FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

UTILIZATION MANAGEMENT	ASPIREHEALTHPLAN	**Effective Date** 8/3/2020
		Policy # AHP ASO-HS027
	UTILIZATION REVIEW CRITERIA	**Review Date** 1/26/2024
		Applicable to: ☑ Medicare Advantage ☑ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Kellie Verdugo, Utilization Management Director

1.0 PURPOSE

1.1 This policy and procedure addresses how Aspire Health Plan (AHP) utilizes written criteria to determine the appropriateness of medical and pharmacy services. It ensures consistent utilization decisions are made based on sound clinical evidence, and it specifies procedures for applying objective criteria based on medical evidence.

2.0 POLICY

2.1 AHP applies utilization review criteria to make determinations regarding authorization, modification, or denial of health care and pharmacy services. These criteria are established and governed with the participation of active practicing health care providers and in accordance to objective clinical evidence and processes. Refer to 'Quality Improvement / Utilization Management Committee (QI / UMC): Part B Utilization Review SubComittee Charter."

2.2 AHP will adopt and apply utilization review decisions that are based on the consistent and appropriate use of evidence-based guidelines.

2.3 AHP will evaluate the consistency with which health care professionals involved in Utilization Management (UM) apply criteria in decision-making and, when appropriate, act on opportunities to improve consistency.

3.0 DEFINITIONS

3.1 Refer to AHP Definitions Manual

4.0 PROCEDURE

4.1 Medicare Criteria Hierarchy

AHP makes coverage determinations in accordance with all current evidence of coverage:

4.1.1 National Coverage Determination (NCD)

4.1.2 Local Coverage Determination (LCD)

4.1.3 Medicare Local Coverage Article (LCA)

4.1.4 CMS Coverage Manuals or other CMS-based Resource

4.1.5 Evidence of Coverage (EOC)

4.1.6 Health Services Coordinator Approval Process

4.1.7 AHP Medical Policy: Developed following an objective, evidence-based process based on scientific evidence, generally accepted and current standards of medical practice, and authoritative clinical practice guidelines.

4.1.8 MCG™ Care Guidelines (most recent edition available): MCG™ guidelines may be applied when available if there are no policy criteria in an NCD, LCD, coverage manual, or existing medical policy for the product or procedures requested.

4.1.9 CMS-approved Compendium (as available):

4.1.9.1 NCCN Drugs and Biologics

4.1.9.2 Truven Health Analytics Micromedex (DrugDEX)

4.1.9.3 Wolters Kluwer Clinical Drug Information Lexi-Drugs (up to date)

4.1.9.4 American Hospital Formulary Service-Drug Information (AHFS-DI)

4.1.9.5 Elsevier/Gold Standard Clinical Pharmacology

4.2 Anthem Hierarchy

4.2.1 Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

4.2.2 Evidence of Coverage (EOC)

4.2.3 Anthem Utilization Management Clinical Guidelines, including applicable Carelon Medical Benefits Management,, set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

4.2.4 Other guideline sets adopted by Anthem

4.2.5 After considering Anthem Utilization Management Clinical Guidelines and Medical Policies, may adopt third-party guidelines such as Carelon Medical Benefits Management Guidelines, IngenioRx or MCG Guidelines.

4.2.6 Carelon Medical Benefits Management—may use other guidelines, as applicable, including imaging and sleep study guidelines.

4.3 Blue Shield Hierarchy

4.3.1 Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

4.3.2 Evidence of Coverage (EOC)

4.3.3 Healthcare Services Coordinator Approval Process

4.3.4 Blue Shield of California Medical Policy

4.3.5 Applicable National Imaging Associates (NIA) Policies

4.3.6 MCG Guidelines

4.3.7 Applicable American Specialty Health (ASH) Policies

4.3.8 Medical Group / IPA Policy (HMO LOB only)

5.0 Self-Funded Employee Health Plans

5.1 Summary Plan Description (SPD) for specific employer group.

5.1.1 Community Hospital of the Monterey Peninsula (CHOMP)

5.1.2 Collaborative Employee Health (CEH)

5.1.3 Montage Health Affiliates (MHA)

5.1.4 Salinas Valley Health (SVH)

5.2 Healthcare Services Coordinator Approval Process

5.3 MCG Guidelines

5.4 Independent Medical Review (IMR) by Board Certified specialist in the same field

5.5 If no guidelines, consensus or expert opinion available, Medical Director Review

5.6 Anthem, Blue Shield or other nationally recognized guidelines

5.7 Criteria Review and Approval

5.7.1 The Medical Director or physician designee will validate that all utilization review criteria and guidelines are evidence-based.

5.7.2 AHP updates its UM criteria and procedures as necessary based on the most recent clinical and medical evidence. If there is no new scientific evidence is available, the Part B Utilization Review Subcommittee may determine whether a criterion requires additional review.

5.7.3 The Pharmacy Director or Medical Director consults with clinicians / practitioners with clinical expertise in the area under reviewed. These practitioners have the opportunity to advise or provide input on development or adoption of UM criteria, as well as guidance or instructions for applying criteria.

5.7.4 AHP consistently compiles relevant clinical information to support non-behavioral health UM decision-making. In doing so, the UM process requires that staff collect

relevant medical information to allow for evidence-based review and determination.

The UM procedure necessitates a compilation of pertinent medical information to enable a review and determination based on evidence.

5.7.5 For Commercial (non-Medicare): AHP recognizes that it is not delegated for behavioral health (BH) reviews and refers cases for commercial members to the appropriate delegated BH provider as determined by contract.

5.7.6 For Commercial (non-Medicare): AHP recognizes that it is not delegated for review of traditional Pharmacy requests for commercial members and would provide education to any requesting provider and notification to the member if a non-delegated pharmacy request were to be received.

5.8 Criteria Application

5.8.1 Reviewers apply utilization review criteria after determining that the requested services are covered benefits under the circumstances requested.

5.8.2 The UM reviewer applies the appropriate review criteria to requests for services or products that require authorization prior to their provision or in circumstances where there is a question by an enrollee, enrollee's representative, or the provider on behalf of the enrollee whether the plan will cover an item or service.

5.8.3 The UM reviewer documents in the member' the specific criteria used to make the review determination in the patient file.

5.8.4 If the requested services do not appear to meet the criteria or there is question about meeting the criteria, the UR reviewer refers the case to the Medical Director or physician designee. When review criteria are not appropriate for an individual member's condition or circumstances, the physician reviewer must take into consideration the following factors:

5.8.4.1 Age

5.8.4.2 Co-Morbidities

5.8.4.3 Complications

5.8.4.4 Progress of treatment

5.8.4.5 Psychological situation

5.8.4.6 Home environment

5.8.4.7 Availability of alternate levels of care within the local delivery system

5.8.4.8 (e.g., Skilled Nursing Facility, home health)

5.9 Provider Request

5.9.1 When a healthcare provider calls to request criteria, the Reviewer may either:

5.9.1.1 Provide a written copy of the requested criteria by email, Fax, or United States Postal Service, or

5.9.1.2 Provide the information verbally over the phone.

5.10 Evaluation of consistency

5.10.1 AHP will assess the consistency with which the Pharmacy Director / Medical Director or physician designee and UM reviewers apply clinical criteria, and evaluates interrater reliability utilizing hypothetical UM test cases, or using a sample of UM determination files.

5.11 Non-Delegated Services (for Commercial / non-Medicare)

5.11.1 AHP only maintains and reviews utilization review criteria that pertain to those services for which it is delegated. At this time, AHP is not delegated prescription or behavioral health services.

6.0 TRAINING

6.1 Training for employees will occur within 90 days of hire and upon updates to the policy.

7.0 REVIEW PERIOD

7.1 N/A

8.0 REGULATORY REQUIREMENTS AND REFERENCES

8.1 Medicare Managed Care Manual, Chapter 4, Section 90, Chapter 6, section 20.1
8.2 CA Health and Safety Code 1363.5 (a)&(b); 1367.01 (b); 1363.5
8.3 NCQA Utilization Management Standards
8.4 Anthem HMO Provider Manual
8.5 Blue Shield HMO Provider Manual

9.0 POLICY VIOLATION

9.1 Any AHP associate or contractor who does not comply with this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for additional information.