CORPORATE POLICY & PROCEDURE

	Policy Name: CE05- Utilization Review
Department: Health Plan Operations	Policy Number: CE05
Version: 9	Creation Date: 04/28/2017
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Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health Management ☐ Umpqua Health - Newton Creek ☐ Umpqua Health Network	
Approved By: Philip H. Greger Jr., MD, MBA, MLS (Chief Medical Officer) Date: 11/18/2022	

POLICY STATEMENT

Prior authorization for services is, at times, required for Umpqua Health Alliance (UHA) members to provide coverage for treatment or diagnostic services. These services must be determined to be both medically appropriate and follow evidence-based standards of care. This process ensures that care is appropriate, cost effective and timely for our members. Related information can be found in polices CE21 - Adverse Benefit Determinations, CE01 – Grievances, Appeals and Hearings, and CE12 - Prior Authorizations.

PURPOSE

Utilization management (UM) determinations are made using a standardized approach. This approach is based on UHA's Coordinated Care Organization (CCO) Contract with the State of Oregon and its requirements; as well as evidence-based guidelines and internal processes.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Authorization: Request for approval of coverage for medical services. Includes prior authorization for pre-service authorization (see below), and retro authorizations for reimbursement of post-service requests.

Continuing Services: Also known as renewal requests or re-authorizations. This is a prior authorization request for a service or item that was previously approved by UHA and furnished to the member.

Pharmacy Technician Can Do List: An internal document that provides the Pharmacy Review Technicians with a list of services that can be approved without the review of a Pharmacy Director or Chief Medical Officer. The items on the list have been reviewed and approved by the Pharmacy Director and act as a means to decrease the amount of time to reach a determination.

Prior Authorization (PA): A process through which a physician or other health care provider is required to obtain advance approval for a service or item furnished to a member. Also known as a pre-service authorization or pre-authorization request. Unless otherwise specified with respect

to a particular item or service, the member is not responsible for obtaining prior authorization. Prior Authorization is not a guarantee of payment.

UMCD List: An internal document that provides the Utilization Review Coordinators with a list of services that can be approved without the review of a Medical Director or Chief Medical Officer. The items on the list have been reviewed and approved by the Chief Medical Officer and act as a means to decrease the amount of time to reach a determination.

PROCEDURES

Medical Review

1. Prior authorization requests that require review by a Utilization Review Coordinator (URC), also referred to as clinical staff, are assessed for medical appropriateness and necessity by using the following resources:
    a. The Prioritized List of Health Services- all practice guidelines including ancillary and diagnostic service notes;
    b. Health Evidence Review Commission (HERC) guidelines;
    c. Oregon Administrative Rules (OAR);
    d. InterQual® Care Guidelines;
    e. Up-to-Date ®- Wolters Kluwer;
    f. CMS Medicare National Coverage Determinations and Local Coverage Determinations for DME;
    g. UHA Clinical Practice Guidelines adopted by Clinical Advisory Panel;
    h. UMCD List (internal document.)
2. Approval determinations that can be made using the guidance provided by the list above will be completed by clinical staff.
3. All PA decisions for medical, pharmacy, dental, and behavioral health services are conducted by qualified healthcare professionals that have the necessary training and expertise to make authorization decisions.
4. Determinations that would deny or limit the requested services or fall outside of the guidance provided by the list above will be reviewed by the Chief Medical Officer for the final determination. Please see policy CE21 – Adverse Benefit Determination for information on the notification process.
    a. Additionally, if clinical staff is unclear how to proceed with a determination, the Chief Medical Officer will be asked to make a determination in accordance with OAR 410-141-3225.
    b. Consultation with the requesting provider for medical services may be conducted by the Chief Medical Officer when appropriate.

5. Any decisions to deny, reduce, or authorize a service in an amount, duration, or scope less than what was requested are made by a health care professional with appropriate clinical expertise in accordance with OAR is 410-141-3835 (f)(B)(i-iii).
    a. Determination to deny or reduce the amount, duration, or scope of a required service will not be arbitrarily made solely because of diagnosis, type of illness, or condition of the member.
    b. UHA does not incentivize providers, employees, or other utilization reviewers to inappropriately deny, limit, or discontinue medically appropriate services to any member.
6. UHA will not deny or reduce the amount, duration, or scope of a Covered Service solely because of diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services.
7. Before denying any member treatment for a condition that is below the funding line on the Prioritized List of Health Services for any member, including without limitation, disabilities, or co-morbid conditions, UHA shall determine whether the member has a funded condition/treatment pair that would entitle the Member to treatment under OAR 410-141-3820.
8. UHA will not apply more stringent utilization or prior authorization standards to out-of-network services, than standards that are applied to medical/surgical benefits as further described in UHA policy CE24 – Mental Health Parity.
9. In accordance with 42 CFR § 438.210(a)(4)(i-ii), UHA may limit services:
    a. Based on criteria applied under the State plan, such as medical necessity, or
    b. For the purpose of utilization control, provided that:
        i. The services furnished are sufficient in amount, duration, and scope as necessary to achieve, as reasonably expected, the purpose for which the services are furnished;
        ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports; and
        iii. Family planning services are provided in a manner that protects and enable the member's freedom to choose the method of family planning to be used.
10. For all services that are determined to be medically appropriate covered services, UHA will provide such services in a manner that is:
    a. In an amount, duration and scope that is no less restrictive than the amount, duration and scope for the same services provided to Clients under Fee-for-Service as set forth in 42 CFR 438.210, and for members under the age of 21, as

set forth in 42 CFR 441 subpart B, and applicable administrative rules, based on the Prioritized List of Health Services and OAR 410-141-3835 (5), 410-120-1160, 410-120-1210, and 410-141-3830; and

b. Sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are provided and include:
    i. The prevention, diagnosis, and treatment of a disease, condition, or disorder that results in health impairments or disability;
    ii. The ability to achieve age-appropriate growth and development; and
    iii. The ability to attain, maintain or regain functional capacity.

11. Emergent care does not require prior authorization. Applicable retro requests for these services relevant to OAR 410-141-0140 follow the same review process listed above.
12. Continuing authorization requests follow the same process for review as initial requests, however, documentation supporting continued medical necessity is also required.
    a. For an appeal or hearing, a member is entitled to continuing benefits while the case is pending consistent with OAR 410-141-3910.
    b. Please reference UHA policy CE22 – Payment and Authorization for Hospital Admission for information on concurrent review.
13. Clinical and support staff will consult with the requesting provider, as needed, based on member's current needs assessment and consistent with person-centered service plan.

Pharmacy Review

1. Prior authorization requests are reviewed using the following resources:
    a. The Prioritized List of Health Services- all practice guidelines including ancillary and diagnostic service notes;
    b. HERC;
    c. Oregon Administrative Rules (OAR);
    d. Up-to-Date ®- Wolters Kluwer;
    e. Food and Drug Administration (FDA) labeling;
    f. Pharmacy Technician can do list (internal document);
    g. UHA Prior Authorization Guidelines (drug-specific) as adopted by the UHA Pharmacy and Therapeutics Committee.
2. Prior authorization requests for medications must meet the following basic principles established by OARs to be considered for coverage.
    a. The medication must be used for treatment of a condition that has been determined funded for coverage consistent with the Health Evidence Review Commission Prioritized List of Health Services for Oregon Health Plan (OHP) members.

b. The medication must be used for an FDA approved indication and prescribed consistent with FDA approved package insert (dosing, duration, etc.).
c. Experimental, investigational, or off-label use of medication is excluded for coverage by OHP, including clinical trials and demonstration projects, and medications for which there is insufficient outcome data to indicate efficacy (e.g. patient populations excluded from clinical trials).
d. Medications not expected to significantly improve the basic health status of the client are excluded from coverage.
e. It is required that the least costly medication be utilized when it is anticipated the outcome for the member will essentially be the same.

3. For continuing requests, documentation supporting the continued medical necessity is also required. This may include documentation that the treatment has been effective, or the condition has stabilized. Additional drug specific criteria may apply in accordance with FDA labeling.
4. Clinical and support staff will consult with the requesting provider, as needed, based on member's current needs assessment and consistent with person-centered service plan.
5. The drug formulary (or Preferred Drug List) is posted online in a publicly accessible manner. Effective January 1, 2020, all prior authorization criteria will be posted online in a publicly accessible manner and in the format designated by the Oregon Health Authority (OHA). If changes are made to the formulary or PA criteria, updated versions will be posted concurrently or before any changes become effective.

Quality Assurance

1. Mechanisms to ensure consistent application of review criteria for prior authorization decisions, such as monitoring, auditing, and inter-rater reliability testing, will be used.
2. Results of auditing should be reviewed by Clinical Engagement and Pharmacy leadership semi-annually.

Dissemination of Guidelines

1. UHA distributes a Provider Newsletter to providers and any staff that subscribe. Information may also be found on the UHA public website. Content may include best practices, guidelines, or other updates as determined by the organization.
2. UHA facilitates training/events, such as the Provider Services Forum, to share information on guidelines and practices.
3. Providers may also request a peer-to-peer or inquire on the guidelines applied to a determination.

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Department	Standard Operating Procedure	Effective Date	Version Number
Health Plan Operations	UM & Services Authorization Handbook	8/9/2020	1