM department, receiving TARs, inputting information into the medical management/documentation system known as QNXT, and checking member eligibility.
3. Case Management Coordinator/Case Manager/RN-duties include managing Complex Case Management patients, coordinating, and overseeing Disease Management Program.

The UM/CM manager is available on a day-to-day basis to supervise the UM and CM staff, participate in training and monitor referral activities including adequacy of documentation and consistency of criteria application. The manager may make decisions regarding approvals for medical necessity and benefit coverage and denials for benefit coverage only.

Utilization Management Committee

The Utilization Management (UM) Committee is established as a standing sub-committee of the QA Committee of VCHCP and reports to the Governing Board through the Standing Committee.

The Committee structures and processes are clearly defined, and responsibility is assigned to appropriate individuals.

The Utilization Management Committee oversees the implementation of the Program and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multi-disciplinary and monitors continuity and coordination of care as well as under- and over-utilization of services. Any perceived or actual utilization management problems are reviewed by the UM Committee. The committee meets quarterly. The Quality Assurance and Utilization Management Committees work together on overlapping issues.

Structure and Membership of the Utilization Management Committee

Physician members of the UM Committee are appointed by the Medical Director in consultation with the UM Committee Chairman and with Plan UM staff. The Medical Director has substantial involvement in the implementation of the UM Program. The UM Committee physician membership includes the Medical Director, the UM Committee Chairman, and a sufficient number of practicing physicians who provide necessary consultation and guidance, including specialists. **See Committee Participation grid for details.**

Non-physician UM Committee members are appointed by the Medical Director, with the approval of the Health Plan Administrator. These members include Director of Health Services, QA Nurse, Clerical Support Staff, and Health Plan Administrators.

Representatives from the Claims/Operations, Provider Relations, and Contracting Departments may be asked to attend the meetings.

A quorum of at least 3 physicians must be present at each meeting. The UM Committee meets on a regular basis, at least quarterly. Only physicians have voting privileges on the UM Committee. Additional UM Committee meetings or subcommittee meetings are scheduled at the discretion of the UM Committee Chairman. The UM Committee members serve a two-year term with the possibility of reappointment, and terms are staggered to allow for continuity on the Committee. During the period of time between UM Committee meetings, the Medical Director or physician designee may function as an interim decision-maker to resolve any UM issues as may need expediting.

Minutes of committee actions are maintained.

Functions of the UM Committee

The UM Committee ("UMC") oversees the timely development and implementation of an effective utilization management program, which includes the following:

1. Continuous monitoring and improvement of the UM program.

2. Determination and description of care and services to be provided to members of the Plan. Such determinations are based on relevant clinical information and physician consultation, which reflect current descriptions of "best practice", and which also describe proper and effective utilization practices.

3. Implementation of UM decision-making criteria based on reasonable medical evidence and professionally recognized standards, with the input of board-certified physicians from various specialties.

4. Oversight of Utilization of services through review of reports regarding major aspects of the Utilization Management Program of the Plan. The analysis of, and the actions taken in respect to, these reports are submitted quarterly to the Standing Committee of the Plan by the Health Services Director. Such reports may include, but are not limited to, the following:
    a. Updates to and changes in the Utilization Management Work Plan
    b. Summaries of UM Program updates
    c. Plan policies and procedures
    d. Criteria for UM decision-making
    e. Status of completed and on-going UM activities
    f. Organizational changes made throughout the year
    g. Response to new legislation that affect the UM process
    h. Trending of UM performance measurements
    i. Analysis of the outcomes of improvement activities
    j. Barriers encountered which defer or delay the achievement of UM goals
    k. Evaluation of overall effectiveness of the UM program
5. Evaluation of measurement tools to ensure the consistent and accurate application of UM criteria.

6. Monitoring and reviewing UM decisions to ensure that qualified health professionals properly assess the clinical information used to support UM decisions. A licensed physician reviews all denials based on medical appropriateness and a psychiatrist reviews all behavioral health denials based on medical necessity ensuring that such denial decisions are based on and meet professionally recognized standards.
7. Supervision of the identification, analysis, and resolution of utilization management problems especially as this function relates to the review of provider practice patterns. In particular, the under- and over-utilization of services, the proper use of network resources, issues of access to care and clinical performance by the provider, are all topics which may be addressed. Findings may require referral of potential quality problems to the Quality Assurance Committee for further review and intervention.
8. Involvement in peer review activities, when based on UM issues.
9. Evaluation of retrospective review and payment determination of claims, when appropriate, and when based on clinical information.
10. Assist in the interpretation of medical benefits associated with medically necessary care and services.
11. Provision of educational programs for VCHCP providers, staff, and members. Ensuring that approved updated criteria and guidelines are communicated to contracted providers and are available upon request.
12. Overseeing establishing of task forces which may assist the UM Committee. The function and goals of such task force may be among the following:
    a. Developing physician education regarding utilization management
    b. Obtaining member and provider feedback about utilization management issues
    c. Analyzing provider utilization, developing, or revising utilization guidelines, and delineating the various provider roles
    d. Monitoring and evaluating referrals to non-contracted providers and facilities
    e. Recommending new specialists for inclusion on the Plan's Provider Panel
    f. Developing criteria for focus studies
    g. Developing care guidelines and preventive health guidelines to be used as references by VCHCP providers
    h. Researching UM criteria to determine medical necessity
13. The UM Committee oversees utilization of services by reviewing reports and other information related to the appropriateness, consistency, and timeliness of actions on treatment authorizations, denials, and appeals, both with respect to individual requests, and in aggregate. Performance is assessed based on the policies and standards of the Plan, State and Federal agencies, and community practice. The Director of Health Services is responsible for collecting reports to submit to the UM Committee on a quarterly basis for review and discussion by the members.
14. The UM Committee oversees and monitors all delegated utilization management activities.

Evaluation of the Utilization Management Program

The UM Program is evaluated on an annual basis through the UM Committee and subsequently through the Quality Assurance and Standing Committees.

The Director of Health Services collects, analyzes data, prepares, and revises the UM program evaluation for presentation to the UM Committee. Based on the UM Committee evaluation and feedback, the program evaluation is revised and finalized by the Director of Health Services. The finalized program evaluation document is approved by the UM Committee.

The VCHCP UM Committee Team, which is comprised of the Medical Director, Associate Medical Director, Director of Health Services and UM/QA Manager, meet at the beginning of the new year to evaluate the previous year's UM program.
The Medical Director and Associate Medical Director are actively involved in the implementation, supervision, oversight, and evaluation of the UM Program.

First, the team highlights the accomplishments and successes of the past year.

Quarterly performance on timeliness of review, inpatient and emergency room utilization, and trends of grievances and appeals as well as clinical denials and appeals, and appropriate claims payment are reviewed and evaluated. Any opportunities for improvement are identified and placed in the recommendations for intervention for the coming year and if needed, added in the work plan.

The previous year's UM work plan is reviewed by the team and action plans are developed as needed. This includes, but is not limited to, member and provider satisfaction with the UM process, consistency with which physicians and non-physician reviewers apply criteria in decision making, potential over- and under-utilization of services and others.

The team reviews the UM program structure to ensure that roles and responsibilities of the UM staff continue to be applicable, and modifications are made as needed. Protocols, medical and administrative policies, and technology assessments are also reviewed. The UM Committee membership is reviewed to ensure that there is appropriate membership for a quorum.

The Disease Management and Complex Case Management Programs are reviewed, and any recommended updates or changes are presented to the UM Committee.

The UM team ensures that the UM Committee continues to analyze aggregate and physician specific UM data for the identification of patterns and trends with recommendations to QAC for intervention. Additionally, the team reviews the UM processes for efficiency and programs (such as reduction in prior authorization and expansion of the PCP to Specialists direct specialty referral) are developed and implemented.

The team evaluates the application of criteria for UM decision making ensuring that all VCHCP Medical Policies, Milliman Care Guidelines and UM Policies and Procedures are updated and approved yearly by the UM Committee and QAC.

Delegation

If any UM activities are delegated to contractors, VCHCP has a responsibility for oversight and evaluation of these activities. A mutually agreed upon contract for delegated UM functions includes:

1. Specific delegated UM activities for which the contractor and VCHCP are responsible
2. Reporting requirements and frequency of the contractor to VCHCP
3. VCHCP's evaluation process of the contractor's performance
4. VCHCP's approval of the delegated contractor's UM program
5. Remedies, including revocation of the contract, if the contractor does not fulfill its obligations

Prior to any delegation, VCHCP conducts a pre-contractual evaluation to determine the contractor's capability to perform the required duties. The contractor's UM program is evaluated annually and submitted for review. Annually, the provider organization assesses the contractor's performance in accordance with VCHCP expectations, regulatory and any accrediting standards. See the VCHCP delegation policy and the individual delegation agreements for details.

VCHCP covers behavioral healthcare services. VCHCP delegates its behavioral healthcare services to OptumHealth Behavioral Solutions of California (OHBS-CA), which includes the triage and referral process for behavioral healthcare services as well as evaluation of service sites and levels of care for behavioral healthcare services as part of the utilization management program.

See the OHBS-CA Utilization Management Program Description 2023, the written delegation agreement and VCHCP's delegation policy for details.

OHBS-CA ensures the involvement of a designated behavioral health care practitioner (Regional Medical Director) in the implementation of behavioral healthcare aspects of the UM program and who is responsible for supervising all medical necessity decisions.

OHBS-CA's Regional Medical Director's Qualifications:

- Doctor of Medicine or Osteopathy
- Current unrestricted California license to practice as a physician without restrictions
- Board certification in psychiatry
- Three (3) years post-licensure clinical experience; two to three years management experience
- Experience in utilization review of mental health/substance use disorder (MH/SUD) services

Responsibilities:

- Clinical oversight of all aspects of the UM program to ensure that quality of care and care advocacy activities are clinically sound. This oversight includes but is not limited to triage, referral and ensuring consistent criteria application in the decision-making process for medical necessity review
- Oversight of adverse and non-coverage determinations, appeals and peer review processes, ensuring compliance with state and federal law and OHBS-CA policies and procedures
- Provides input into policy development and implementation
- Oversight of the Quality Management and Improvement Program
- Provides clinical supervision, training, and consultation to Care Advocates
- Makes utilization review/coverage determinations
- Conducts peer and appeal reviews
- Chair of the Quality Improvement Committee and Clinical Advisory Board
- Serves as liaison with network clinicians and other medical delivery systems
- Reports to the Regional Vice President of OHBS-CA

Associate Medical Director(s)

Qualifications:

- Doctor of Medicine or Osteopathy
- Current unrestricted California license to practice as a physician without restrictions
- Board certification in psychiatry
- Three (3) years post-licensure clinical experience
- Knowledge of the principles and techniques of psychiatric diagnosis/treatment
- Knowledge of substance use disorder (MH/SUD) diagnosis/treatment
- Prior managed care experience

Responsibilities:

- Provides clinical supervision and consultation to Care Advocates
- Makes utilization review/coverage determinations
- Conducts peer and appeal reviews
- Chair of the Utilization Management Committee and Peer Review Committee
- Member of the Optum/OHBS-CA Clinical Technology Assessment Committee

As part of the delegation oversight process, The UM team reviews OHBS-CA's UM Program Evaluation and annual onsite audit, and action plans are developed as needed.

Overall review includes:

- The UM Program Description
- UM Protocols and medical and administrative policies
- Policies for new technology assessment
- Clinical criteria and its appropriate application
- UM work plan
- Program evaluation of goals and accomplishments
- Grievances/complaints and appeals
- Under- and over-utilization

- Time standards for decision making
- Inter rater reliability
- Delegation Oversight
- Member and practitioner satisfaction
- Review of Disease Management and Complex Case management Programs
- Evaluation of retrospective review and appropriate claims payment

INTERFACE: UTILIZATION MANAGEMENT AND QUALITY ASSURANCE

Purpose

To describe the interactive relationship between the Utilization Management process and the Quality Assurance process

Scope

The Utilization Management Committee and Quality Assurance Committee interact to ensure that services delivered and managed by VCHCP are of high quality and are appropriate, cost-effective, efficient, and accessible.

The Plan employs a system of reporting utilization information and identifying areas of service such as medical, pharmacy and behavioral health. By aggregating such data, and reporting it for further evaluation, VCHCP identifies patterns of care that are proper, or alternately, that may suggest inappropriate provision of service(s).

When such patterns are discovered, the Plan takes such actions as are necessary to ameliorate the conditions, up to and including, when necessary, the preclusion of specific care providers from providing service to members.

Description

1. The Utilization Management department and the Quality Assurance department strive to identify and monitor issues of concern related to the utilization and quality of services that are provided to members of VCHCP.
2. The formal reports of these departments, including aggregate UM data, denial, and appeals, with pertinent findings, are presented to the appropriate committees, at least annually, and are documented in the meeting minutes.
3. The UM Program is evaluated and submitted for review and approval annually by both the UM Committee and the QAC, with final review and approval by the QAC.
4. It is understood that such findings often will overlap, and elements of any problem may be found in the reports of either department. VCHCP Medical Director will have substantial involvement in the implementation and maintenance of this UM/QA program interface.
5. Reports to the Standing Committee include, when appropriate, a summary of combined Utilization and Quality Assurance activities. The Plan monitors such UM/QA activities

and reports on the following:

a. Utilization review criteria. These are reviewed and updated at specified intervals, at least annually.

b. UM decisions made by qualified health professionals. The Plan supervises the decision(s) made by appropriately licensed professionals using medically appropriate standards. Denials of service which are based on lack of medical necessity are only made by licensed physicians, and all such decisions are monitored on a regular basis.

c. Determinations of medical appropriateness. VCHCP has a panel of actively practicing medical specialists and sub-specialists in various clinical areas who are consulted when necessary to determine medical appropriateness of requested therapies.

6. Standards for timeliness of UM decision-making are approved, implemented, monitored, trended, and reported. Action is taken to improve performance, as appropriate.
7. Patterns of utilization are monitored to detect potential under- and over-utilization of services, as related to the quality of care provided.
8. Member and provider satisfaction with the UM process are evaluated.
9. The UM staff may identify actual or potential quality issues during utilization review activities. These issues are referred to QA staff for follow up.

Areas to be Examined

VCHCP has identified the following as examples of issues that may involve both quality and utilization management:

1. Accessibility of services
2. Appropriateness of care and services
3. Continuity and coordination of care
4. Member compliance and risk minimization
   a. Health education
   b. Health maintenance
   c. Treatment recommendations
5. VCHCP compliance with regulations, standards, and any accreditation requirements
6. Analysis of prospective services, such as hospitalization
7. Analysis of concurrent review of services and discharge planning
8. Analysis of retrospective review of services
9. Retrospective review reports
10. Problem areas that are specific to different types of practice
11. Review and analysis of timeliness, appropriateness, and consistency of UM decisions
12. Peer review process implementation as necessary

13. Analysis of Emergent and Urgent Services
14. Analysis of Ancillary Services, such as Imaging and Laboratory Testing
15. Analysis of Specialty Care referrals, such as Surgery or Tertiary Care
16. Clinical management of chronic conditions such as diabetes and asthma

Sources to Aid in Identifying and Monitoring Interface Issues

VCHCP has identified the following as sources that may provide useful and meaningful data for analyzing compliance with standards of utilization as well as those of quality:

1. Plan-conducted surveys:
   a. Member access to service
   b. Providers' telephone triage systems
2. Laboratory and x-ray reports including provider follow-up documentation
3. VCHCP's medication utilization reports for prescription medications
4. Reports:
   a. Hospitalization data
   b. Member claims
   c. Third Party Claims
   d. Referral patterns
   e. Timeliness of service
   f. Ancillary service utilization
   g. Outpatient data
   h. Prescription logs
   i. Member complaints/grievances
   j. Staff interviews/suggestions
   k. Provider surveys
   l. Satisfaction surveys
   m. Time studies
   n. Peer review
   o. Re-credentialing
   p. Incident reports
   q. Care follow-up, especially ER and Urgent Care facilities
   r. Medical Records Reviews

PRIMARY CARE PHYSICIAN RESPONSIBILITIES

Purpose

To establish the overall responsibilities of the Primary Care Physician (PCP) in the delivery of clinical services to the member. VCHCP considers the following specialists as PCPs: Family Medicine, Internal Medicine, Pediatrics, and OB/GYN.

To establish a system to support continuity of care for the member.

Scope

Established descriptions of PCP responsibilities may be reviewed, approved, and utilized by VCHCP (e.g., Milliman Care Guidelines). VCHCP also may develop its own description of the Primary Care Physician responsibilities. The following example describes in general the role of the primary care physician:

- The PCP serves as the provider of the member's care. The PCP provides medical expertise and direction concerning the member's healthcare needs, functioning as a manager for all healthcare services provided to the member.
- The PCP provides, or arranges for, 24 hour/seven day per week coverage in his or her primary care practice.
- PCPs are expected to provide services within their scope of duties and privileges, without referral to a specialist, unless such provision of care has been conducted without a significant improvement of the member's condition, or unless the PCP recognizes that further treatment or procedures are necessary and can only be provided by a specialist or other consultant. Services rendered by the PCP include preventive services that are timely for children and adults including well-childcare, immunizations, and health screenings.
- The PCP receives and evaluates specialist reports and determines (with specialist provider input, when necessary) if additional specialty services are needed. This involvement of the PCP helps to ensure continuity of care and eliminates duplication of services.
- The PCP submits authorization requests for medically necessary services to the UM Department for approval.

  Following authorization for a requested specialist, said specialist (as approved by the committee) may directly submit requests to the UM Department for approval.
- During the member's hospitalization, stay in a skilled nursing facility or utilization of home healthcare services, the PCP continues to monitor the medical necessity of services being provided and facilitates the appropriate transfer of the member to a lower level of care. The facility attending physician may be responsible for monitoring the member's care.

Medical Guidelines

1. Specialist Referral: Direct Specialty Referral for certain specialties identified by the Plan is utilized by the primary care physicians. Authorization for referral to a specialist where direct specialty referral does not apply, will be granted if medically necessary and after an adequate initial work-up and trial of treatment (if indicated) are performed by the primary care physician. The adequacy of this work-up will be judged based on the usual best practice guidelines for the condition or disease process in question. These guidelines can be accessed through UpToDate (http://www.utdol.com/) and/or National Guideline Clearinghouse (http://www.guideline.gov).
2. Non-Preferred Medications: Authorization for certain non-preferred medications will be granted after the member has met particular criteria set forth in the appropriate guidelines approved by the Pharmacy & Therapeutics Committee. These guidelines are created based on approved FDA uses, current literature, and community standards.
3. Non-Routine Studies: Authorization for certain non-routine studies will be granted if they are

medically indicated, considered medically appropriate by best practice guidelines and/or community standards, and their results will impact the ongoing diagnosis, treatment, or prognosis of a member's health care.

4. Decision to approve requests for authorization of services requiring prior authorization such as magnetic resonance imaging using Milliman Care Guidelines will be made by the VCHCP Utilization Management Nurses. Decision to deny requests for authorization will be made by the medical director or physician reviewer using Milliman Care Guidelines.

5. Physical or Occupational Therapy: Direct Specialty Referral for Physical and Occupational Therapy is utilized by the primary care physicians and certain specialties identified by the Plan. Authorization for additional physical or occupational therapy after the initial eight visits, where direct specialty referral does not apply, will be granted if either is medically indicated and not contraindicated and there is a reasonable expectation that improvement in musculoskeletal function will be realized with therapeutic intervention.

Surgical Guidelines

Decisions regarding authorization for elective surgery will be made using the Milliman Care Guidelines when they are available. When the guideline is not available in Milliman, decisions regarding authorization for elective surgery will be made using the criteria set forth by each specialty's college or association of currently recommended guidelines and our community standard as determined by the usual and customary practices at the Ventura County Medical Center, St John's Regional Medical Center, Simi Valley Hospital, and Community Memorial Hospital (Note: Community Memorial Hospital for cardiac services only). In the event a member or a physician requests a surgery that falls outside our community standard, further research using current literature in that specialty and discussions with tertiary care providers in our network will be used to make a final determination. Additionally, the Plan utilizes external review organizations such as "I medics" for reviews.

CASE MANAGEMENT PROGRAM

Purpose

To facilitate the delivery of cost-effective, appropriate healthcare services for members with complex and chronic care needs.

To ensure that all medically necessary care is delivered in the most cost-efficient setting for members who require extensive or ongoing services.

To assist in the development of realistic treatment goals for catastrophic and complex cases, and for chronically ill or injured members of the Plan.

To facilitate continuity and coordination of care and services.

Program Description

Qualified health professionals and appropriately licensed health professionals are involved in the case management program. Case managers coordinate individual services for members whose needs include ongoing medical care, home health and hospice care, rehabilitation services and preventive services. Coexisting medical and behavioral conditions are included in the continuity and coordination of care. The case managers work collaboratively with all members of the

healthcare team, including discharge planners at the affiliated hospitals. The Medical Director or physician designee is substantially involved in these case management functions. The Utilization Management Committee oversees the implementation of the case management program.

This case management process is directed at coordinating resources and creating appropriate cost-effective alternatives for catastrophically, chronically ill, or injured members, and for those members with complex illnesses, on a case-by-case basis, in order to facilitate the achievement of realistic treatment goals. Physicians from appropriate specialty areas assist in making decisions of medical appropriateness for the case management process.

Through monitoring and case coordination, case management assures that care is delivered in a timely and efficient manner, and at the same time, effectively screening for inappropriate authorizations. This process may include searching for the following:

1. Authorization of elective admissions

2. Application of criteria for the evaluation of surgical necessity.

3. Inadequate medical management of ambulatory care cases.

4. Implementation of programs in which more cost-efficient measures have not been pursued.

5. Inadequate research to determine the most appropriate and most cost-effective plan of care for the member.

Clinical and administrative data is used to anticipate those members who may benefit from Case Management interventions. Sources used for the accumulation of data may be:

1. Hospital admission records

2. Eligibility/Benefits information

3. Provider referrals

4. Member utilization records

5. Outpatient clinical records

6. Interdisciplinary team conferences

7. Management team conferences

8. Claims Data Mining

To ensure the effective management of complicated and costly cases, the case management staff utilizes various resources. The process is coordinated by the effective utilization of appropriate clinical, individual, and environmental resources such as:

1. Synthesizing primary care and specialty provider input.

2. Utilizing applicable clinical guidelines

3. Interpreting benefits and assigning appropriate services.

4. Attending to individual member's physical and psychosocial characteristics and needs.

5. Applying knowledge and information gained from case studies and research.

6. Following up with member to ensure compliance with his/her treatment plan.

VCHCP's case management program is intended to accomplish the following:

1. Coordinate and document the management of high-quality cost-effective services.

2. Facilitate care that is accessible, with no access barriers, in accordance with members' benefit structure.

3. Promote early treatment intervention in the least restrictive setting.

4. Facilitate continuity and coordination of general medical care with behavioral health care.

5. Apply Plan approved UM decision criteria to the management of complex and chronic cases.

6. Comply with Plan approved time frames and standards for timeliness of UM decision making.

7. Provide accurate and up-to-date information to providers regarding care guidelines, preventive health guidelines and member information.

8. Utilize multidisciplinary clinical, rehabilitative and support services.

9. Provide appropriate resources for members.

10. Maintain confidentiality.

11. Provide ongoing case management program analysis and development.

12. Protect member rights and encourage member responsibility.

Case Management Procedure

1. Referrals to case management may be made by VCHCP staff, providers, hospital staff, employers, and members to facilitate the continuity and coordination of the member's care.

2. The referral is made to VCHCP case manager who is a qualified licensed health professional and functions within the scope of his/her license to practice (e.g., RN).

3. The referral source provides the case manager with demographic, healthcare and social

data about the member being referred.

4. The case manager obtains eligibility and benefit coverage information on the member and notifies the referral source of the member's eligibility status for involvement in the case management program.

5. If the member is eligible and has benefit coverage, the case manager continues to work with the referral source to obtain necessary information for implementing the case management process.

6. If a licensed physician deems the services requested by the treating physician medically inappropriate, VCHCP denial/appeal process is implemented.

7. The case manager gathers the appropriate information to complete a case assessment for the member (which may include speaking with the member over the telephone).

8. The case manager completes an assessment that includes an evaluation of member-related clinical, psycho-social, and socio-economic factors.

9. Access to appropriate individual, VCHCP and community-based resources are evaluated and included in the assessment, including the "Coordination of Benefits" or other insurance or coverage resources that may be available to the member.

10. The case manager coordinates the providers' treatment plan which may include an interdisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and expected outcomes. The plan is based on ensuring continuity and coordination of the member's care.

11. The treating providers and the member are responsible for implementing the plan of care.

12. The case manager monitors the progress of the implemented plan of care.

13. The case manager serves as a resource throughout the implementation of the plan and makes revisions as appropriate.

14. The case manager also coordinates appropriate educational sessions and encourages the member's role in self-help.

15. Progress toward the member's achievement of treatment plan goals is monitored in management program.

See Disease Management and Complex Case Management Program Descriptions for details.

NOTIFICATIONS:

Members are notified of the availability of UM criteria either in writing upon request or on the website and through the EOC brochure mailed to all members.

Practitioners are notified of the availability of UM criteria, either in writing upon request or on the website and through the provider manual mailed to all practitioners. Providers are also

notified, annually, through Plan newsletters and mailings, of the process by which such information may be obtained. Members receive pertinent criteria information with every denial letter, by mail.

Practitioners receive pertinent criteria information with every denial letter, by fax, or if no fax access, by mail.

UM COMMUNICATION

Utilization Management and Member Services representatives are available to answer questions from members, practitioners, and providers concerning utilization management information and issues. Representatives can be reached during the hours of 8:30 a.m. to 4:30 p.m. Monday through Friday by calling (805) 981-5050 or toll-free at (800) 600-8247. For members with special needs, representatives can be reached at:

- For hearing impaired members: TDD to Voice (800) 735-2929
- For hearing impaired members: Voice to TDD (800) 735-2922 for English or (800) 855-3000 for Spanish
- For members needing language assistance: (805) 981-5050 or (800) 600-8247

Members, practitioners, and providers with behavioral health utilization management questions can contact the Plan's behavioral program administrator, Optum Healthcare Behavioral Solutions of California (OHBS-CA). Members can call (800) 851-7407 Monday through Friday from 8:00 a.m. to 5:00 p.m. Practitioners and providers can contact Optum's Physician Consultant Line at (415) 547-5433 to speak with an Optum Behavioral Services Medical Director to discuss behavioral health utilization management issues.

For contact after hours for urgent issues, the Plan has an answering service covering the Plan's main phone number. The answering service will answer member, practitioner, and provider calls, take initial information including caller name, phone number, and issue, and contact the On-Call Plan Administrator for assistance. On Call Plan Administrators have a cell phone specifically to take off hours calls and will respond directly to the callers to resolve issues.

Providers and practitioners are encouraged to contact the Plan by phone for any urgent issues and not to fax urgent treatment authorization requests after hours since there is no staff to cover faxed requests. The On-Call Plan Administrators who are clinical can make decisions regarding urgent treatment requests. For any potential denials or complex requests, the Medical Director will be contacted on his/her cell phone to review the request and discuss with the caller as necessary. Non-clinical Plan Administrators can contact the Plan Medical Director via cell phone for assistance with urgent treatment requests. On-Call Plan Administrators document calls on a log including name of caller, reason for call, outcome, and any comments. Any calls regarding authorizations will be documented in QNXT the next business day and followed up by utilization staff as appropriate.

A. Attachments: None
B. References: Utilization Management Policy for Appeals

C. History:

Committee Reviewer: Utilization Management Committee; Quality Management Committee; Medical Director; QA/CM Manager; Asst. Medical Director/Senior Level Physician; Health Services Director: Effective Date: May23, 2006
Reviewed/Approved: UMC May 8, 2006
Reviewed/Approved: QAC May 23, 2006
Reviewed/Updated: UMC: February 20, 2007
Reviewed/Updated: UMC: August 20, 2009
Reviewed/Updated: QAC: September 1, 2009
Reviewed/No Updates: UMC: May 12, 2011
Reviewed/No Updates: QAC: February 20, 2011
Reviewed/Updated: UMC February 9, 2012
Reviewed/Updated: QAC February 28, 2012
Reviewed/Updated: UMC February 14, 2013
Reviewed/Updated: QAC February 26, 2013
Reviewed/Updated: UMC August 8, 2013
Reviewed/Updated: QAC August 27, 2013
Reviewed/Updated: UMC November 14, 2013
Reviewed/Updated: QAC: November 2013
Reviewed/No Updates: C. Sanders, MD, Faustine Dela Cruz, RN
Approved by UMC: February 13, 2014; QAC: February 25, 2014
Reviewed/ No Updates: C. Sanders, MD, Faustine Dela Cruz, RN
Approved by UMC: February 12, 2015; QAC: February 24, 2015
Reviewed/Updated: C. Sanders, MD, Robert Sterling, MD, Faustine Dela Cruz, RN
Approved by UMC: February 11, 2016; QAC: February 23, 2016
Reviewed/Updated: C. Sanders, MD, Robert Sterling, MD, Faustine Dela Cruz, RN
Approved by UMC: February 9, 2017; QAC: February 28, 2017
Reviewed/Updated: C. Sanders, MD, Robert Sterling, MD, Faustine Dela Cruz, RN
Approved by UMC: February 8, 2018; QAC: February 27, 2018
Reviewed/No Updates: C. Sanders, MD, Faustine Dela Cruz, RN
Approved by UMC: February 14, 2019; QAC: February 26, 2019
Reviewed/Updated: H. Taekman, MD, Faustine Dela Cruz, RN
Approved by UMC: August 8, 2019; QAC: August 27, 2019
Reviewed/No Updates: H. Taekman, MD, Faustine Dela Cruz, RN
Approved by UMC: February 13, 2020; QAC: February 25, 2020
Reviewed/No Updates: H. Taekman, MD, Faustine Dela Cruz, RN
Approved by UMC: February 11, 2021; QAC: February 23, 2021
Reviewed/Updated: H. Taekman, MD, Faustine Dela Cruz, RN
Approved by UMC: February 17, 2022; QAC: February 22, 2022
Reviewed/No Updates: H. Taekman, MD, Faustine Dela Cruz, RN
Approved by UMC: February 2, 2023; QAC: February 7, 2023
Reviewed/Updated: H. Taekman, MD, Faustine Dela Cruz, RN
Approved by UMC: February 8, 2024; QAC: February 27, 2024
Reviewed/No Updates: H. Taekman, MD, Faustine Dela Cruz, RN
Approved by UMC: February 20, 2025; QAC: February 25, 2025

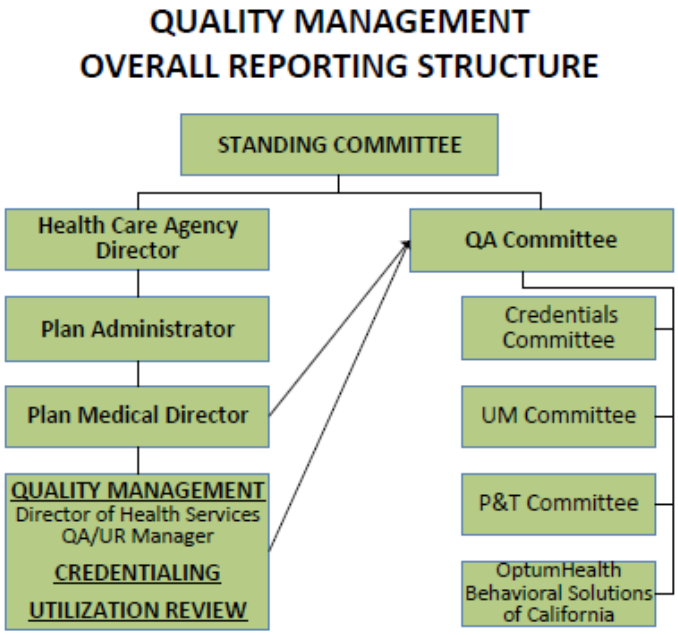
Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/9/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual Review: clarification of direct referral that PCPs directly refer to specialists.

2/8/18	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual Review: under "Responsibilities of Health Services Director", added management of CM/DM and QA staff
			and oversight of CM, DM, and QA programs. Removed QA/CM Manager.
5/23/2018	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Organizational Charts – updated the Quality Management Committee Reporting Structure: in the QA Committee, added the Plan Administrator, insurance administrator changed to Director of Health Services and Services Administrator, removed Optum committee and added to Delegate JOCs. Under the Quality Management Overall Reporting Structure, added MPEC, Peer Review and Delegate JOCs reporting to the QA Committee.
2/14/19	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual Review
6/25/19	Yes	Howard Taekman, MD; Faustine Dela Cruz, RN	Organization Chart – updated to reflect a solid line reporting of the Plan's Medical Director to the Plan Administrator. Removed the dotted line reporting of Medical Director to the Standing Committee. Changed reporting of Plan Medical Director to Health Care Agency Director to a dotted line.
2/13/20	No	Howard Taekman, MD; Faustine Dela Cruz, RN	Annual Review
2/11/21	No	Howard Taekman, MD; Faustine Dela Cruz, RN	Annual Review
2/17/22	Yes	Howard Taekman, MD; Faustine Dela Cruz, RN	Updated with DMHC's definition of Emergency Care.
2/2/23	No	Howard Taekman, MD; Faustine Dela Cruz, RN	Annual Review
2/8/24	Yes	Howard Taekman, MD; Faustine Dela Cruz, RN	Updated to meet NCQA requirements
2/20/25	No	Howard Taekman, MD; Faustine Dela Cruz, RN	Annual Review

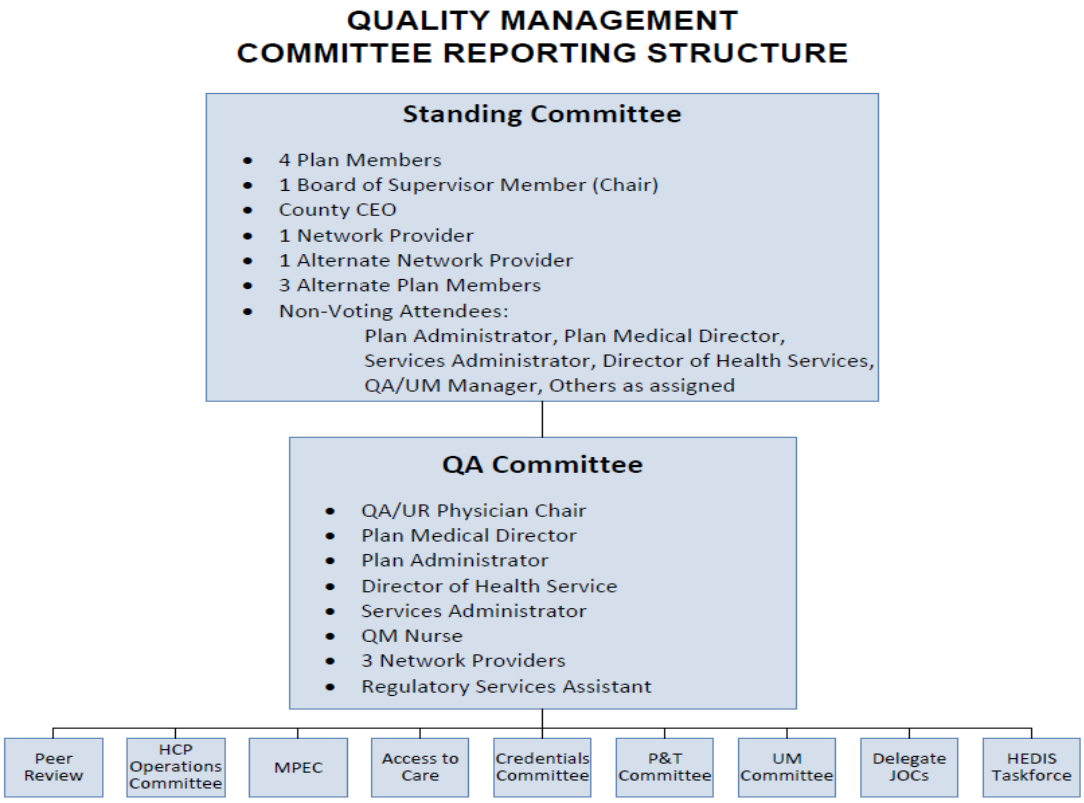
Appendix I

Quality of Care Review System and Organization Chart

QUALITY MANAGEMENT



QUALITY MANAGEMENT
COMMITTEE REPORTING STRUCTURE



Call Transfer Process to Medical Management (UM/CM) Department

When a Member Services Representative receives a phone call with a question regarding Medical Management (UM/CM) from a member or a provider, the Rep has access to view authorizations and give basic information statuses, provider, dates, etc. to the caller.

If the Member Services Rep. determines that the caller needs additional assistance or information, or is requesting a change etc., the call will need to be transferred to UM/CM. This transfer should be a "warm transfer" (warm transfer consists of calling the person you are transferring the call to, staying on the line, explaining who the caller is and what the caller needs).

Note: when answering, or returning a call always identify yourself with name, title, and organization name.

Transfer steps are:

Transferring to a specific extension/person in UM/CM or to the department line x5060 (warm transfer):

1. Inform the caller that you need to transfer them and why.
2. Inform the caller who you are transferring the call to.
3. Make sure they have your name in the event the call drops.
4. Inform the caller that if the call goes to voicemail, they should leave a detailed message with the best contact phone number and the best time for the member to be reached.
5. Dial the person and stay on the line if the person picks up the call:
   - Explain who the caller is
   - Explain what the issue is
   - Verify they will take the call
   - Transfer the call
6. If the person doesn't pick-up, transfer to call to voice mail.
7. Create a detailed phone log (be sure to include who you transferred the call to).
8. Send a follow-up email to the individual who will be getting the voice mail, which includes:
   - Details of the transfer
   - Member ID
   - Call Log ID

Caller with an urgent need

1. If the person you are transferring the call to for the department line (x5060) doesn't pick up and it is an immediate issue, get the call back number.
2. Explain that the transfer didn't go through and ask the caller if you can place them on hold and that you will check to see if the person is available.
3. Walk to the Department and find someone who can help the caller.
4. Transfer the call.
5. Create a detailed phone log (be sure to include who you transferred the call to).