

Overview

The Utilization Guidance program description summarizes policies, processes, and standards that govern Scott and White Health Plan's (SWHP) utilization guidance programs. The description outlines the program structure and accountability, Medical Director involvement, scope, processes, and information utilized for decision making for Members in Commercial, Self Insured and Senior Care lines of business. This document further identifies the goals and objectives of the program, the Committees and the staff. The program is evaluated and updated at least annually by senior management, approved by the QI Committee with recommendations from the utilization guidance committee.

Goals and Objectives of Utilization Guidance

The goals and objectives of the Utilization Guidance Program are balanced to advance the management of medical services, and are designed to support the delivery of services in a timely, appropriate, and cost efficient manner for SWHP membership. SWHP provides enrollees with a comprehensive health care delivery system within the specifications of the Member's Evidence of Coverage (EOC) as well as Federal and State requirements. To continually assess and improve the quality of care available to Members, the goals and objectives of the Utilization Guidance Program are implemented by the SWHP Care Coordination Division (CCD).

Goals and Objectives include:

- Management of resources to maximize the effectiveness of care provided
- Use of standardized national and internally based criteria for decision making
- Audit of processes and decisions
- Coordination of care between settings
- Identification and appropriate referral of potential quality/safety issues
- Use of a credentialed network of providers for services
- Facilitation of the management of care for complex case management
- Facilitation of the management of care for Members with chronic disease for disease management
- Facilitation of access to appropriate resources
- Prospective, concurrent, and retrospective review of services proposed or rendered to Members
- Use of data and information to identify areas of focus for management activities, based on population and sub population characteristics, provider behavior, benchmarks, and needs
- Production of reports that analyze the utilization of resources and identify trends
- Design of mechanisms to prevent or improve areas of over or under utilization
- Use of policies to interpret benefits and assess new technology

- Facilitation of new enrollees into the Health Plan to transition acute care
- Provision of services according to the standards and timelines of: The Texas Department of Insurance (TDI) for commercial and fully-insured products; The Centers for Medicare and Medicaid Services for SWHP Senior Care products; and/or The Department of Labor for Self Insured product services.

Delegation

SWHP has developed a broad policy and procedure regarding delegation should delegation of any components of UM during the year be required. At the time of any completed formal delegation agreement, supporting policies and procedures and/or agreed process workflows are developed in coordination with the delegated entity, but with approval of SWHP medical and administrative leadership. SWHP recognizes that delegation does not relieve the Member of full responsibility for compliance with the Texas Department of Insurance (TDI), Centers for Medicare/Medicaid Services (CMS) or Department of Labor (DOL) standards and regulations for specific products and services.

Scott and White Health Plan delegates behavioral health utilization management to Health Integrated, Inc., a NCQA UM certified organization.

Behavioral Health (BH) Practitioner: The Health Integrated (HI) Medical Director is a physician with a current Texas license without restriction who is Board-certified in Adult Psychiatry. The Health Integrated Medical Director serves as the BH Medical Director responsible for oversight of the behavioral health UM related components of the SWHP UM program per direction of the SWHP Chief Medical Officer (CMO). The BH Medical Director participates in annual review of BH evidence – based screening criteria, assists in review/development of behavioral health related UM policies and processes, participates in UM/CM Rounds Meetings and UM Committee /TAC meetings as required, performs individual case reviews and peer-to-peer discussions to support UM processes.

Organizational Structure and Oversight of the Program

Management Positions: The following are the key staff directly accountable for Utilization guidance decision, systems and processes:

Chief Executive Officer (CEO)

The Board of Directors of the Plan delegates responsibility for the operational process of the Plan to the CEO. While the CEO may delegate some of the responsibility for the utilization guidance program through appropriate staff appointment (i.e. Chief Medical Officer, Associate VP of Care Coordination Division) the CEO maintains overall responsibility for the Plan. The Board of Directors has endorsed the Quality Sub Committee (QIS) to oversee the day-to-day management activities of the utilization guidance program at the Plan level.

Chief Medical Office (CMO)

The SWHP Chief Medical Officer (CMO) is directly responsible for the UM/CM/DM Programs under Medical Services and reports to the SWHP President, SWHP Chief Executive Officer, and the SWHP Board of Directors. The CMO is a board certified physician in Genetic and Pediatric specialty, with an unrestricted license in Texas. The SWHP CMO works in conjunction with the SWHP Medical Directors to actively implement and administer medical policies, disease and medical care guidance programs, integrate physician services, quality assurance, appeals and grievances, regulatory compliance programs with medical service and delivery systems to ensure the best possible quality health care for SWHP Members. The SWHP CMO participates in various SWHP committees including, but not limited to, Utilization, Technology Assessment, Pharmacy & Therapeutics, and Quality Improvement.

Responsibilities

- Chair of the QI Committee and the Credentials Committee
- Member of the Executive Quality Committee
- Facilitates guideline and indicator development, review, approval and implementation
- Solely (and by delegation to the medical directors) responsible for denial of services to a Member. The denial may be due to an issue of the service or product request not meeting criteria for medical necessity or lacking benefit coverage, under the Plan product design.
- Available for peer review discussions with providers (as are the delegated directors).

Medical Management

The medical management department is made up of five medical directors, Associate Vice President, Director of Data Analysis, three data analysts, and administrative assistants.

Medical Directors

All Medical Directors are physicians with an unrestricted license in the state of Texas. The SWHP Medical Directors at all levels are physicians with current licensure and credentials specific to their respective areas (i.e. Family Practice, Internal Medicine, Anesthesiology, Psychiatry, etc.). The SWHP Medical Directors participate in various SWHP committees including, but not limited to, Utilization, Technology Assessment, Pharmacy & Therapeutics, and Quality Improvement. The SWHP Medical Director(s) are involved in individual case reviews (including peer -to- peer reviews) related to benefit determinations and/or UM coverage determinations on an as needed basis, assist with annual review of clinical criteria and annual evaluation of the UM Program.

Responsibilities:

- Reviews all authorization requests that cannot be approved based on medical necessity
- Writes medical policy
- Educates clinical staff
- Supports clinical committees
- Establishes program for processing compliant and appeal requirements
- Supports marketing functions

Assistant Vice President, Care Coordination:

The Assistant VP of Care Coordination is responsible for overall coordination, implementation and monitoring of activities to yield quality driven, compliant, efficient, and cost effective results. In addition, is responsible for the strategic direction, management, and oversight of the operations of the Care Coordination Division. The person with this accountability will be a licensed clinician with extensive clinical experience. The VP of Care Coordination reports to the Chief Medical Officer of the Health Plan.

Responsibilities

- Serves as an advanced clinical resource to staff with responsibilities concerning Utilization Guidance decisions
- Implements policies and procedures concerning utilization guidance processes and systems, including the processes for authorization, concurrent review, discharge planning, case management and referral management
- Ensures the use of Scott and White identified utilization guidance criteria for decision making. Recommends to the QI/Utilization Guidance Committee/Executive QI Committee, policies and procedures to guide the utilization guidance process
- Ensures referral of all authorization request that cannot be approved based on medical necessity to the Medical Director for review
- Ensures referral of cases with potential quality of care concerns to the Medical Director for review
- Ensures the appropriate documentation of utilization guidance decisions
- Participates in the utilization guidance decisions
- Provides adequate staff coverage for utilization guidance processes
- Delegates to other staff with responsibilities concerning utilization guidance decisions as needed to meet Plan goals

Care Coordination Division

The department is made up of clinical and non clinical staff providing roles that assist in executing the benefits of Members that are requiring either outpatient or inpatient services.

Utilization Manager

Nurse Utilization Managers assist the SWHP Chief Medical Officer and SWHP Medical Directors in directly supervising the nurse CCCs /UM staff. SWHP employ three Utilization Managers. The Managers perform functions of which are to include: responsible for the clinical reviewers that provide the review of services that require authorization, responsible for monitoring, evaluating and improving the performance of the pre-authorization and referral process. The Managers report to the Assistant VP of Care Coordination.

Responsibilities

- Responsible for clinical staff, including staffing, training, and resource contact
- Prepares the monthly reports and assists in the presentation of the information to committee for oversight
- Weekly rounds to collaborate with staff
- Ensures consistent criteria application through coordination and analysis of inter rater reliability testing
- Assists providers in managing care for Members in an acute level of care, as well as discharge planning in a manner that results in improved outcomes

Continuing Care Coordinators

All of the staff is registered professional nurses licensed in the State of Texas. Weekly reviews are held with the Medical Director to determine the appropriate plan of care. Any decisions for denial of inpatient services or a reduction in the level of reimbursement are made by the Medical Director. The Care Coordination Coordinators report to the Utilization Managers.

SWHP UM staff is enhanced by additional RN staff from Health Integrated, Inc., a NCQA UM certified organization for behavioral health UM/CM. Health integrated utilizes psychiatrist, licensed counselors and social workers, psychologists, addictionologists and other behavioral health specialists.

Complex Case Guidance Team Leader

The Complex Case Manager is a registered nurse responsible for the assessment, planning, implementation, coordination, monitoring, evaluation of the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes. Specialized focus is provided to assist Members to transition to

other care, if necessary, when benefits end. The Complex Case Team Leader reports to the Assistant VP, Care Coordination Division.

Claim Nurse Coordinators

Review retrospective request and resolve claim issues regarding the utilization management process.

Professional Staff Compliance and Training Nurse

Provides orientation, ongoing educational feedback; ensures consistent criteria application through coordination and analysis of inter rater reliability testing.

Non Clinical Staff Supervisor

The Pre Authorization Supervisor is responsible for the daily supervision of preauthorization to include the telephone/fax authorizations and processes. The phone call system allows efficient access to reviewers 8AM – 5 PM, Monday through Friday. Clinical staff is available on call after business hours. Provides day to day involvement in the oversight and direction in areas of staffing, training, and resource contact. Reviews daily letters and files to determine accuracy and distribution. The non-clinical Staff Supervisor reports to the Assistant VP, Care Coordination Division.

Non-Clinical –Staff Representatives

Support staff includes clerical and administrative staff utilized for data entry and other support functions. These individuals do not interact with Members nor are they involved in any Utilization Guidance determinations.

Credentials/qualifications of SWHP staff specifically performing UM duties include, but are not limited to:

- Medical Directors at all levels (including the CMO) are board certified physicians with current Texas licensure without restriction and credentials specific to their respective areas (i.e., Genetics, Family Practice, Internal Medicine/Cardiology; Anesthesiology; Pediatrics, Psychiatry; etc.).
- Assistant VP, Care Coordination– Master’s prepared registered nurse with a minimum of five years of Managed Care /Guidance experience;
- UM Managers – Bachelor’s-prepared registered nurses with a minimum of 5 or more years of broad medical/surgical experience and three or more year of managed Care/Guidance experience;
- Continuing Care Coordinator and Claims Nurse Coordinators – RNs (with Bachelor’s prepared-registered nurses preferred) with current Texas licensure and 5 years of broad medical/surgical and/or community-based experience;
- MOMS-licensed vocational nurse (LVN) with > 10 years experience (registered nurse

plus 1-2 years preferred) of OB/GYN, Nursery, Pediatric or Public Health experience

Support Systems for UM

A combination of an automated and paper system facilitate the documentation of UM and benefit determinations. Each CCC has access to an automated total census and their daily work queue which includes Member name, medical record #, Member #, Provider Group Name/#, facility name and room location, PCP name, Admitting/Attending MD name, diagnosis and/or procedure, date of admission, running LOS total, and a hard copy census at the end of each day from both the AMISYS and MEDecision systems.

The CCCs utilize InterQual® evidence – based online criteria CareEnhance® Review Manager Enterprise Integration (CERme), documented written SWHP criteria developed through TAC and/or with policies and procedures based upon input from SWHP-approved specialists. Case tracking/monitoring and documentation is maintained on-line in this software in conjunction with the SWHP imaging system, MACCESS.

To improve timeliness along with increasing provider and Member satisfaction, a more recent addition to the suite of decision support tools is iEXCHANGE®. iEXCHANGE® is a Web-based product that allows physicians and other health care providers to quickly and easily submit transactions to SWHP. iEXCHANGE® integrates with existing systems and is easily accessible for SWHP staff review. It is a simplified, smart solution for both administrative and clinical users. In many cases iEXCHANGE® can automate and approve the requests significantly reducing administrative procedures.

Communication Services/Hours of Operation

SWHP provides access to staff for Members and Practitioners seeking information about the UM process and the authorization of care. SWHP Medical Directors, Associate Vice President of Medical Services, Assistant Vice President of Care Coordination, UM Managers, and a SWHP nurse CCC, as well as any delegated UM review staff, designated for “on-call” coverage are available 24/7 as needed to provide coverage determinations/clarifications through UM and discharge planning processes. CCD has both local and toll free telephone direct access phone lines to the Division and direct lines to each staff member to handle UM-related issues during normal business hours.

During all calls, the CCD staff identifies themselves by name, title and organization name when initiating or returning calls regarding UM issues. Any delegated UM review staff are accessible through toll-free numbers and/or direct lines answered as “SWHP” (i.e., “SWHP Behavioral Health unit”). Inbound calls during normal business hours, Monday-Friday, 8AM-5PM CST are answered by both support staff and/or nurse CCCs to handle UM-related issues.

Support staff do data intake to start cases in the UM software and/or page the nurse for urgent/emergent calls. Only the nurses' CCCs and/or delegated behavioral health clinician UM staff prepare and discuss cases for coverage determinations with the Plan Medical Director(s). After hours and on Holidays, the phone lines are linked by computer transfer to the Scott and White Memorial Hospital (SWMH) operators. The SWMH operators transfer any clinical-related calls to the SWHP *VitalCare* nurse advice service via a toll-free number that is available to all SWHP, Insurance Company of Scott and White (ICSW) and Members to be triaged by clinical nurses with physician-approved protocols and/or the SWMH operators will page the SWHP nurse CCC/UM Delegate on-call for SWHP (as needed) by Members, Practitioners or Providers. During normal business hours, outbound communications related to UM issues are handled by telephone, fax, or e-mail (behind the S&W firewall, and/or via Secure E-Mail).

In an effort to improve communication with non-English speaking Member, SWHP uses the interpretive services of AT&T. Members do not have to call a special line for this service. When contacting SWHP, Members may notify the CCD UM staff and/or customer service of their primary language and the call will be completed with the help of an AT&T interpreter at no charge to the Member. SWHP CCD staff follows established internal SWHP policies related to provision of interpretive services for SWHP Members.

SWHP utilizes a toll free TTY number to assist with communication services for Members with hearing or speech difficulties. The TTY number is listed on the SWHP webpage at www.swhp.org and is included in Member correspondence and Member publication materials.

Enhanced Web-based UM communications are currently in development for the future and are actively being assessed for HIPAA compliance at all stages of development. Through SWHP *VitalCare*, SWHP/ICSW Members also have access to additional health information through the web via SWHP's homepage at www.swhp.org.

Training for Professional Nursing Staff Performing UR/UM/DCP/CM

All SWHP professional nursing staff performing screening UR, UM, DCP, and/or CM activities for SWHP Members will be oriented to and trained in the principles and procedures of UR/UM, Texas Department of Insurance (TDI) standards, Center for Medicare and Medicaid (CMS) standards, Joint Commission Accreditation of Health Organization (JCAHO) standards (when applicable) for the Plan as part of the integrated system, National Committee for Quality Assurance (NCQA) standards, and peer review activities as they apply to their job responsibilities/job description. The purpose of the orientation and training will be to familiarize these employees with SWHP expectations/standards related to the operational issues of completing the required daily job functions and assure consistency in the application of policies and procedures among employees performing these functions for the membership.

Monitoring and evaluation of each professional employee performing these functions and the processes will be conducted on an ongoing basis to assess compliance with standards which are reflected in the policies and procedures of the SWHP Care Coordination Division.

Oversight of Delegated Utilization Guidance Function

SWHP may elect to delegate select Utilization Guidance activities to certain external organizations. Contractual documents are in place to specify:

- The scope of the activities delegated
- The delegate's accountability for those activities and the type and frequency of reports that must be submitted to SWHP
- The process by which the delegates performance is evaluated

SWHP has established accountability and oversight mechanisms which are supported by detailed policies describing the process that would be instituted should the organization fail to maintain compliance with SWHP standards, accreditation standard, state and federal regulations.

An audit is performed at least annually to ensure the delegate's compliance with applicable standards of SWHP, National accreditation organizations, federal and state regulations. Deficiencies detected at the time of the monitoring audit are communicated to the delegate and a corrective action plan during the reassessment phase and at least annually thereafter, as indicated. The Utilization Committee provides oversight of the respective delegated entities.

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Data Sources

In order to make a coverage determination, SWHP may utilize multiple data sources including but not limited to:

- Medical records;
- Verbal/written communication with medical providers/practitioners;
- Verbal/written communications with the healthcare service providers (e.g., discharge planners, case managers, social workers, etc.);
- Verbal/written communications with Member or Member's legal representative;
- SWHP Membership eligibility information;
- Contractual information from the Evidence of Coverage (EOC) or Standard Plan Document (SPD), etc.

Scope and Processes

The scope of the Utilization Guidance Program includes prospective, concurrent, and retrospective review activities as well as discharge planning. These processes are designed to result in equitable access to care for all Members throughout the network.

Prospective review is managed through a list of services requiring prior authorization. The services on the list are services which are not available within the network and/or have demonstrated a high rate of variability. Criteria are utilized to equitably monitor the utilization of the services. Care Coordination's staff approves these services when criteria are met and request review by a Medical Director when the criteria are not clearly met.

Concurrent review/Discharge Planning

Nurse Reviewers conduct review of inpatient stays, focusing on severity of illness and intensity of service. Key care steps and milestones in optimal treatment and recovery, appropriate of level of care, and safety of services are part of the review. Medical Director review of all pertinent inpatient cases is required if medical necessity is in question. Nurse Reviewers collaborate with inpatient staff and with physicians in early and effective discharge planning. The goal is to provide a smooth transition of care from the inpatient to the outpatient setting, or an alternative level of care, in a timely manner and without gaps in service.

Retrospective Review

Care Coordination staff claims nurses engage in retrospective review of services to resolve claims issues, to determine appropriateness of services for payment, to respond to Member or provider inquiries requiring health services input, and to analyze areas of concern (focused review).

Description of UM and Non-UM Activities

Medical Necessity and Appropriateness and Non-UM related Determinations.

SWHP has utilizes the same regulatory requirements for both Medical Necessity and Non UM determinations. (eg. Timeliness of processing, notifications, etc.) to maintain consistency of responses to members and providers by the UM Staff. Specific types of reviews and the requirements are outlined in the sections below.

- Precertification/Pre-Service/Prospective Review is required for selected routine or elective inpatient hospitalizations
- Medical/surgical and behavioral health related to requests for coverage of procedures/services that are non-covered benefits by the Plan;
- Selected specialty procedures/services; selected home health care services skilled nursing facility admissions with non-Plan providers;

- Inpatient rehabilitation admissions; and any Out-of-Network referrals.
- Precertification/Pre-Service/Prospective review is carried out through paper/electronic coverage requests/authorization forms, telephonically, limited e-mail (behind the internal S&W systems firewall) requests, or through individual case review requests (memo/forms).

Participating physicians/providers telephone, e-mail/electronic or fax the SWHP Care Coordination Division (CCD) for urgent/emergent coverage request determinations. For routine/elective care or services, physicians/providers send a paper/electronic request (memo/individual case review/referral/authorization forms) by fax or mail to the Continuing Care Coordinator (CCC) who reviews the requests against the benefit contract guidelines, limitations of coverage outlined in the Evidence of Coverage (EOC) or Standard Plan Document (SPD), written established criteria developed with specialist's input for consideration of Plan coverage, or coverage policies developed by the Plan Medical Director(s). The SWHP CCCs have the designated authority to approve all situations that meet criteria and refer all potential denials or questionable cases to the Medical Director(s) for review. No denials are issued without Plan Director review and approval. The CCCs are supervised by the Utilization Managers and the Associate VP of Care Coordination Division. The purpose of the pre-certification/Pre-Service/Prospective Review function is to:

- A. Confirm Member Eligibility Status;
- B. Insure that all hospital, skilled nursing, mental health/substance abuse, and rehabilitation inpatient admissions are limited to those patients who qualify for the designated level of care;
- C. Insure that the practitioners are aware of alternatives available to inpatient care (and are supported by the Plan); and/or
- D. Deny payment for procedures/care that are not covered benefits under the EOC/SPD.

II. Hospital/Facility Admission Reviews

It is noted that the majority of determinations made by SWHP are related to benefit coverage interpretations according to the evidence of coverage(EOC) and/or Summary Plan description (SPD) and do not involve issues of medical necessity or appropriateness. Other decisions about medical necessity or appropriateness are made by the SWHP Medical Directors with input from the treating clinical Practitioners as appropriate. SWHP benefit determinations are related to payment for care or services based upon input from the Practitioner/Provider and according to the terms of the benefit contract.

SWHP does not require preauthorization, pre-certification or prospective review for any urgent/emergent care, including initial hospital admission, for evaluation and/or stabilization of

medical and/or behavioral health conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- A. Placing the Member's health in serious jeopardy;
- B. Serious impairment to bodily functions;
- C. Serious dysfunction of any bodily organ or part;
- D. Serious disfigurement; or In the case of a pregnant woman, serious jeopardy to the health of the fetus.

SWHP requires **notification** of hospital admissions to the Care Coordination Division within 24-48 hours (or as quickly as medical stabilization allows) from SWHP Members on Commercial and Fully Insured groups and for SWHP SeniorCare Members. Notification allows SWHP to authorize automatic payment for electronically submitted claims.

If a claim denies due to the absence of the notification, the claim requires manual processing for payment. [Any requirement of pre-authorization or pre-certification/pre-service or prospective review for a Self Insured employer group for hospital admission will be handled according to the terms of the SPD according to Department of Labor (DOL) standards and timelines]. SWHP moves to concurrent review processes at the time of the notification of a hospitalization.

III. Surgical and Non-Surgical Procedures Review

Precertification/Pre-Service/Prospective Review is required for selected routine or elective medical/surgical and behavioral health procedures/services that potentially are non-covered benefits by the Plan. [See Section I] SWHP Screening Criteria (InterQual[®]), the EOC/SPD terms and limitations, SWHP Healthcare Management Guidelines (Target Length of Stay [LOS]), and any Plan-approved criteria developed through the Technology Assessment Process are utilized in conjunction with internal policy and procedures to accomplish the reviews.

No denials are issued without SWHP Medical Director review/approval. Physicians are provided the opportunity to speak directly to a Plan Medical Director prior to issuance of an adverse determination [TIC 4201.206] to discuss the procedure/treatment plan and any potential SWHP adverse determination or benefit denial.

IV. Courses of Outpatient Treatment Reviews

SWHP requires preauthorization of selected covered outpatient treatments ordered by SWHP-approved Primary Care Physicians (PCPs) and/or SWHP-approved Specialists and received from SWHP-fully contracted providers or facilities. A formal referral from the PCP to the specialist is

required to be documented in the medical records and/or to be on file in the referring and receiving Practitioner's offices. For coverage determinations on benefits, which appear to be non-covered under the EOC, SPD or internal policies and procedures, the benefit coverage determination is made and a denial issued only with review/approval of a SWHP Medical Director. This may include use of the Technology Assessment Committee (TAC) and/or review of experimental or investigational nature of requested therapy. Courses of treatment that may require a pre-service/prospective and/or preauthorization review are handled the same as Section I noted previously.

V. Second Surgical Opinion Reviews

Unless required by a Self-Funded employer's SPD, SWHP does not routinely require second surgical opinions prior to procedures. If a SWHP-approved Practitioner and/or a SWHP Member desire a second surgical opinion prior to receiving an invasive procedure, they may obtain one without prior authorization/pre-service review if the second surgical opinion is received from Plan-approved providers. Any requests for out-of-Plan second surgical opinions are addressed in the same manner as any other pre-service out-of-Plan request in terms of review process. [See Section I.]

VI. Inpatient Hospital/Facility Concurrent Review

The SWHP CCCs and/or any SWHP UM delegated entities conduct onsite or telephonic concurrent review on all patients admitted to hospitals (medical/surgical and behavioral health), rehabilitation units, skilled nursing facilities, and mental health/substance abuse facilities. Concurrent review includes a review of the medical record and/or supporting documentation for medical necessity, discharge planning, and coordination of alternatives to inpatient care, if appropriate. Conversations with appropriate Primary Care and/or Specialist Practitioners are held as needed to determine the overall plan of care/treatment that the Member will receive.

The CCCs use nationally-established acuity criteria (indications for hospitalization/treatment) [InterQual[®] Criteria] and LOS acute care targets developed by SWHP. Such criteria have been reviewed and approved by the Scott and White Division/Departmental Practitioner Director(s) and identified contracted network Practitioners on an annual basis and/or as needed. Formal patient/Member review rounds between the SWHP Medical Director(s) and the CCCs/Case Managers (CM) are held weekly and as needed. Tracking of certain quality indicators may be performed during the course of the utilization review activity with regard to the impact of the item on the level of care that the Member is currently receiving. Examples of indicators may be (but are not limited to) the following:

- Outpatient Treatment Failure,
- Readmission within 31 days,
- Premature Admission or Discharge,
- Non-Acute Admission or Observation Stay,

- Case Complication,
- Mortality as an Outcome,
- Hospital Factors, Physician Factors,
- Patient/Significant Other Factors,
- Social/Environmental Factors.

The purpose of the concurrent review function is to:

- A. Assess appropriateness of admission for those patients requiring a hospital level of care;
- B. Assess that diagnostic or therapeutic care, which could be provided at a non-hospital level of care
- C. Assess that patient medical record documentation reflects medical necessity for the inpatient hospital admission;
- D. Assess that hospital admissions are not inappropriately delayed;
- E. Assure that discharge planning is initiated as soon as possible when post-discharge problems are anticipated. Some areas targeted are SeniorCare Members, ICU patients, Psychiatric patients, Substance Abuse patients, Oncology patients, HIV/AIDS patients, Transplant patients, etc.;
- F. Assess that the health services provided to a patient are appropriate.
- G. Collect data for use in health/medical care evaluation studies as needed

On-site review and/or faxed information may be required when the telephonic UM reports do not match the expected level of care/services for the patient's diagnosis/treatment or there is requested continued stay in a facility. The review is in order to finalize the case documentation for UM activities and verify the required level of care meets the terms and limitations of the EOC/SPD. The cases are reviewed using SWHP Screening Criteria [InterQual[®] Criteria] and SWHP target LOS. All reviews are as noted above and inpatient cases are paid based upon the approved LOS provided by the Plan subject to the terms and limitations of the EOC/SPD. Even though these reviews may be conducted after the patient is discharged, for appeal and Independent Review Organization (IRO) purposes, such review will be considered to be concurrent review.

VII. Retrospective (Post-Service) Review

Retrospective (Post-Service) review is conducted by the CCCs or the SWHP Claims RN(s) as needed on cases that have been missed during the inpatient or concurrent review.

When retrospective (Post-Service) review is performed, the review will be based upon written screening criteria (e.g., SWHP Screening Criteria - InterQual[®] and/or internally-developed criteria through SWHP TAC and/or through specialty input on criteria to support the Plan's policies and procedures) established and annually updated with appropriate involvement from Practitioners (practicing physicians) and other health care providers as appropriate.

The CCCs or the SWHP Claims RN(s) will review any potential issues with regard to medical

necessity or appropriateness and/or to determine the experimental or investigational nature of the requested health care treatments or services with the Plan Medical Director(s). No denials are ever issued without Medical Director review and approval [TIC 4201.001(1) and (13)]. If any denial is issued, appeal rights are provided to both the Member and the Practitioner or Provider per the requirements of the Texas Department of Insurance (TDI).

Additionally, some retrospective review(s) may be conducted to collect data for health/medical care evaluation studies and are not related to the payment of claims.

VIII. Discharge Planning

Discharge Planning shall be initiated early during the hospital stay to facilitate effective continuing care outside the inpatient hospital/facility setting. Discharge planning shall occur under the general supervision of the SWHP Primary Care and/or Attending Practitioner through the hospital/facility discharge coordinators (e.g., registered discharge planning nurses, Social Workers, Nurse Clinicians and/or Practitioners, etc.). The CCC will monitor all cases under concurrent review to insure discharge planning has been initiated and is progressing satisfactorily. The CCC **shall** work as part of the multi-disciplinary team and/or independently as needed to address individual Member discharge planning needs, and will provide updated input regarding SWHP contractual provisions and constraints, including, but not limited to, Member eligibility verification, DME coverage, home care coverage, skilled nursing facility (SNF) coverage, home IV coverage, medication coverage, and current balance regarding annual service allotments. The SWHP CCC is charged to promote cooperation and collaboration among all health care professionals involved in discharge planning activities and to bring issues with regard to out-of-contract coverage requests to the SWHP Medical Director(s) for review and Member coverage determination(s). Discharge planning shall include an assessment of the patient/Member's needs, including but not limited to, the following:

- A. Prior health status of the Member;
- B. Current level of care required;
- C. Projected time frame for moving the Member to the next level of care;
- D. Identification of therapy and education that must be accomplished prior to discharge and appropriate referrals are made;
- E. Available resources for post-hospital level of care;
- F. Mechanisms for facilitating transfers to other levels of care;
- G. Potential referrals to Case Guidance and/or Disease State Management programs.

IX. Inpatient Hospital/Facility Readmission Review

Case reviews for Members who are readmitted to a hospital and/or inpatient facility within 31 days of a previous hospitalization are reviewed according to the concurrent hospitalization review processes noted above, but with a focus toward documenting any potential quality

indicators that may have led to the readmission. These cases are highlighted at case reviews/rounds with the Plan Medical Directors.

X. Inpatient Hospital/Facility Continued Stay Authorization

Continued stay reviews occur through the inpatient concurrent review process noted above and prior to the end of the LOS that has been provided. If there is a question of the case meeting SWHP Screening Criteria [InterQual[®] Criteria] for an extension of the LOS, the CCC will attempt to discuss and document the case details with the Attending Physician and/or designee. Approvals for continued stay are transmitted within 24 hours of the related concurrent review. The Attending Practitioner is notified by the CCC that they can access the Plan Medical Directors to discuss issues with any potential or apparent adverse determination that may be in process and/or to make requests for out-of-contract coverage consideration for any potential non-covered benefits. If a denial is to be issued, SWHP gives a verbal notice to the Member (if determined stable to receive the notice per the Attending Practitioner), the Attending Practitioner and/or designee and the Hospital/Facility as quickly as possible, but no later than 24 hours for Commercial and Self-funded Members, as to the date/time of non-coverage for ongoing services. Written notification of non-coverage for a continued stay follows the verbal notice within three (3) calendar days. Both notifications for Commercial and fully-funded Members will contain an option for expedited complaint/appeal processes and the IRO process if the denial is due to medical necessity and/or appropriateness and/or a determination of the experimental or investigational nature of the requested health care treatments or services [TIC 4201.001(1) and (13)]. For SeniorCare Members, SWHP provides a required verbal and written three (3)-calendar day notice of potential non-coverage per CMS regulations and includes expedited appeal (reconsideration) rights.

XI. Focused Reviews

Focused review is a process used when an analysis of an area of inappropriate utilization is suspected. As determined by the Management team, under the direction of the CMO and/or Plan Medical Director(s) and the SWHP Board-designated Committees, these areas may include a particular diagnosis, procedure, Practitioner or department, or any problem affecting patient/Member care. Practitioner or department focused review may be identified by the Medical Services Associate Vice President and/or the Plan Medical Director(s) from the routine utilization review process and statistics, Utilization Guidance Committee activities, consistently high LOS, hospital costs, occurrence screens, or other utilization data. Focused review shall also serve to identify classes of admissions requiring more or less scrutiny than usual, and the CCD shall present its recommendations for changing applicable criteria. Focused review may be concurrent, retrospective, or a combination and may be conducted by the CCC's, the QI Coordinator or designee, and/or the Medical Director(s).

XII. Preauthorization Reviews

If SWHP requires a preauthorization as a condition of payment to a contracted provider, then SWHP complies with all TDI regulations. Preauthorization requirements are available on the SWHP website (www.swhp.org), in the Provider Manual and are provided within 10 days upon any request of a contracted provider.

If the proposed medical care or health care services involves inpatient care, SWHP shall review the request and, if approved, issue a LOS for the admission to the health care facility based on the recommendation of the PCP and/or Attending Physician, and whether the Member meets the SWHP Screening Criteria InterQual[®] Criteria and/or internally-developed criteria for indications for hospitalization and/or inpatient treatment. The timeframes of response are addressed in the sections below on UM and Non-UM Timeliness of Determinations.

XIII. Lack of Information Impact in the Review Process

When a case request and/or concurrent review process is impacted by the inability to obtain any meaningful/significant feedback or clarification from the requesting and/or attending physician/provider to the case, SWHP will not continue to process the request due to the inability to make a coverage determination. The SWHP UM nurse(s) will contact the Medical Director(s) and forward the case to the SWHP Medical Director(s) in the UM/CM software with a summary of the attempts to obtain the necessary information within the required regulatory timeframe of response to the request for action by the Medical Director(s) regarding a coverage determination based solely on the information available. SWHP recognizes that inadvertent denials may occur that may not have otherwise occurred had the information been available within the regulatory timeline. Any initial coverage determination/authorization forms received by SWHP Care Coordination Division that do not have the minimum required elements/information to process the request and make a coverage determination will be returned via fax to the requesting physician/provider/facility with a cover sheet that indicates what is required for SWHP to be able to accept and complete the processing of the request.

Identification of Individuals with Special Circumstances

SWHP will provide for flexibility in the application of its screening criteria for utilization review decisions based on individual needs assessment (including individuals with special circumstances) and upon case finding through:

- Utilization review case screenings;
- Case Guidance activities internal to the Plan and/or its delegated entities; and/or
- Case Guidance activities in conjunction with other Members of the multi-disciplinary discharge planning teams;
- Disease state management initiatives;

- Verbal or written contact by the Primary Care Physician (PCP) and/or Attending Practitioner and/or approved SWHP providers; and/or
- Contact from the SWHP Member or their legal guardian/power-of-attorney or Member-designated significant other.
- Committee initiatives (i.e., Utilization, Quality).
- Health Risk Appraisals that may be implemented through Wellness initiatives.

Special circumstances include, but are not limited to, a person who has a disability, acute condition, or life-threatening illness. Factors considered also include, but are not limited to:

- Age;
- Comorbidities;
- Complications;
- Progress of treatment(s);
- Psychosocial situation; and/or
- Home environment, when applicable

SWHP also considers characteristics of the local delivery system available for specific patients, such as:

- Availability of skilled nursing facilities, sub-acute care facilities or home care in the Member's service area to support the patient after hospital discharge;
- Coverage of benefits for skilled nursing facilities, sub-acute care facilities, rehabilitation facilities or home care where needed; and
- Local hospitals' ability to provide all recommended services within the estimated length of stay.

Cases involving identified special circumstances will be reviewed with the SWHP Medical Director(s) at regular physician/reviewer Rounds Meetings weekly and/or as needed more urgently to ensure comprehensive evaluation of Member needs against the terms of the EOC/SPD.

Utilization Review Processes Related to Behavioral Health Services

Scott and White Health Member delegates behavioral health utilization management to Health Integrated, Inc., a NCQA UM certified organization.

Behavioral Health (BH) Practitioner:

The Health Integrated (HI) Medical Director is a physician with a current Texas license without restriction who is Board-certified in Adult Psychiatry. The Health Integrated Medical Director serves as the BH Medical Director responsible for oversight of the behavioral health UM related components of the SWHP UM program per direction of the SWHP Chief Medical Officer (CMO). The BH Medical Director participates in annual review of BH evidence – based screening criteria, assists in review/development of behavioral health related UM policies and processes, participates in UM/CM Rounds Meetings and UM Committee /TAC meetings as required, performs individual case reviews and peer-to-peer discussions to support UM processes.

SWHP does not require as a condition of treatment approval, or for any reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes. SWHP does require submission of medical records as needed to make coverage determinations. SWHP accepts information in the form of summaries and recommendations as deemed appropriate to release by the attending Practitioner/Provider and/or Member to facilitate timely benefit coverage clarifications regarding proposed or ongoing treatment(s).

If further or more explicit details are needed, the HI behavioral health licensed UM reviewer(s) request that the information be provided to the HI Behavioral Health Medical Director and/or to an identified SWHP-approved behavioral health specialist to review and make recommendations to HI Behavioral Health Medical Director regarding coverage of requested services under the terms of the Member's EOC/SPD. Any need for agreement and release of the information on behalf of the Member is handled by their Practitioner/Provider. Any review and approval of new behavioral health treatments or procedures may be referred to the formal SWHP Technology Assessment Committee (TAC) (meeting Membership to include representatives from SWHP-approved behavioral health practitioners/providers) for evaluation and a coverage determination policy recommendation to the Plan.

The HI behavioral health UM staff perform utilization review/case guidance (case management) activities for Members receiving Behavioral Health Services the same as any other Member with any other medical illness/injury utilizing SWHP Screening Criteria (InterQual[®] and internally-developed criteria), but with a special sensitivity to the confidentiality of the Member. Factors considered also include, but are not limited to:

- Age;
- Comorbidities;
- Complications;
- Psychosocial situation; and/or
- Home environment, when applicable;

SWHP also considers characteristics of the local delivery system available for specific patients, such as:

- Availability of behavioral health treatment/facilities in the Member's service area to support the patient after hospital discharge;
- Coverage of benefits for behavioral health treatment/facilities where needed; and
- Local hospitals' ability to provide all recommended services within the estimated length of stay.

Any review and approval of new treatments or procedures may be referred to the formal SWHP TAC (meeting Membership to include representatives from SWHP-approved behavioral health practitioners/providers) for evaluation and a coverage determination policy recommendation to the Plan.

Interactions for benefit clarifications and Case Guidance (CM) activities are with the approval of the treating Practitioner/Provider and generally the Member (and/or parent/guardian if a minor). Treatment Team meetings are only attended to assist with Case Guidance (CM) or discharge planning issues, including coordination of ongoing care if transfers into one system is needed from another. These efforts are to assist in the continuity of care of the Member, who may be identified as a Member with special circumstance. Case status reports for concurrent review/Case Guidance (CM) activities are traditionally limited in a group setting, and are usually performed one-on-one between the assigned nurse CCC and/or Case Manager and the SWHP Medical Director(s).

Triage/Referral Process

SWHP does not provide triage of Members for behavioral health related services. Members have direct access to their behavioral health specialist(s) during business hours and afterhours have Emergency Department access. SWHP PCPs and specialists provide routine initial triage of Members and referral to a SWHP-approved behavioral health/chemical dependency provider. Authorization requests are then submitted to SWHP CCD by the SWHP-approved behavioral health/chemical dependency provider(s) and processed in the SWHP UM/CM software by the HI BH UM reviewer(s) the same as any other case request as noted above. Urgent/emergent services do not require pre-authorization but are paid subject to the terms and limitations of the Member's EOC/SPD. SWHP Medical Directors are available 24/7 for any needed case determinations and/or coverage clarifications with treating Practitioners/Providers.

Evaluation of Service Site/Level of Care

SWHP utilizes InterQual[®] evidence-based criteria for initial review for medical necessity and appropriateness for level of care for behavioral health and chemical dependency treatments. Practitioners/Providers may provide justification for an alternate level of care for consideration

by the Plan Medical Director(s) and always have the right to speak to a Plan Medical Director about treatment plans and potential authorizations. Service sites are determined through Plan credentialing activities and determination as to whether a specific site has the specific services determined to be medically necessary and/or appropriate in a specific case on individual case review between Plan Medical Director(s), delegated behavioral health Medical Director(s)/specialists and the requesting behavioral health Practitioner/Provider.

Utilization Review Processes Related to Medical Services

SWHP does not require as a condition of coverage approval, or for any reason, the observation of a patient's exam, treatment, or procedure. SWHP does require submission of medical records as needed to make coverage determinations for a minimal number of services requiring prior approval. SWHP accepts information in the form of summaries and recommendations as deemed appropriate to release by attending practitioner/provider and/or the Member to facilitate timely benefit coverage clarifications regarding proposed or ongoing treatment. In fact, the majority of primary care services within Plan-approved providers do not require any more than a notification to SWHP to be able to set up the claims shell to facilitate payment upon arrival of the claim at SWHP and without intervention from staff. If further or more explicit details are needed for services requiring prior approval, SWHP CCCs request that the information be provided to the identified SWHP-approved Practitioner/Provider to review and make recommendations to the SWHP Medical Director(s) regarding the coverage under the terms of the Member's EOC/SPD. Any need for agreement and release of the information on behalf of the Member is handled by the attending Practitioner/Provider

Continuity of Care/Transition of Services

The Care Coordination Division UM staff will administer the coverage determinations regarding continuation of services for Members with non-Plan Practitioners/Providers according to the terms and limitations of the EOC/SPD.

If a Practitioner/Provider who has been terminated by SWHP identifies in writing the Members (transitional Members) with special circumstances (i.e., such as disability, acute condition, life-threatening illness, hospitalized at the time of change onto SWHP or is past the 24th week of pregnancy) to the Plan Medical Director(s), an individual case review for a coverage determination will occur. The Plan Medical Director(s) will review the request and its details against the Member's contracted benefits and make a determination. The review will include any required SWHP specialty physician input and/or any negotiated payment parameters for any continued care with a non- Plan Practitioner/Provider during a transition of care situation.

Members (and/or their legal designee) may request assistance in the process of transitioning services into the SWHP-approved Practitioners/Providers through the SWHP Customer Service Coordinators (1-800-321-7947) and/or through the SWHP Care Coordination Division (CCD)

staff (1-888-316-7947) for complex medical situations. Members, or potential transitioning Members, are encouraged to quickly select a Primary Care Physician (PCP) to coordinate their care and arrange for any needed notifications/referrals within Plan Practitioners/Providers according to the medical necessity/urgency of their care if their EOC/SPD requires a PCP designation. Requests for any continued out-of-network services are required to be sent to SWHP CCD. The request may be forwarded by the specialist, but can also be facilitated by the SWHP PCP, to the CCD, which will allow for the smoothest transition. Product-specific forms have been developed for web access that can be used to fax the information to the SWHP Customer Services Department for assistance in obtaining a Plan PCP (if required) and getting advance notification of a need for assistance in coordination of care to the CCD and/or its delegated staff.

Patients Currently Receiving Inpatient Care in a Non-network Hospital

Patients that are currently receiving inpatient care at the time of their effective date on Scott and White Health Plan (SWHP) need to have SWHP Care Coordination Division (CCD) notified of their admission/facility as soon as possible upon active Membership (if not before for coordination of care as described above). A nurse CCC will contact the facility/Practitioner for an update on the Member's status and inquire as to medical stability for transfer into the SWHP-approved system of Practitioners/Providers (if required by the EOC/SPD and/or is the Member's preference). Information on the status and medical stability for transfer will be relayed to the SWHP-approved Practitioners/Providers/Facility for ability to accept transfer and to receive their clinical recommendation as to whether to leave the Member for continued care until the next level of care is required and /or whether to arrange for transfer if the Member's attending Practitioner/Provider and the SWHP-approved Practitioner/Provider agree the Member is stable for a transfer. All information will be provided to the Plan Medical Director(s) for a SWHP coverage determination and action agreement. The CCC will proceed as directed in terms of coordinating transfer of care. In no case would transfer be mandated for any patient that the attending Practitioner and/or the SWHP-approved accepting Practitioner do not deem stable for the transfer.

Patients Currently Receiving Outpatient Services with Non-Member Providers

Patients currently receiving outpatient services would be handled as previously described in the transition of care process for continuity of care noted above. If transition of care is required, depending on the medical situation of the individual Member, a SWHP Medical Director may review the situation and approve a limited number of visits with the existing non-network Practitioner/provider while care is in the process of transition back into the SWHP-approved provider network system. Otherwise, Members are required to receive services within the Plan if they are available in order to receive coverage from SWHP.

Case Guidance/Disease Guidance

SWHP Utilization Guidance coordinates with Care Guidance programs through internally developed triggers via routing through the SWHP systems for review as to the appropriateness for entry into either Program. SWHP employs multiple methods and tools to enable the earliest possible identification of Members who would benefit most from the CM/DM Programs. Separate policies and program descriptions for complex case management and disease management provide further details.

Confidentiality

SWHP preserves the confidentiality of individual medical records and information, in accordance with Federal and State statutes. SWHP does not disclose or publish individual medical records, personal information, or other confidential information without the Member's written consent or specific legal authority. If there is an urgent/emergent situation, the only mechanism of release may be an initial verbal authorization (witnessed by at least one additional CCD UM review staff in addition to the UM nurse) from a Member to allow conversation with another party regarding UM issues; medical care and/or services; discharge Members; case and/or disease management plans. SWHP staff will follow legal standards concerning who they may speak with about the Member to discuss issues if the Member is rendered unable to provide verbal and/or written authorization. In cases of guardianship and/or Power of Attorney (POA), the nurse will attempt to have a copy of the documents faxed to SWHP for file documentation prior to discussions regarding the Member.

If authorization for the release of confidential information is submitted by anyone other than the individual who is the subject of the personal or confidential information requested, such authorization must be dated and contain the signature of the enrollee whose information is to be disclosed and this signature must be within the year prior to the date of the disclosure request.

Member identifiable medical information will not be shared with employers.

SWHP may permit the use of personal health information (PHI) for treatment, payment or health care operation needs including, but not limited to: treatment; coordination of care (UM/CM/DM); quality assessment/measurement; accreditation; billing/claims issues; and research.

All staff in the Care Coordination Division (CCD) will have the confidentiality policy/practice covered at the organizational and department level orientations.

SWHP will provide prior written notice to a Practitioner or health care provider when publishing data, including quality review studies or performance tracking data which identifies a particular Practitioner or health care provider.

The CCD Assistant Vice President/Managers (and/or designee) will identify any confidentiality issues and report them to the Quality Improvement Director (or designee), who will routinely compile a report for the SWHP Administrative Subcommittee's consideration and oversight of compliance to confidentiality policy and procedures.

Use of Specialist Consultants

SWHP utilizes physician consultants from appropriate specialty areas of medicine and surgery, including psychiatry/psychology. Greater than 850 consultants representing the specialties are available in the S&W multi-specialty group practice and network providers. All consultants are board-certified by one of the recognized boards of the American Board of Medical Specialties or an American Osteopathic Association (AOA) recognized specialty.

Upon request and direction of the Chief Medical Officer and/or Plan Medical Director(s) Board-certified consultant(s) may assist in review of individual cases. Consultants may be contacted by phone, fax or email by SWHP UM licensed clinical staff in order to obtain specialty review of individual cases. UM staff provides clinical information as available to the physician consultant to support the requested specialty review.

Examples of situations in which Plan Medical Directors may direct UM nurses to obtain specialty review may include but are not limited to: cases that do not meet the Member's established medical necessity criteria and may potentially result in an adverse determination by the Plan Medical Director, cases involving Member's with special circumstances, other medically complex cases or cases in which there is concern over availability of contracted local delivery system to provide the requested medical services, etc. Consultants may provide their feedback via fax, phone or email depending on the urgency of the case review.

SWHP Medical Directors may also utilize Board-certified consultants to participate in peer review activities, review and assist in the development of practice guidelines, assist in the development of UM screening criteria including Technology Assessment and pharmaceutical reviews, and annual review of UM clinical criteria, etc.

Committees

The CCD is responsible for developing the UM policies and procedures for review and approval by the Plan Medical Director(s) at the direction of the SWHP Board of Directors. UM criteria regarding specific benefit coverage issues for new technology, medical procedures, behavioral health procedures and devices/equipment are submitted through TAC [if appropriate]. Pharmaceuticals are submitted through the Pharmacy and Therapeutics Committee (P&T). Changes to UM Criteria and recommendations made through the TAC are reported through the UM Committee and SWHP Quality Improvement Subcommittee (QIS) for review and

recommendation. If the policy is related to medical necessity/appropriateness and or UM coverage or benefit determinations, the specialty consultant (i.e., psychologist/psychiatrist) and/or primary care provider is requested to participate in the development of the criteria either through cross-functional team Membership and/or through the formal SWHP TAC.

If the issue for policy development is strictly an internal one with regard to administration of the EOC/SPD, the SWHP Medical Director(s) and the Administrative staff participate in a cross-functional team on the issue and/or review and approve the proposed policy, seeking advice of Plan specialists as needed and appropriate. If the issue involves the drugs/biologicals, then the issue is reviewed by the SWHP P&T Committee for recommendations on policy regarding coverage determinations.

Monitoring for underutilization and overutilization is performed through data reviews in the UM Committee, P&T Committee, Quality Improvement Sub-Committee and Credentialing Committee and Sub-Committee.

The oversight of CCD, includes teams of CCC's and support staff (and representatives from other Divisions as appropriate) that draft proposed policies and procedures for review and approval of the Chief Medical Officer, SWHP Medical Director(s) and the Assistant Vice President of CCD (e.g., General Policy and Procedure Committee, Office Support Policy and Procedure Committee, and the MEDecision Alineo & iEXCHANGE Project Teams.) The teams generally meet on a monthly to bimonthly basis; however, all teams can be assembled on an ad hoc basis as needed if the issue is more urgent to resolve.

The Utilization Guidance (UM) Committee meets on a quarterly basis; the SWHP Directors meet on a weekly basis; the SWHP TAC meets on a monthly and/or on an as needed basis, but at a minimum of once per year. All these Committees report through the SWHP QIS.

Coordination with the QI Program

As previously outlined in the types of review activities, the SWHP CCC's collect specific quality indicator data during their UM inpatient case reviews (concurrent, retrospective, focused) for review within the CCD; identify high-risk adverse occurrences; facilitate continuity and coordination of care through discharge planning; provide follow-up of patients in alternative care settings (e.g., home care, SNF, rehabilitation, behavioral health, etc.); assist in ambulatory Care Guidance as part of a multi-disciplinary team; and document patient satisfaction/dissatisfaction with the plan/policies by directing Members/Providers to the Customer and Provider Relations staff so that occurrences can be tracked and trended. Data from Member and Provider complaints is reviewed by the Assistant VP of Care Coordination and Medical Director(s) on a monthly basis and reported to the SWHP QIS on a quarterly basis and to the SWHP QIC as requested/needed due to any significant changes in rates compared with SWHP standards.

Coordination with Credentialing

Utilization information in the form of Primary Care Physician (PCP) and Specialist profiles are obtained through various reporting mechanisms and incorporated into the provider file for re-credentialing review. This data may include, but is not limited to, a PCP index that includes lab, x-ray, and pharmacy cost for the physician's panel of patients, preventive care measures (HEDIS), and complaint/appeal information. The QI Division, under the direction of the Chairman of the SWHP QIC, reports the information to the SWHP Credentials Committee for incorporation into the formal re-credentialing review process.

Coordination with Pharmacy

The SWHP Pharmacy and Therapeutics Committee make the determinations regarding pharmaceutical management processes, policies and procedures that are then operationalized for the Plan. SWHP Pharmacy/Formulary coverage determinations and supporting documentation regarding evaluation and management proposals for those services are reviewed by the SWHP Pharmacy designee (usually a Pharm.D) with the Plan Medical Director, who is the Co-Chairman for the Pharmacy and Therapeutics Committee. The same timeliness standards, documentation requirements, appeal/expedited appeal/IRO/redetermination/reconsideration processes/notifications as outlined for the medical utilization review/case Guidance processes apply for Commercial Members (per TDI requirements), for SeniorCare (per CMS requirements) and for Self Insured Members (per DOL standards) and are followed in the pharmacy review area. Separate documentation, policies and procedures are maintained in the Pharmacy area regarding these specific activities. Pharmaceutical management procedures are reviewed at least annually and updated as new pharmaceutical information becomes available. Appropriate pharmacists and practitioners are involved in both the development and periodic updates of the pharmaceutical management procedures. Annually, and when changes are made, the Plan provides pharmaceutical management procedures to the Plan's practitioners. Exceptions policies and procedures describe processes for making exceptions based on medical necessity; obtaining medical necessity information from prescribing practitioners; using appropriate pharmacists and practitioners to consider the exception requests; and timely request handling. File audits to document timeliness of reviews and notifications are included in the quarterly and/or semiannual audits that are performed in the CCD.

Use of Criteria

SWHP uses InterQual[®] evidence - based criteria as the base for indications for hospitalization and treatment (acuity criteria) in conjunction with SWHP internally developed target LOS criteria. These criteria are reviewed and approved by the Scott and White Clinic

Division/Departmental Practitioner Director(s) and SWHP network Practitioner representation. The Practitioner (physician) Division Director(s) review them with the medical staff and provide input back to SWHP during the development/review process on an annual basis in terms of a recommended LOS for a service and/or acceptance of the established norm.

Where criteria has not previously been established by SWHP through the use of InterQual[®] criteria, formal Technology Assessment process or criteria developed through internal multi-disciplinary teams with SWHP-approved specialist input for policy and procedure clarifications for use in preauthorization/authorization processes, SWHP utilizes CMS's criteria as the base of coverage determinations.

Additionally, SWHP Medical Director(s) may perform literature reviews, participate in peer-to-peer individual case discussions, and /or direct CCC UM staff to obtain specialty review by a SWHP-approved board-certified physician(s)/specialist(s) to facilitate UM review process in cases in which clinical criteria is not met or is not available for requested treatment(s).

The UM Program Description with the target LOS is reviewed by the SWHP UM Committee and approved by the SWHP QIS as a SWHP Board-appointed Committee. It is reviewed and revised/approved on an annual basis per policy/procedure. The initial review/revision of the document will be performed by the CCD with oversight from the SWHP Chief Medical Officer and Plan Medical Director(s). The criteria are then formally presented to the UM Committee and then forwarded to any Board-appointed committees as appropriate, with final approval through SWHP QIS. Review of clinical criteria/UM related policy is available to practitioners/providers via phone, fax, secure email, mail or through SWHP onsite review upon request to the Assistant Vice president of CCD. The Health Care Management Guidelines (Target LOS) and TAC or internally-developed criteria is also provided in the Provider Manual online at www.swhp.org under the "Providers" tab. It is also highlighted in the Provider Newsletter as additions, deletions, or revisions are made, with target LOS published annually. Practitioners/Providers are advised of whom they may contact in the CCD for more information verbally, or in writing. SWHP CCCs may read the criteria to Practitioners/Providers telephonically during the course of a case review to assist in better understanding of the medical necessity documentation being sought in the review process. SWHP strives to maintain a collegial/advisor role with practitioners/providers.

Note: UM decision-making is based only on appropriateness of care and service. SWHP does not compensate/reward Practitioners or other individuals conducting utilization review for denials of coverage or service. There are no financial incentives to encourage denials of coverage or service.

Utilization Decisions

I. Consistency of Application

Application of criteria used by the CCC UM reviewers is assessed at the time of scheduled patient/Member “Rounds” with the Plan Medical Director(s) and Assistant Vice President of CCD weekly. Record of attendance and an outline of topics of discussion are maintained at each meeting. Additionally, UM Managers review on-line work in the Division’s UM software that the CCC UM reviewers utilize for their work on a daily basis, which includes InterQual[®] evidence-based medicine review criteria to standardize the review process for medical necessity and/or appropriateness and/or a determination of the experimental or investigational nature of requested health care services [TIC 4201.001(1) and (13)]. Additionally, UM Managers review on-line work in the Division’s UM software that the CCC UM reviewers utilize for their work on a daily basis, which includes InterQual[®] evidence-based medicine review criteria to standardize the review process for medical necessity and/or appropriateness. Any errors or exceptions are noted at that time, and the CCC UM reviewer is counseled as to how to correct the information or system documentation or record information for the future. Also, the Assistant Vice president of CCD, SWHP Medical Directors and UM Managers review issues to facilitate discussion and identify ambiguities in the criteria among all the CCCs during a monthly staff meeting. The purpose is to facilitate consistent UM decision making and correct inconsistent application of the criteria.

Inter-rater reliability testing is performed (at a minimum) biannually for licensed professional UM clinical staff (nurses and physician Medical Directors) for both outpatient and inpatient case review scenarios as per CCD policy and procedure. Inter-rater reliability testing results are individually scored. Blinded results are provided to the UM staff and a group discussion is conducted with both UM staff and UM Management participation. Inconsistencies and actions taken to correct any significant problems identified related to consistent application of criteria will be reported to the SWHP UM Committee, the SWHP Administrative Committees, and SWHP QIS as needed, but at a minimum of annually during the UM Program evaluation.

II. Timeliness of UM Decision Making

Standards for time frames for decision making on the basic types of case reviews received within the Division have been established to minimize any disruption in the provision of health care to SWHP Members. By Texas Department of Insurance (TDI) definitions, UM refers only to those determinations based upon medical necessity or appropriateness and/or a determination of experimental/investigational nature of requested treatments or services [TIC 4201.001(1) and (13) and do not include decisions

based upon other contractual (i.e., benefit or administrative) issues. Formulary requests are sent directly to the Pharm.D and the SWHP Medical Director that is the Co-Chair of the SWHP P&T Committee for review and answer according to Plan standards. The standards for all types of case reviews are as outlined below:

**Note: For all UM and benefit determinations regarding Commercial Members, SWHP uses TDI timeframes to ensure timeliness of decision-making by UM staff. For Self Insured Members, SWHP uses Department of Labor timeframes for UM decision-making. For SeniorCare Members, SWHP uses Centers for Medicare and Medicaid (CMS) timeframes for UM decision-making.*

Preauthorization Reviews

All routine preauthorization case requests will have a determination issued and transmitted no later than three (3) calendar days after the date the request is received. If the request is received outside of the period requiring the availability of appropriate personnel (6AM-6PM, Monday – Friday on each day not a legal holiday and between 9AM –12N on Saturday, Sunday and legal Holidays), the determination will be issued and transmitted by SWHP within three (3) calendar days from the beginning of the next time period requiring such personnel.

If the proposed medical or health care services are for concurrent hospitalization care, SWHP issues and transmits a verbal determination indicating whether a proposed service is preauthorized within 24 hours of receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel (6AM-6PM CST, Monday – Friday on each day not a legal holiday and between 9AM –12N on Saturday, Sunday and legal Holidays), SWHP will issue and transmit a verbal determination within 24 hours from the beginning of the next time period requiring such personnel.

If the proposed medical care or health care services involves post-stabilization treatment, or a life-threatening condition, SWHP will issue and transmit a verbal determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no case to exceed one (1) hour from the receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel (6AM-6PM CST, Monday – Friday on each day not a legal holiday and between 9AM –12N on Saturday, Sunday and legal Holidays), the determination will be issued and transmitted within one (1) hour from the beginning of the next time period requiring such personnel. In such circumstances, the determination will be provided to the treating physician or provider. If the determination is an adverse determination in response to a request for post-stabilization treatment of a request involving a life-threatening condition, SWHP will provide the enrollee or person acting on behalf of the enrollee, and the enrollee's provider of record, the required notification. The written notification to the Practitioner/Provider will be provided within three (3) calendar days of receipt of the request.

SWHP's toll free numbers (main and CCD) are covered through the S&W system operators taking the calls from those numbers after routine business hours and paging the SWHP nurse CCC on-call to discuss any preauthorization and/or case Guidance issues with physicians/providers as needed and to obtain any needed Medical Director determinations, as no denials are issued without the Plan Medical Directors agreement and authorization. All calls are acknowledged usually within 1 hour of the call and/or no later than within 24 hours from the time of the call.

Once a preauthorization for medical care or services has been provided by SWHP to the physician/facility/provider, SWHP will not deny or reduce the coverage payment to the party for those services based on medical necessity or appropriateness of care and/or a determination of experimental/investigational nature of requested treatments or services [TIC 4201.001(1) and (13) unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the preauthorized medical or health care services.

[For SeniorCare and Self Insured Members for "Pre-Service Medical Necessity Determinations", SWHP will make the determination within 72 hours of receipt of the request. However, if necessary information is missing from the request, SWHP will notify the Member or their legal representative within 24 hours of receiving the request to specify what information is needed to make the determination. This information must be supplied by the Member and/or their representative or physician within 24 hours after receiving the notice. SWHP will then inform the Member/Practitioner of the determination within 24 hours after a response is received to the notice. The notice will be made verbally and followed within 3 days by written or electronic notice. If the Member or their representative/Practitioner fails to follow SWHP's procedures for requesting a pre-service determination, SWHP will notify them of the failure and describe the proper procedures for filing within 24 hours of receiving the request. This notice may be provided only orally unless a Member or their representative or Practitioner requests written notification.]

Emergent Case Review

All cases will have a decision by the Plan Medical Director(s), Assistant Vice president of CCD, and/or CCC within one (1) working day. Approvals, by the nature of the case, will have verbal notifications (or email behind the S&W firewall) within one (1) working day of receipt.

[EXCEPTION: If written notice can be generated and faxed to the Member and/or Practitioner/Provider within one (1) working day of the receipt of the request, then no "verbal" notice will be required.] Written documentation for approvals will follow within three (3) working days by regular mail. [For SeniorCare and Self Insured Members, SWHP will make the determination within 72 hours of receipt of the request. However, if necessary information is missing from the request, SWHP will notify the Member or their legal representative within 24

hours of receiving the request to specify what information is needed to make the determination. This information must be supplied by the Member and/or their representative or Practitioner within 24 hours after receiving the notice. SWHP will then inform the Member/Practitioner of the determination within 24 hours after a response is received to the notice. The notice will be made verbally and followed within 3 days by written or electronic notice. If the Member or their representative/Practitioner fails to follow SWHP's procedures for requesting a determination, SWHP will notify them of the failure and describe the proper procedures for filing within 24 hours of receiving the request. This notice may be provided only orally unless a Member or their representative or Practitioner requests written notification.]

All case denials will require verbal notifications ASAP but no later than within one (1) working day of the receipt of the request. All denials will be called to all Members and/or their legal representative. Practitioners/Providers will receive verbal notice (or email if behind the S&W firewall) ASAP but not later than one (1) working day of the receipt of the request. All verbal notifications will include all regulatory requirements of TDI for denial notices, including access to complaint/appeal processes (expedited if appropriate) and the IRO process (expedited if appropriate). [SeniorCare Members receive notice of grievance/appeal (reconsideration) rights. Self Insured Members will receive their appeal rights per Department of Labor standards and regulations.]

All case denials will have written notices sent to Members/Practitioners within three (3) working days of the receipt of the request and the notice will contain all required regulatory items required by TDI. Denial letters will be sent to Members by regular mail. [SeniorCare Member notices of potential non-coverage will be sent via certified mail with a return receipt requested. Self Insured Members will receive their appeal rights per Department of Labor standards and regulations.]

Any referrals to the Emergency Room (ER) by Practitioners, SWHP *VitalCare* nurse advice line nurses, physicians or their designees, or the SWHP CCCs will be paid by the Plan less any required copayments. ER post-stabilization coverage determinations are made within one (1) hour of the receipt of the call from the ER or the provider of service. SWHP covers emergency services necessary to screen and stabilize Members without precertification in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

Urgent Case Review

It is noted that the majority of determinations made by SWHP are related to benefit coverage interpretations according to the EOC and/or SPD and do not involve issues of medical necessity or appropriateness. Other decisions about medical necessity or appropriateness and/or a determination of experimental/investigational nature of requested treatments or services [TIC 4201.001(1) and (13)] are made by the SWHP Medical Directors with input from the treating

clinical Practitioners as appropriate. SWHP benefit determinations are related to payment for care or services based upon input from the Practitioner/Provider and according to the terms of the benefit contract.

SWHP defines “Urgent Care” Case Authorization Reviews to mean determinations for services provided for the immediate treatment of a medical condition that requires prompt medical attention, but where a brief time lapse before receiving services will not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion and breathing difficulties other than those of a sudden onset and persistent severity. An individual Member’s “urgent” condition may be determined “emergent” upon evaluation by a participating provider. SWHP notes that it does not routinely require authorization (or preauthorization) through the Care Coordination Division for urgent/emergent care inpatient or outpatient under the prudent layperson definition and/or if care is being sought through Plan -approved Providers.

Urgent Outpatient Case Review

For outpatient UM case determinations are made ASAP but no later than two (2) working days of the date of the receipt of the request.

Case approvals will have a written notice issued to the Member and Practitioner/Provider within two (2) working days of the date of the receipt of the request.

Case denials will have written notification to the Member and Practitioner/Provider within three (3) working days of the date of the receipt of the request. (For expedited cases, out of necessity the initial determination may be called or verbally provided with the written notice following.) Denial letters will include all TDI regulatory items required and will be sent by regular mail to the Member and to the Practitioner/Provider.

[For SeniorCare and Self Insured Members, SWHP will make the determination within 72 hours of receipt of the request. However, if necessary information is missing from the request, SWHP will notify the Member or their legal representative within 24 hours of receiving the request to specify what information is needed to make the determination. This information must be supplied by the Member and/or their representative or Practitioner within 48 hours after receiving the notice. SWHP will then inform the Member/Practitioner of the determination within 48 hours after a response is received to the notice. The notice will be made verbally and followed within 3 days by written or electronic notice. If the Member or their representative/physician fails to follow SWHP’s procedures for requesting a determination, SWHP will notify them of the failure and describe the proper procedures for filing within 24 hours of receiving the request. This notice may be provided only orally unless a Member, their representative or Practitioner requests written notification.]

Urgent Inpatient Case Review:

Urgent concurrent approval decisions will be provided verbally within 24 hours. It is noted that initial determinations may be provided verbally to both the Member and the Practitioner/Provider with the written notification following within three (3) working days of the date of the receipt of the request.

For urgent concurrent review denials, decisions will be made within 24 hours of the date of the receipt of the request and provided verbally to the Member and to the Practitioner/Provider (or email if behind the S&W firewall). Verbal notices will be followed by written notification also within three (3) working days of the date of the receipt of the request. Both verbal and written notifications will include all TDI regulatory element requirements. Members will be “held harmless” until notified unless the treatment was not initially approved or authorized.

[For SeniorCare and Self Insured Members, SWHP will make the “concurrent medical necessity determination” within 24 hours of receipt of the request. The notice will be made verbally and followed within 3 days by written or electronic notice.]

Post-Stabilization Care

For requests of coverage due to medical necessity or medical appropriateness involving post-stabilization care and/or services, determinations will be provided within the time appropriate to the circumstances relating to the delivery of the services and condition of the patient but will not exceed one (1) hour from the point of notification by the treating Practitioner/Provider during the emergency. In such circumstances, verbal notification of approvals or denials shall be provided to the treating Practitioner or health care Provider. Written documentation will follow to the Member and Practitioner/Provider within three (3) working days for approvals if requested. Written notification will be provided within three (3) working days for all denials. All verbal and written denials will include all TDI regulatory element requirements.

Life-Threatening Condition Determinations

For life-threatening conditions, any notification of adverse determination by SWHP will be provided verbally as quickly as possible, but not later than one (1) working day from the receipt of the request. Verbal approvals will only be followed in writing upon specific request. At the time of the notification of any adverse determination, SWHP shall provide the Member (enrollee) or person acting on behalf of the Member, and the Practitioner and/ Provider of record, the independent review notification and the form prescribed by the Commissioner of Insurance for the State of Texas. Written notification of denials will follow within three (3) working days of the receipt of the request. Both the verbal and written notifications will include all TDI regulatory element requirements.

Routine/Elective Case Review

It is noted that the majority of determinations made by SWHP are related to benefit coverage interpretations according to the EOC and/or SPD and do not involve issues of medical necessity or appropriateness. Other decisions about medical necessity or appropriateness are made by the SWHP Medical Directors with input from the treating clinical Practitioners as appropriate. SWHP benefit determinations are related to payment for care or services based upon input from the Practitioner/Provider and according to the terms of the benefit contract.

Initial Outpatient Determination: Decisions regarding the coverage request are made within two (2) working days of the receipt of the request. Approval notifications are given in writing within two (2) working days of the receipt of the request. Denial notifications are given in writing to Member and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioners/Providers within three (3) working days of the receipt of the request and will include all TDI regulatory element requirements. For expedited cases (Members who are hospitalized and/or who develop an urgent situation), out of necessity, the initial decision may have to be verbal within one (1) working day and with the written notification following within three (3) working days. The CCC and/or Medical Director will use their professional judgment as to that process on an individual case review basis.

[For SeniorCare and Self Insured Members, determinations will be made within 14 calendar days of receiving the request. However if more time is needed because SWHP has determined that such extension is needed for reasons beyond SWHP's control, SWHP notifies the Member that such extension is needed prior to the expiration of the initial 14 day period and notes the circumstances requiring the extension of time and the date SWHP expects to render a decision, the determination period may be extended one time for 14 days. Verbal notification and written notification will occur within the timeframes noted.]

Routine/Elective Outpatient Extension Determination: Decisions related to coverage requests for extensions of routine/elective outpatient services are processed in the same manner as any other routine/elective initial outpatient determinations as per the timeframes outlined above.

Initial Inpatient Determination: Decisions regarding the coverage request are made within one (1) working day of receipt of the request for utilization review and provided verbally within that timeframe. The Member and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioner or Provider-of-record is notified in writing within three (3) working days from the date of receipt of the request. At the time of any denial determination, written notifications will be provided within three (3) working days of receipt of the request and will include all TDI regulatory element requirements. [For expedited requests, out of necessity the initial

determinations may have to be verbal as quickly as possible under the one (1) working day timeframe and with the written notice following in three (3) working days.]

Concurrent Inpatient Extension Determination: SWHP performs daily and/or periodic reviews and LOS determinations. SWHP does not routinely notify currently hospitalized Members of approval for continued stay. SWHP will notify the requesting Practitioner within one (1) working day of the request for continued stay extension determination, unless the provider or facility that has a contractual agreement with SWHP that Practitioners are to assume approval in the absence of notification. Written notification of LOS continued stay approvals will be provided to the Member and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioner/Facility/Provider within two (2) working days of receipt of the request and all information necessary to complete the review has been obtained [TIC 4201.302]. The notification process will include all TDI regulatory element requirements.

Benefit denial decisions and verbal notification of Members and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioners/Providers of denial is transmitted within one (1) working day of the receipt of the request to SWHP. The Member and practitioner or provider-of-record are provided written notification within two (2) working days of the date of the receipt of the request and will include all TDI regulatory element requirements. For expedited case situations, out of necessity the initial decision may have to be verbal in less than one (1) working day and with the written notice following within two (2) working days.

Retrospective (Post-Service) Case Review Determination: Decision is made after SWHP receives a request for retrospective (post-service) review for coverage, but no later than thirty (30) calendar days after the original date of receipt of the request. Members and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioners/Providers are notified of the decisions in writing within five (5) working days of the determination, but within the thirty (30)-calendar day timeframe from the original date of receipt of the request to SWHP. Any review resulting in denial includes written notification of the Member and Practitioners/Providers within two (2) working days of the decision and within the original thirty (30) calendar days from the receipt of the request and must provide the IRO option and/or expedited review (if appropriate). All regulatory requirements of TDI for denial notification in this category will apply.

[For SeniorCare and Self Insured Members, if SWHP determines there is a need for additional information to make the determination and provides the Member notification of such need prior to the end of the initial fifteen (15) day period of the post-service review, and notifies the Member of the date anticipated to make the determination, the time period may be extended once for up to fifteen (15) days.]

III. All Other Benefit Coverage Determination Timelines (Non-UM Decisions)

Benefit Determination Reviews: All routine benefit determination case requests will have a determination issued and transmitted no later than three (3) calendar days after the date the request is received.

Emergent Benefit Determination: All case requests will have a decision within one (1) working day of the receipt of the medically emergent request. By the nature of the cases, approval notifications will occur verbally (or by email behind the S&W firewall to Practitioners/Providers). [EXCEPTION: If written notice can be generated and faxed to the Member and/or Practitioner/Provider within one (1) working day of the receipt of the request, then no verbal notice will be required. Written notification (if verbal was provided) will be provided by regular mail within three (3) working days of the receipt of the request.

[For SeniorCare and Self Insured Members, SWHP will make the determination within 72 hours of receipt of the request. However, if necessary information is missing from the request, SWHP will notify the Member or their legal representative within 24 hours of receiving the request to specify what information is needed to make the determination. This information must be supplied by the Member and/or their representative or physician within 48 hours after receiving the notice. SWHP will then inform the Member/Practitioner of the determination within 48 hours after a response is received to the notice. The notice will be made verbally and followed within 3 days by written or electronic notice. If the Member or their representative/Practitioner fails to follow SWHP's procedures for requesting a determination, SWHP will notify them of the failure and describe the proper procedures for filing within 24 hours of receiving the request. This notice may be provided only orally unless a Member or their representative or Practitioner requests written notification.]

All denials within this category require verbal notifications ASAP, but no later than within one (1) working day of the receipt of the request. All denials will be provided verbally to Members (as appropriate to their medical condition) and/or their legal representative. Practitioners/Providers will receive verbal notices (or email if behind the S&W firewall) ASAP but no later than one (1) working day from the receipt of the request. Written notification will be sent to Members and Practitioners/Providers within three (3) working days of the receipt of the request and contain all TDI regulatory element requirements [SeniorCare Member notices of potential non-coverage will be sent via certified mail with return receipt requested and will include notice of grievance/appeal (reconsideration) rights. Self Insured Members will receive their appeal rights per the standards and regulations of the DOL.]

Urgent Outpatient Benefit Determinations

SWHP defines "Urgent Care" Case Authorization Reviews to mean determinations for services provided for the immediate treatment of a medical condition that requires prompt medical

attention, but where a brief time lapse before receiving services will not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion and breathing difficulties other than those of a sudden onset and persistent severity. An individual Member's "urgent" condition may be determined "emergent" upon evaluation by a participating provider. SWHP notes that it does not routinely require authorization (or preauthorization) through the Care Coordination Division for urgent/emergent care inpatient or outpatient under the prudent layperson definition and/or if care is being sought through Member-approved providers.

Approval determinations will have written notifications provided to Members and Practitioners/Providers within two (2) working days after the receipt of a request.

[For SeniorCare and Self-Insured Members, notification will be within 72 hours of the receipt of the request.]

Denial determinations will have written notifications provided to Members and Practitioners/Providers within three (3) working days after the receipt of a request. [For SeniorCare and Self Insured Members, notification will occur within 72 hours of receipt of the request.]

For expedited cases, out of necessity the initial determination may be provided verbally as quickly as possible with the written notice following within the original two (2) working days from the receipt of the request.

[For SeniorCare and Self Insured Members, SWHP will make the determination within 72 hours of receipt of the request. However, if necessary information is missing from the request, SWHP will notify the Member or their legal representative within 24 hours of receiving the request to specify what information is needed to make the determination. This information must be supplied by the Member and/or their representative or Practitioner within 48 hours after receiving the notice. SWHP will then inform the Member/Practitioner of the determination within 48 hours after a response is received to the notice. The notice will be made verbally and followed within 3 days by written or electronic notice. If the Member or their representative/Practitioner fails to follow SWHP's procedures for requesting a determination, SWHP will notify them of the failure and describe the proper procedures for filing within 24 hours of receiving the request. This notice may be provided only orally unless a Member or their representative or Practitioner requests written notification.]

Concurrent Inpatient Extension Benefit Determinations

Urgent concurrent approval and denial decisions will be provided verbally within 24 hours of receipt of the request. It is noted out of necessity that the initial determinations may have to be provided verbally to both the Member and the Practitioner/Provider, with the written notification following within three (3) working days.

[For SeniorCare and Self-Insured Members, urgent concurrent approval decisions will be provided orally (or by email behind the S&W firewall) within 24 hours if the request is received within 24 hours of the authorization expiring. [EXCEPTION: If the written notice can be generated and faxed to the Member and/or Practitioner/Provider, then it can serve in place of the verbal notice.] For expedited cases, out of necessity the initial decision may have to be provided verbally in less than the 24-hour timeframe and with the written notice following within three (3) working days.

Post-Stabilization Care Benefit Determinations

All contacts to SWHP regarding a coverage determination on post-stabilization care will be returned verbally within 1 hour with a determination per TDI regulatory requirements.

For post-stabilization denials only, written notification will be provided to the Member and Practitioner/Provider within three (3) working days from the receipt of the request and will include all TDI regulatory element requirements. For expedited cases, out of necessity the initial decision may have to be provided verbally with the written notice following within three (3) working days.

“Life-Threatening” Care Benefit Denials

Decision and verbal notification to Member (if medically appropriate) and Practitioner/Provider is provided within one (1) working day of the receipt of the request. Written notification follows within three (3) working days of the receipt of the request. Both verbal and written notifications will include all TDI regulatory element requirements.

Routine Initial Outpatient Benefit Determinations

All determinations are made within two (2) working days of the receipt of the request.

Approval notifications are provided in writing to Members and Practitioners/Providers within two (2) working days of the receipt of the request.

Denial notifications are provided in writing to Members and Practitioners/Providers within three (3) working days of the receipt of the request. For expedited cases, out of necessity the initial decision may have to be provided verbally as quickly as possible with the written notice following within three (3) working days. All denial notifications will include all TDI regulatory element requirements.

[For SeniorCare and Self Insured Members, SWHP may extend one time for up to fourteen (14) calendar days if the Plan is unable to make a determination due to matters beyond its control. The Member (or their representative) must be notified in writing of the need for an extension and a date by which the Plan will make the decision. If SWHP can't make a decision due to lack of medical information, CCD will notify the Member (or their representative) of what specific information is necessary to make the decision within the initial fourteen (14) calendar days of the

receipt of the request. SWHP will give them fourteen additional calendar days to provide the specified information. The time period is suspended from the date of notification to the above noted parties until the earlier of:

- Date SWHP receives a response, whether or not all the information is provided, or
- The end of the fourteen (14) day period.

SWHP may deny the request if it doesn't receive the information that is needed to make the decision in this time frame. Verbal and written denial notifications will be made and will include all TDI regulatory element requirements.

Routine/Elective Outpatient Extension Determination:

Decisions related to coverage requests for extensions of routine/elective outpatient services are processed in the same manner as any other routine/elective initial outpatient determinations as per the timeframes outlined above.

Initial Inpatient Benefit Determinations

Determinations will be provided verbally within one (1) working day of the receipt of the request. Written notification will follow within three (3) working days of receipt of the request. Both the Member and the Practitioner/Provider will be notified of all denials verbally and in writing, and both will include all TDI regulatory element requirements.

Concurrent Inpatient Extension Benefit Determinations

SWHP performs daily and/or periodic reviews and LOS determinations. SWHP does not routinely notify currently hospitalized Members of approval for continued stay. SWHP will notify the requesting Practitioner within one (1) working day of the request for continued stay extension determination unless the practitioner/provider or facility that has a contractual agreement with SWHP that Practitioners are to assume approval in the absence of notification. LOS approvals will be transmitted within three (3) working days to the Member and Practitioner/Facility/Provider.

Denial decisions and verbal notification to Members and Practitioners/Providers is made within one (1) working day of the receipt of the request to SWHP. The Member and practitioner or provider-of-record are notified within three (3) working days of the receipt of the request and will include all TDI regulatory element requirements. For expedited case situations, out of necessity the initial decision may have to be provided verbally in less than one (1) working day and with the written notice following within three (3) working days.

Retrospective (Post-Service) Benefit Determinations: Decision is made after SWHP receives a request for retrospective (post-service) review for coverage, but no later than thirty (30) calendar days after the original date of receipt of the request. Members and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioners/Providers are notified of the decisions in writing within five (5) working days of the determination, but within the thirty (30) day timeframe from the original date of receipt of the request to SWHP. Any review resulting in denial includes written notification of the Member and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioners/Providers within two (2) working days of the decision and within the original thirty (30) days from the receipt of the request and must provide the IRO option and/or expedited review (if appropriate). All regulatory requirements of TDI for denial notification in this category will apply.

[For SeniorCare and Self Insured Members, if SWHP determines there is a need for additional information to make the determination and provides the Member notification of such need prior to the end of the initial fourteen (14) day period of the post-service review, and notifies the Member of the date anticipated to make the determination, the time period may be extended once for up to fourteen (14) days.]

IV. Availability of Medical Directors for Assistance in Case Determinations

It is the policy of SWHP to have availability of Medical Directors 24 hours/day, seven days/week to handle urgent/emergent medical necessity determinations for both inpatient and outpatient Members, Members requiring post-stabilization determinations, and the Practitioners or providers of record within one (1) hour to one (1) working day per the requirements of TDI. This availability will be in person or via beeper/telephone.

For routine outpatient case determinations only, the Medical Directors will also be available electronically (electronic mail or UM software) for contact by the nurse CCCs/delegated UM Staff during routine business hours. When communications with the Medical Directors is occurring by electronic means, it is expected that the response will be within 24 hours. For any period where electronic communication is not possible, SWHP Medical Directors will give explicit alternate instructions for communication.

V. Denials (Adverse Determinations and Non-UM Determinations)

The Medical Director(s) review all potential denials. Practitioners/Providers requesting services may be contacted by the Medical Directors, Assistant Vice president of CCD, Utilization Managers or CCCs for additional information or to discuss alternatives to care. Members and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioners/Providers receive written notification of all denials. Denial notifications include the specific reason (principal reason) for the denial (in easily understandable language and the appeal mechanism. SWHP provides access for Practitioners/Providers at all times to the SWHP Medical Director(s) to

discuss by telephone and/or in person determinations based upon medical necessity and/or appropriateness and/or determinations of the potential investigational or experimental nature of proposed treatments or services [TIC 4201.001(1) and (13)], including the right to expedited appeals to the SWHP Appeal Panel and/or an Independent Review Organization (IRO) per Texas Department of Insurance (TDI) regulations for the fully insured Commercial Members. [For SeniorCare and Self Insured Members, processes will be followed as outlined in the respective EOC and/or SPD with regard to CMS and/or DOL standards and regulations.] SWHP has a very limited number of denials usually required to be issued. SWHP sends written notification to Members SWHP sends written notification to Members and/or person acting on behalf of the enrollee [TIC 4201.301] and Practitioners/Providers (as appropriate) of the reason for each denial, including the specific utilization review criteria or benefits provisions used in the determinations, Board-certification specialty of Member Medical Director and Board-certified specialty of specialty physician reviewer (if applicable). All verbal and written denial notifications include appeal rights/expedited appeal rights/IRO options as required by State (and/or federal, as appropriate to the product) regulations. UM determinations are based only on appropriateness of care and service under the terms of the Member's EOC or SPD.

SWHP does not compensate/reward (financially or otherwise) Practitioners/Providers or other individuals conducting utilization review for denials of coverage or service. Annual notice is provided to both Members and Practitioners/Providers of the ability to request copies of SWHP criteria used for coverage determinations of medical necessity and appropriateness.

VI. Appeals

Members and Practitioners/Providers may appeal denial decisions through the Customer Service Department or through the CCD's Dispute Resolution Department. The process for Complaints and Appeals for Members is outlined in the SWHP EOCs and/or Self Insured Employer Group SPD. Provider Appeal rights are located in the Provider Manual. The EOCs/SPDs with the Complaint/Appeal Rights are also available for Members and Practitioners/Providers online through the Member and Provider portals located on the SWHP website at www.swhp.org

There is an avenue for expedited appeals initiated by the Member (and/or by the Practitioner/Provider acting on behalf of the Member) and/or to respond to requests for Independent Review Organization case review/determination if the decision involves a denial for UM determinations (i.e., medical necessity and/or appropriateness denials). Expedited appeals for non-UM determinations are processed through the same intake process in the Customer Service Department and a Plan Medical Director makes the determination as to whether the request qualifies for an expedited process. There are supporting policies and procedures within the CCD. No limits are placed by the Member on the timeframe to be able to file a complaint/appeal unless outlined specifically in the Member's EOC/SPD.

SWHP makes any requested/Medical Director-approved expedited appeal decision utilizing a different Medical Director than the one making the initial determination and notifies the Member and Practitioner(s)/Provider(s) verbally as expeditiously as the medical condition requires, but no later than one (1) working day from the date that all information necessary to complete the appeal is received. SWHP provides written confirmation of its decisions as quickly as possible but within three (3) calendar days of providing verbal notification of the decision (and within three calendar days of the receipt of the original request by the Plan).

Complaint/Appeal data is tracked and trended by the SWHP on a monthly basis and reported to the SWHP QIS on a quarterly basis. Because of the integrated complaint/appeal process in the system/ Plan that includes UM as a category, the CCD does not track/trend UM complaints separately from the staff performing this function and who are already reporting to QIS.

VII. Evaluation of Medical Technology and Procedures

SWHP and ICSW have a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in the benefit package to keep pace with changes and to ensure that Members have equitable access to safe and effective care. An internal system TAC evaluates the efficacy, safety, and cost effectiveness of new or currently uncovered medical procedures or treatments (i.e., medical technologies; behavioral health procedures; pharmaceuticals; devices/equipment; etc.) for consideration of coverage by the Plan.

The standing committee is co-chaired by a SWHP Medical Director, S&W Health Care Chief Medical Officer, and includes but is not limited to: SWHP Medical Directors, SWHP Health Services Director, S&W Health Care systems Medical Directors; System large department physician Chairs, System finance representatives, Quality and Safety representatives, Pharmacists, System Materials Management leadership, and other Hospital/Clinic leadership.

The clinic department whose specialty is most directly involved in the technology under review will collaborate on an analysis of the literature with SWHP resources as available (i.e., Hayes Technology Assessment reports), complete a comprehensive financial analysis and a Failure Mode and Effect Analysis (FMEA) tool (as applicable to the issue under review).

Recommendations from the SWHP TAC are then forwarded to the SWHP /Utilization Guidance Committee and the SWHP QIS for review and approval. A summary of the recommendations is provided to the SWHP Board-appointed QIC for their review and final approval. The findings and recommendations of the SWHP TAC Program are also highlighted at the SWHP Administrative Subcommittee (Directors) meetings. Decisions resulting in changes to the UM criteria are developed into policy statements and/or formal policy and procedure documents. The information is disseminated through monthly UM staff (CCC) meetings, Medical Director meetings, and Provider Newsletter, The SWHP Technology Assessment Program Description,

Committee Membership, procedures, and actions are reviewed on an annual basis and as needed for any potential revisions.

Note: Any evaluation of new pharmaceuticals and/or biologicals is deferred for processing through the SWHP Pharmacy and Therapeutics Committee.

VIII. Program Evaluation

Annually the Vice President of Care Coordination, in conjunction with the Chief Medical Officer, evaluates the impact of the UM Program using measurement data including, but not limited to:

- Member complaints;
- Member grievances;
- Member appeals;
- Results of Member satisfaction surveys;
- Provider complaints;
- Provider grievances;
- Provider appeal data;
- Provider satisfaction surveys; and
- UM decision-making time frames statistics;
- Inter-rater reliability testing

The evaluation identifies problems and/or concerns that might limit Member's equitable access to health care and provides recommendations for improvement (as appropriate). Evaluation includes assessments of data to detect and correct potential under-and over-utilization of services, with at least one monitor related to behavioral health. The evaluation is submitted to the SWHP UM Committee, SWHP QIS and any SWHP Board-appointed Committees (as appropriate) for review, action, follow-up, with final approval through the QIS unless otherwise determined by the QIS. Additionally, the UM Program Description is reviewed within the CCD and updated annually or as needed.

APPROVALS:

SWHP Chief Medical Officer

DATE

Attachments: SWHP Health Care Management Guidelines (Target LOS)
SWHP Technology Assessment Program Description