Anthem is providing this information as a general educational tool to assist Provider Organizations with compliance. Anthem does not represent this information as legal advice. Provider Organizations are responsible for conducting final research regarding health plan and regulatory requirements.
This Guideline Workbook has been created as a tool for Policy and Procedure development with additional informational documents.

** Please note: Areas that are italicized and underlined pertain only to Anthem Organizations that are URAC accredited. All other Provider Organizations should not add this information into their templates. It must be deleted from any non-URAC accredited Organization’s documents.
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Behavioral Health Utilization Review Attestation

Sample Policies and Procedures and Informational Attachments - Medicare

- Medicare Standard Authorizations & Denials
- Medicare Expedited Initial Organization Determinations (EIOD)
- Expedited Initial Organization Determination Tracking Log
- Non-Coverage of Concurrent Care/Termination of SNF, HHA and CORF Services
- Anthem QIO Process
- Medicare Appeals

Commercial and Medicare Informational Attachments

- Flesch-Kincaid Reading Level Using MS Word
Guideline Workbook Online Access Process

1. Go to http://www.anthem.com/ca/home-providers.html:

2. Left click on center of screen “select State e.g. “CA” in drop down box:
3. Left click on center of screen "to enter site, click here":

![Health Insurance Offered by Anthem Blue Cross and Blue Shield - Window...](image)
4. Left click “Answers @Anthem”: 
5. Select the Guideline Workbook you would like to access and left click on it:
6. The Guideline Workbook will open as a PDF file that you may view or download and save.
EXTERNAL RESOURCES

Centers for Medicare and Medicaid Services

Federal Insurance Department
Web site: http://www.medicare.gov

Federal Register The Federal Register informs citizens of their rights and obligations and provides access to a wide range of Federal benefits and opportunities for funding. Documents published in the Federal Register as rules and proposed rules include citations to the Code of Federal Regulations (CFR) to refer readers to the CFR parts affected. The CFR contains the complete and official text of agency regulations organized into fifty titles covering broad subject areas. The CFR is updated and published once a year in print, fiche and on-line formats.
Website: http://www.archives.gov/federal-register/

Department of Aging
Website: http://www.aging.ca.gov/

ICE (Industry Collaboration Effort)
Website: http://www.iceforhealth.org

Health Services/Technology Assessment Text (HSTAT)
(Practice guidelines, Evidence reports, publications, National Institute of Health Clinical Studies, Preventive Services, Treatment Improvement Protocols)
Website: www.nlm.nih.gov/pubs/factsheets/hstat.html

HIV/AIDS Fact Sheets: Role of Medicaid and Medicare
Website:  http://www.kff.org/hivaids/hiv1

NCQA (National Committee for Quality Assurance)
Web site: http://www.ncqa.org/

Case Management Society of America
Website: http://www.cmsa.org/

ERISA (Employee Retirement Income Security Act)
Website: http://www.dol.gov/ebsa/compliance_assistance.html

DMHC (California Department of Managed Health Care)
Website: http://www.dmhc.ca.gov

Diagnoses Coding Guidelines and Resources
Free Online Resources
Official ICD-9-CM Coding Guidelines: These are the only official guidelines for ICD-9-CM coding. They are developed by the ICD-9-CM coding committee in conjunction with MEDICARE and the National Center for Health Statistics. There are separate guidelines for Inpatient and Outpatient (including Physicians services) encounter/claims coding. All ICD-9 Code books contain these guidelines.
Website: http://www.cdc.gov/nchs/icd.htm

ICD-10 CM Official Guidelines for Coding and Reporting (2013)
Although the release of ICD-10-CM is now available for public viewing, the codes in ICD-10-CM are not currently valid for any purpose or use. The effective implementation date for ICD-10-CM (and ICD-10-PCS) is October 1, 2014. Updates to this version of ICD-10-CM are anticipated prior to its implementation.
Website: http://www.cdc.gov/nchs/icd/icd10cm.htm

American Health Information Management Association (AHIMA):  AHIMA is the premier organization related to Health Information. The archives contain guidance on compliance issues related to coding, reimbursement, medical records maintenance and more.
Website: http://www.ahima.org

Procedure Coding Resources
Just Coding: Just Coding has a premium subscription available. a free e-mail subscription with alerts, active discussion forums, and a number of free articles is also available.
Website: http://www.justcoding.com

Code Correct: Website features require a subscription. However, there is also a free e-mail subscription that has timely coding and compliance.
Website: http://www.codecorrect.com

Coding and Reimbursement Network
Free Information, Templates, Etc.

Don Self:  Free downloads, including a number of specialty oriented superbills.
Website: http://www.donself.com/superbills.html

Website: http://www.cms.gov/mcd/overview.asp

Complete Claim Requirements

MEDICARE-1500 Data Element Requirements: Chapter 26 of the Medicare Claims Processing Manual details the required data elements and claim review processes for the MEDICARE-1500 form.

Medicare Information
The Medicare Learning Network: The Medicare Learning Network contains a wealth of resources. Request or download (for free) information for residents about to enter private
practice, video tapes on HIPAA, Home Health, Ambulance Fee Schedule, and numerous “Quick Reference Guides.” On the same page is a link for MEDICARE Electronic ListServs.

Medicare Criteria

The Federal Register: The Federal Register is published every business day. Medicare is required to post Notices for comment, proposed rules, final rules, and public meeting notices in the Federal Register.
Website: [http://www.gpo.gov/fdsys/](http://www.gpo.gov/fdsys/)


Website: [Medicare Fraud & Abuse: Prevention, Detection, and Reporting](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf)

ICE Medicare FWA Training and General Compliance Training (4/30/2013)

Compliance Program Policy and Guidance

HIPAA
One of the best resources on HIPAA is the Administrative Simplification home page. The page has links to Regulations, free implementation guides, data sets and a HIPAA regulations list serv.
Website: [http://www.hhs.gov/ocr/privacy/](http://www.hhs.gov/ocr/privacy/)

**INTERNAL RESOURCES**

**ANTHEM MEDICAL POLICIES**
Anthem has Medical Policies online for Provider Organization to refer to when looking for authorization criteria.
Web site: [http://search.auth.wellpoint.com](http://search.auth.wellpoint.com)
Guide For Internet Location of State and Federal Law

State Law
To locate state law, enter website address http://www.leginfo.ca.gov/
This site will give you access to state assembly bills, senate bills and codes.

To Search for Assembly or Senate Bills
Step 1: Enter Web site address http://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml
Step 2: Click “Bill Information”
Step 3: Select “session” “house” and “hits”
Step 4: Enter keyword, Bill Number, or Author
Step 5: Click on “search” This will narrow the search to your search terms and will list all bills for
the time period selected

To Search for California Codes
Step 1: Enter Web site address http://leginfo.legislature.ca.gov/faces/codes.xhtml
Step 2: Click on “California Law”
Step 3: Select code you which to search

Federal Regulations, Federal Register, Public Laws
To locate Federal Regulations, the Federal Register or Public Laws, enter Web site address
http://www.access.gpo.gov/ or
This site will give you access to a large variety of Federal Regulations and other Federal material.

To Search For Federal Regulations
Step 2: Select year and click go.
Step 3: Scroll down and select CFR title you wish to search (e.g., Title 42 includes Medicare
regulations).
Step 4: Select the year of the Title you wish to search (e.g., October 1, 2002)
Step 5: Scroll down and click on the Chapter you wish to search
Step 6: Scroll down and click on the Part you have selected (e.g., Part 422)
Step 7: Locate the section in the Part you have selected and click to enter (e.g., 422.214)

To Search Federal Register Via Search Term
Step 1: Enter web address http://www.gpo.gov/fdsys/
Step 2: Enter keyword or section you want to review in search box
Step 3: Select “Advanced Search“ to specify dates, collections, or other search criteria
Step 4: Select “Retrieve by Citation“, “Code of Federal Regulations“ and enter year, title and
section
Step 5: Click “Retrieve Document”

To Search Federal Register Via Date
Step 2: Click the Year
Step 3: Click the Month
Step 4: Click the Day
Step 5: Click “The Agency“ e.g. Health and Human Services Department
Step 6: Select Rules and Regulations and Click choice of PDF, Text, More
To Locate Centers for Medicare and Medicaid (CMS) Quarterly Provider Updates

To locate CMS Quarterly Provider Updates go to Web site address https://www.cms.gov/QuarterlyProviderUpdates/

This site includes all OPLs issued to date.

Step 1: Enter Web site address https://www.cms.gov/QuarterlyProviderUpdates/
Step 2: Select the QPU you are looking for
How to Use the California Code of Regulations (CCR) Web site

- Log onto http://ccr.oal.ca.gov
- Step 2: Click on Title of California Code of regulation
- Step 3: Select the Division
- Step 4: Select the Chapter
- Step 5: Select the article

- You may access the online CCR by clicking one of the following: Search forewords, Specific Regulatory Section, List of CCR titles or Searching thru Agency list of CCR.
REQUIRED UM HEALTH PLAN SUBMISSIONS
Anthem Provider Organization Reporting and Documentation Requirements

The following table lists each required program report, due dates, and reporting content. The last column identifies the specific sections within each report template that must be completed; sections not listed are optional.

All reports are to be sent to your assigned Auditor. An evaluation of each report will be completed and sent to you within 30 calendar days of receipt. The evaluations are based on timeliness of submitting the report and content comprehensiveness per the enclosed report instructions. The results of your report evaluations will be reflected on your annual audit score summary report.

<table>
<thead>
<tr>
<th>Report Type</th>
<th>Due Date</th>
<th>Required Report Content</th>
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<tbody>
<tr>
<td><strong>Utilization Management</strong></td>
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<tr>
<td>2014 2(^{nd}) Semi-Annual Report and Annual Evaluation</td>
<td>2/15/15</td>
<td>Tabs 1-6, and contact/signature page</td>
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<tr>
<td>2015 UM Program Plan</td>
<td>15 calendar days after Committee approval</td>
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<tr>
<td>2015 UM Work Plan</td>
<td>2/15/15</td>
<td>Tabs 1-6, and contact/signature page</td>
</tr>
<tr>
<td>2015 1(^{st}) Semi-Annual Report</td>
<td>8/15/15</td>
<td>Tabs 1-6, and contact/signature page</td>
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<tr>
<td>2015 2(^{nd}) Semi-Annual Report and Annual Evaluation</td>
<td>2/15/16</td>
<td>Tabs 1-6, and contact/signature page</td>
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<tr>
<td><strong>Complex Case Management</strong></td>
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<tr>
<td>2015 CCM Program Plan</td>
<td>15 calendar days after Committee approval</td>
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<tr>
<td>2015 2(^{nd}) Semi-Annual Report and Annual Evaluation</td>
<td>2/15/16</td>
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<td>2015 1(^{st}) Semi-Annual Report</td>
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<td>2014 2(^{nd}) Semi-Annual Report and Annual Evaluation</td>
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<td><strong>Disease Management</strong></td>
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<tr>
<td>2015 DM Program plan</td>
<td>15 Calendar days after Committee approval</td>
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<td>2015 2(^{nd}) Semi-Annual Report and Annual Evaluation</td>
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<td>2015 1(^{st}) Semi-Annual Report</td>
<td>8/15/15</td>
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<tr>
<td>2014 2(^{nd}) Semi-Annual Report and Annual Evaluation</td>
<td>2/15/15</td>
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<tr>
<td><strong>Credentialing</strong></td>
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<tr>
<td>2014 2(^{nd}) Semi-Annual Report and Submission Form</td>
<td>2/15/15</td>
<td>Entire Submission Form and complete report</td>
</tr>
<tr>
<td>2015 Credentialing Policies</td>
<td>15 calendar days after Committee approval</td>
<td></td>
</tr>
<tr>
<td>Corrective Action Plan (if applicable)</td>
<td>Corrective action plan addressing any identified audit deficiencies in Anthem Audit Summation letter.</td>
<td>30 calendar days from Audit Summation letter date</td>
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<tr>
<th>2015 UM Work Plan / Semi-Annual Report / Annual Evaluation Template and Instructions</th>
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<th>2015 Credentialing Submission Form and Report Instructions</th>
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<tr>
<td>2012_ICE_CRD_Report_Template_Instructions.xlsx</td>
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Outline for Sample Utilization Management Plan

I. Purpose

The purpose of the Utilization Management Program is to assure the delivery of medically necessary, optimally achievable, quality patient care through appropriate utilization of resources in a cost effective and timely manner.

To ensure this level is achieved and/or surpassed, programs are consistently and systematically monitored and evaluated. The evaluation process is fully documented and when opportunities for improvement are noted, recommendations are provided.

*Evaluations also confirm that the population is served by utilization activities conducted within the organizational framework and service model in accordance with the mission statement. Oversight and reporting of utilization activities are the responsibility of the Utilization Management Committee and Senior Medical Director as indicated in organization charts.*

II. Goals and Objectives

A. To provide ongoing monitoring and evaluation activities which address and correct over-utilization and under-utilization and inefficient coordination of medical resources.

B. To maintain a systematic process for educating practitioners/providers regarding utilization management issues.

C. To ensure that governmental and other regulatory agency guidelines, standards and criteria are adhered to.

D. To ensure that services rendered are compliant with the guidelines of and are authorized by the member’s health plan benefits and are delivered by contracted practitioners/providers.

E. To respond to member and practitioner/provider complaints/appeals regarding UM issues after coordinating a comprehensive and timely investigation.

F. To perform peer review in conjunction with the Quality Management Program, as applicable.

G. To ensure that delivered services are timely, medically necessary and consistent with the diagnosis and required level of care.

H. To facilitate communication and develop positive relationships between members, practitioners/providers, and contracted health plans by preserving the patient-practitioner relationship and providing education related to appropriate utilization.

I. To ensure that contracted practitioner/provider, and employee awards are based on appropriateness of care and service and not under utilization of care. To ensure that practitioners/providers are not prohibited from acting on behalf of members.

J. To ensure that appropriate care is delivered to high risk, catastrophic, high volume and chronic members by identifying them, accessing the most efficient resources, and preventing hospitalizations through proactive planning and prevention, and providing a treatment continuum.

K. To ensure the development and implementation of effective health education/promotion programs in order to reduce overall healthcare expenditures.

L. To implement procedures to prevent the re-occurrence of problematic utilization issues.

M. To ensure that Behavioral Health (BH) services are effectively delivered.

N. To ensure continuity and coordination of care between medical and behavioral health practitioners.
III. Organizational Structure and Responsibilities of Oversight Committee
(Describe responsibilities/functions – may reference organizational charts and job descriptions)

A. Governing Body – responsibilities include the development, maintenance and oversight of the Utilization Management (UM) Program. The responsibility for creating and implementing the UM Program’s infrastructure may be delegated to the UM Committee (UMC) which will report to the Governing Body on at least a quarterly basis.

B. CEO/President/Executive Director - responsibilities include oversight of the organization and management of the UM Program with a focus on the program’s financial viability, allocation of resources and staffing, and the interdepartmental effectiveness of the program.

C. The Medical Director/CMOChief Medical Officer (CMO) is a designated senior physician with a current unrestricted license to practice in the state of California. The designated physician is qualified to perform clinical oversight, has relevant post-graduate direct patient care experience, and is board certified.
   1. Responsibilities include the development, implementation and supervision of the UM Program, setting policies, reviewing cases and participating in UM committee meetings.
   2. The CMO/Medical Director provides guidance and is responsible for all clinical aspects of the UM Program.
   3. If necessary, consultation with practitioners in the field is obtained.
   4. The program’s effectiveness is enhanced under the governance of the CMO/Medical Director who functions either in a part-time or full-time capacity.
   5. A behavioral health practitioner has involvement in key aspects of the UM program, such as setting policies, reviewing cases and participating in the UMC meetings.

D. The UM Manager/Director is responsible for the operational execution of the UM Program under the direction of the CEO/President/Executive Director and the CMO/Medical Director.
   1. The UM Manager/Director is responsible for managing the UM staff which may include, but not be limited to, the following positions: UR Coordinator/UM Nurse, Case Management Coordinator/Case Manager, HMO Coordinator, UM Clerk.
   2. The UM Manager/Director must have a current, unrestricted license or, if the license is restricted, there are guidelines in effect to ensure that job functions do not violate the restrictions imposed by the State Board.

E. Staff responsibilities, role descriptions and staff ratios are tied to work needs.

F. Verification of staff and consultant current licensure and credentials is performed upon hire or contract and thereafter no less than every 3 years. Staff and consultants are required to notify the organization immediately if there are any adverse changes to licensure or certification status. If adverse changes are noted, then corrective actions are implemented to respond to those changes.

G. UM Resources include a description of the resources (i.e., personnel, analytic capabilities, data resources, and information systems) needed to support and meet the UM program needs.

H. The UMC will meet at least <insert meeting frequency, e.g., quarterly, monthly> with urgent issues addressed separately, as needed, by the designated senior physician and/or subcommittee.

I. The UMC will report to the Governing Body at least quarterly. Subcommittee activity and documentation must be presented to the UMC, if applicable.

J. The UMC processes and activities include:
   1. Responsibilities of the Committee and Subcommittees (including reporting relationships)
   2. Responsibilities of the Committee Chairperson
3. Linkage to the Quality Management Committee (QMC) and oversight by the governing body

4. Linkage with the following departments: QM, Credentialing/Recredentialing, Health Improvement Program, Contracting, Provider Relations, Member Services, Claims Administration, Information Systems, and Pharmacy

5. Term of membership

6. Committee composition (at a minimum, 3 practitioners of primary care and specialty care must be represented, as regular committee attendees.) A Behavioral Health (BH) practitioner is involved in the implementation of the BH aspects of the UM Program and as an ad hoc member of the UM committee.

7. Practitioner participation in meeting discussions must represent a broad spectrum of specialties as appropriate and ensure practitioner participation in the UM Program through planning, design, implementation or review.

8. Physician consultants from appropriate specialty areas of medicine and surgery and/or additional specialty sources/organizations specified are available to review case pertaining to their specialty.

9. Medical Director or Physician Reviewer/Clinical Peer conducts review on all medical necessity review denials/modifications.

10. Physician reviewer is available via telephone to practitioners/providers to discuss UM determinations.

11. Voting rights - only licensed practitioners may have voting rights on issues involving clinical decisions

12. Definition of quorum of voting members <insert specific quorum required e.g., at least 3 licensed health care practitioners> which may include behavioral health care practitioners

13. Health Plan representative attendance at Committee meetings

14. Description of mechanism for processing urgent issues between meetings

15. Description of mechanism for communicating to practitioners/providers and members

16. Description of utilization of departmental data collection systems used to monitor and evaluate care and service in relation to specific aspects of each department - i.e. Practitioner/Member Satisfaction Surveys, Referral Turn Around Time audits, UM Reviewer Inter-rater Reliability Surveys, Denial/Appeal Turn Around Time audits

17. Description of mechanism for establishment of thresholds and annual clinical data collection/analysis of outpatient and inpatient data for tracking, trending, education and improvement purposes:
   - Acute and SNF Admits/1,000
   - Acute and SNF Beddays/1,000
   - Acute and SNF Average Length of Stay by physician, by clinical service category, ICD/ CPT
   - Acute and SNF Readmissions/year
   - Adverse Outcomes
   - Utilization Patterns for Over and Under Utilization
   - Pharmacy Patterns of overall rates of use and generic substitution
   - High Risk/High Volume Procedures/Diagnoses
   - Appeals
   - Referral Cancellations

18. Description of mechanism for reporting UM activities to all appropriate staff to keep them informed of ongoing monitoring and evaluation activities and related outcomes

19. Confidentiality/HIPAA Compliance
   a. Description of Confidentiality/HIPAA standards - separate policies and procedures may be referenced.
   b. UMC Members will sign a confidentiality agreement annually and the agreement will be kept in the practitioner or employee file.
c. All health plan representative guests of the UMC will also sign a confidentiality agreement.

d. A description of how correspondence and meeting minutes will be handled and stored

e. A description of how member information will be protected

20. Problem resolution

a. Description of process for identifying, monitoring and evaluating clinical issues, utilizing performance goals

b. Reports from ancillary departments linked to and impacting the UM department will be reviewed and monitored

c. Any UM problems identified by the QMC and referred to the UMC will be addressed

d. Any Quality problems will be referred to the QMC for review and follow-up

e. Corrective action when indicated to include intervention, measurement of intervention effectiveness, and correction as applicable

f. Any actions or decisions will be documented in the UMC minutes

g. Any actions or decisions affecting the process by which medical services are provided to health plan members will be provided to the contracted health plan on a regular basis

21. Documented evaluation of delegated contractor activities (may reference separate policies and procedure and Documentation of Agreement)

a. Delegated activities and delegated entity’s activity accountability

b. Reporting requirements

c. Process of initially, semi-annually and annually evaluating delegated entity’s performance

d. Remedies, including revocation of delegation available to the Provider Organization if delegated agency does not fulfill its obligation

22. The Utilization Management Program’s plan will be reviewed and revised as necessary on an annual basis. Policies and procedures will be reviewed and revised, as necessary. Documents will be submitted to the Provider Organization’s Governing Body and contracted health plans, as required.

23. The Utilization Management Annual Program Evaluation Report of utilization activities will be submitted annually to Provider Organization’s Governing Body and as required by contracted health plans. Upon member/practitioner/provider request, a description of the Utilization Management program and a report of the progress made in meeting goals will be provided.

24. Utilization Management Semi-Annual Reports will be reviewed and approved, submitted to the Provider Organization’s Governing Body, and contracted health plans, as required.

25. The Utilization Management Workplan is developed and implemented each year by the Utilization Management Committee. The plan is reviewed and approved by the Governing Body and includes the following: scope, goals, objectives, projects and plans for the year (including follow-up on issues identified previously). It describes a process in which responsibility and time frames are delineated and reviewed annually, and evaluations and revisions to the Plan are accomplished. Reports on effectiveness, outcomes and recommendations are prepared for the CEO/President/Executive Director and/or the Governing Body. The Workplan is submitted to contracted health plans, as required.

26. Description of the Information System (i.e., EZ CAP, Care Link) utilized in Utilization Management.

27. Description of monitoring all UM data for any contracted practitioner/provider at financial risk (i.e. PCPs, SCPs, SNF, etc.).
IV. Utilization Management Committee Meeting Minutes

A. Documented, contemporaneous, clear, accurate, dated, signed by UMC Chairperson by
the date of the next meeting, current and available to contracted health plans for review,
as required
B. Indicate attendees
C. De-identify members/practitioners/providers
D. Include attachments of applicable reviewed items
E. Stored in a confidential area with authorized staff access only
F. Indicate general description of content
G. Reflect the Utilization Management process - committee decisions, action plan
implementation and evaluation/follow-up (e.g.):
   1. Approval of Utilization Management Policies and Procedures, Practice and
      Preventive Care, Medical Necessity and LOS Guidelines, UM Criteria, UM Plan,
      Workplan, Semi-Annual Reports, Program Evaluation
   2. Reports to Governing Body and contracted health plans
   3. Results/reports of clinical data/statistics and audits/studies/surveys
   4. Inpatient and Outpatient review
   5. Review of emergency services (appropriate ER use is promoted), contracted
      providers, new medical technology and delegated activities
   6. Review of Practitioner UM statistics, Denials/Appeals
   7. Evidence feedback to, ongoing education of and communication with
      practitioners/providers and/or members by the UM Committee
   8. Utilization Management information relevant to Quality Management identified and
      reported to the Quality Management Committee and any applicable subcommittees
   9. Review of subcommittee reports (as applicable)
10. Minutes reflect continuity of issues from meeting to meeting, problem identification,
    policy decisions, analysis and evaluation of UM activities, needed actions, follow-up
    and re-evaluation.

V. Policies and Procedures

A. Describe the systematic process for conducting Utilization Management activities (to
   include methods for identifying and monitoring) for the following (may be referenced in
   separate policies and procedures):

   1. Utilization Review (UR) Criteria policies consider the following standards:
      • Medical necessity and Length Of Stay (LOS) criteria include levels of automatic
        authorization, service specific utilization protocols, including appropriate setting,
        length of stay, type of provider/practitioner, indications/contraindications for
        requested service, information gathering process
      • Appropriate practitioners are involved in criteria
        adoption/development/application, or new medical technology
      • Resources include but are not limited to MCG, McKesson's InterQual, Apollo
        Group Inc., Hayes Inc., Medicare Guidelines, DSM-IV and DSM-IV-TR,
        contracted health plan criteria and generally accepted standards of medical
        practice based on medical necessity.
      • Guidance for applying criteria based on the needs of individual patients, the local
        delivery system and how practitioners can obtain criteria and policies and
        procedures.
      • Written operational policies and procedures and clinical support tools are
        provided to staff as appropriate.
      • Initial screening tools to support UM staff, such as scripts or algorithms, are
        developed and approved by a senior medical practitioner prior to use.
• UM Review/Management policies, procedures and criteria are distributed to contracted practitioners/providers, members and the public upon request.
  • Upon request, UM criteria or guidelines for specific procedures or conditions as requested are disseminated to members.

2. Referral Process policies address:
• Inpatient and Outpatient Authorization/Review, Discharge Planning and Case Management Processes to include all time frames for emergent, urgent, concurrent, non-urgent and post service requests;
• Other requests related to post service emergency care; experimental/investigational, standing specialist referrals, second opinion, Ready Access (Speedy Referral/Direct Access); Cancellations
• Outcomes of review including member/practitioner/provider notification, collection and data entry of specific utilization, adverse outcomes/sentinel events;
• Collaboration with health plans including notification of encounter data, catastrophic, transplants, high cost/high risk cases,
• Emergency services and behavioral health triage and referral; and
• Minimum educational background for staff reviewers, including staff licensure requirements/specifications for referral review and staff availability to process UM issues.

3. Telephone Advice Services

4. Referral decision/notification turnaround times and Compliance Audits

5. Practitioner/Provider/Member Communication mechanism

6. Continuity and Coordination of Care/Case Management, gathering of clinical information process and transition to alternate level of care process

7. Inter-rater Reliability Evaluation of physician and non-physician reviewers at least annually

8. Denials and Appeals inclusive of turnaround times, appropriate sample letter documentation, and compliance audits

9. Affirmative statement is distributed to practitioners/providers, members and employees, and method by which the Provider Organization tracks the acknowledgement of receipt of statement:
  • UM decision making is based only on appropriateness of care and service and existence of coverage.
  • The Provider Organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care.
  • The Provider Organization does not offer financial incentives to UM decision makers that encourage decisions that result in underutilization.
  • A statement that practitioners are ensured independence and impartiality in making referral decisions that will not influence:
    • Hiring
    • Compensation
    • Termination
    • Promotion
    • Any other similar matters
    • Staff confirmation that member healthcare is not compromised.

10. Collection of UM statistics- authorizations, denials, cancellations

11. Utilization of QM population based audits to determine high risk, high volume, chronic members for case management and health education/promotion

12. Practitioner/Member Satisfaction Assessment

13. Pharmaceutical management
14. Contracted services  
15. Delegated services  
16. HIPAA compliance  
17. Provisions of Language Assistance Program Translation for non standard vital documents  

B. Studies/Surveys/Audits  
1. All UMC audit/study/survey results (as well as audits from ancillary departments impacting upon the UMC goals) will be presented to the UMC for analysis, determination of performance goals thresholds, and applicable corrective action plan implementation as required by contracted health plans.  

The UM Plan will be annually reviewed, updated, approved, signed and dated by the UMC Chairperson.
SAMPLE
UM Program/Plan Signature Page

Provider Organization Name______________________________

Review and approval of the attached UM Program/Plan performed by:

SIGNATURE OF UM CHAIRPERSON:

________________________________________DATE____________________

SIGNATURE OF AUTHORIZED GOVERNING BOARD REPRESENTATIVE:

____________________________________DATE____________________

SUBMITTED BY:

________________________________________DATE____________________

It is mandatory that this signature page (or one containing the above information) be submitted along with the Annual Program/Plan Description to each contracted Health Plan within 15 calendar days after UMC approval.

FOR HEALTH PLAN USE ONLY

PROGRAM/PLAN REVIEWED
BY________________________________________

DATE___________
CORRECTIVE ACTION PLAN

<table>
<thead>
<tr>
<th>Provider Organization Name</th>
<th>Audit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action Plan (CAP) Date</td>
<td>Audit Conversion Year and Type</td>
</tr>
<tr>
<td>CAP Due Date</td>
<td>Re-evaluation Date</td>
</tr>
</tbody>
</table>

Provider Organization:  
To ensure correction of deficiencies in all audited categories, please address interventions to correct all deficiencies identified during the audit. List measurable improvement goals, individuals responsible for implementing the plan, and the time frame for implementation in the last 3 columns in the grid below. Return to [AUDITOR NAME], Auditor, Regulatory and Accrediting Oversight, Anthem at [AUDITOR E-MAIL ADDRESS AND PHONE #] within 15 calendar days of the date of the attached Audit Summation Letter.

Failure to submit the required report timely may result in a formal review of your delegation status and be reflected in the next annual audit. We strongly encourage you to review the Anthem Delegation Agreement which outlines each contracted Provider Organization’s reporting requirements and delegated responsibilities.

Date CAP Sent to Anthem: ______________ CAP Completed By: ____________________________

<table>
<thead>
<tr>
<th>Audit Category</th>
<th>Audit Indicator &amp; Applicable Indicator Header</th>
<th>Audit Score</th>
<th>Area For Improvement</th>
<th>Corrective Action</th>
<th>Timeframe for CAP Implementation</th>
<th>Responsible Provider Organization Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>[UM, CR, BH CR, DM, CCM]</td>
<td>[NUMBER &amp; DESCRIPTION]</td>
<td>[FROM COMMENTS SECTION IN AUDIT TOOL]</td>
<td>[TO BE COMPLETED BY PO]</td>
<td>[TO BE COMPLETED BY PO]</td>
<td>[TO BE COMPLETED BY PO]</td>
<td></td>
</tr>
</tbody>
</table>
UTILIZATION MANAGEMENT COMMITTEE
UMC Meeting Process

UMC Meeting Frequency
- Meetings are held as defined in the UM Program, with urgent issues addressed separately as needed
- Adequate subcommittee activity and documentation is presented to the UMC at least quarterly

UMC Composition
- Practitioners represent a broad spectrum of specialists, including behavioral health practitioners as appropriate in relation to the clinical discussions scheduled to take place
- A senior physician is an active participant in the UMC meeting
- A voting quorum is present at each meeting and only physicians are voting on medical decisions

UMC Responsibilities
- The UMC reports to the governing body/board of directors at least quarterly
- Ensure practitioner participation in the UM program through planning, design, implementation or review
- Review/approval of UM Program, UM Workplan, UM Annual Evaluation, and UM Semi-Annual Reports
- Review and Approval of policies and procedures
- Review of UM statistics: e.g., Admits/1,000, Bed-days, LOS by clinical service category and/or ICD/CPT, adverse outcomes, utilization, readmissions/year, high risk/high volume diagnoses/procedures, ER utilization, rates of selected referrals, procedures, pharmacy and utilization patterns for over/under utilization
- Review of denials and appeals and referral of appeals to contracted health plan as required
- Tracking/trending referral turn-around time
- Review of any UM issues referred to the UMC
- Ensure that UM inter-rater reliability audits are conducted
- Review/approval of UR criteria and revisions to UR criteria if necessary
- Review of inpatient/outpatient referrals
- Review of new medical technology
- Review of emergency services
- Review of case management
- Follow up documentation to identified issues
- Member and practitioner satisfaction with UM process
- Evidence of appropriate communication to all contracted providers/practitioners and members
- Review of any delegated functions
- Identification of issues, corrective action plan formulation, follow-up and reevaluation as applicable

UMC Minutes
- Attendance sign-in sheets are utilized
- Meeting minutes are contemporaneous, accurate, provide accountability for follow-up, promote continuity from meeting to meeting, reference and include discussion of attachments
as appropriate, are produced within 30 calendar days prior to the subsequent meeting, and are dated and signed by UMC Chairperson

- Confidentiality statements are signed
- Practitioner and member names are de-identified
- There is a written meeting agenda
- Minutes reference and include discussion of attachments
- There is review/approval of previous minutes and F/U on issues from previous minutes
Documentation of UMC Meeting Minutes

PURPOSE

- To maintain a clear and accurate record, in a standardized format, of decision-making process, discussion, provider’s participation, analysis and resolution of the Utilization Management activities.
- To promote continuity from meeting to meeting and accountability to follow through on the decisions, actions and recommendations in a timely manner.
- To ensure that meeting minutes will be contemporaneous, dated and signed by the chairperson.
- To provide meaningful information so that the UMC members can fulfill their obligations as members.
- To protect the identity of members/practitioners/providers and still accurately portray pertinent facts of each case.
- To provide accountability as to who will follow through on decisions, actions and follow-up.

PROCEDURE

1. It is suggested that a standard format be used for UMC meeting minutes. The following headings are recommended:
   a. Agenda Item/Issue
      - The issue or subject to be reviewed by the Committee
   b. Discussion/Findings/Recommendations
      - Identify specific performance standards and timeframes
      - What issue or subject was reviewed and was the evaluation within the specified timeframe?
      - Was the performance standard met?
      - Is there need for performance or process improvement?
      - Were any problems caused by defects, deficiencies, or gaps in the established systems or in performance?
      - What is the severity of the problem?
      - Does this finding represent a trend?
      - Does further study or monitoring need to be done?
      - If further monitoring or study is needed list specific areas to be monitored and the planned timeframe.
   c. Plan of Action
      - Provide what action is appropriate even if no action is taken based on the conclusions
      - Construct a time frame for the development and implementation of the action
      - Assign responsibility to the appropriate person for action and follow-up
   d. Follow-up
      - Provide information on when further information will be presented and who is responsible for presenting it.
      - Provide information on what type of information is expected, what trended information is gathered and what actions are developed.

2. All UMC attendees and guests must sign the UMC meeting attendance sign in sheets. Physician attendance by teleconference or web-ex is acceptable as long as it is documented within the minutes and the Medical Director’s signature confirms the attendance.
3. There must be a written UMC meeting agenda in place and made available for the attendees.
4. All attendees must sign confidentiality statements.
5. Practitioner and member names and PHI must be de-identified. Unique identifiers must be used for practitioners and members when documenting peer review activity, grievances, quality issues or other sensitive discussions.
6. Members of the UMC, guests and Health Plan representatives must sign confidentiality statements.
7. There must be adequate PCP and SCP representation.
8. There must be a voting quorum (as defined in the UM Program, e.g., 3 licensed practitioners at a minimum) present at each UMC meeting.
9. UMC meetings must be held as defined in the UM Program, with urgent issues addressed separately as needed by a designated physician or subcommittee.
10. The UMC must report to the governing body/board of directors at least quarterly.
11. Minutes should be taken simultaneously during the meeting and reflect all discussions from each agenda item including committee discussions and actions. Reference materials must be attached to the minutes and referenced in the minutes.
12. Meeting minutes must be contemporaneous, accurate, provide accountability for follow-up, and promote continuity from meeting to meeting.
13. UMC meeting minutes must be produced within 30 calendar days prior to the subsequent meeting, and must be dated and signed by the UMC Chairperson.
14. Minutes of the UMC meeting must be numbered, dated, and include but not be limited to discussion of the following:
   • Review/approval of UM Program, UM Workplan, UM Annual Evaluation, and UM Semi-Annual Reports
   • Review and Approval of policies and procedures
   • Review of UM statistics: e.g., Admits/1,000, Bed-days, LOS by clinical service category and/or ICD/CPT, adverse outcomes, utilization, readmissions/year, high risk/high volume diagnoses/procedures, ER utilization, rates of selected referrals, procedures, pharmacy and utilization patterns for over/under utilization
   • Review of denials, cancellations and appeals and referral of appeals to contracted health plan as required
   • Tracking/trending referral turn-around time
   • Review of any UM issues referred to the UMC
   • Ensure that UM inter-rater reliability audits are conducted
   • Review/approval of UR criteria and revisions to UR criteria, if necessary
   • Review of inpatient/outpatient referrals
   • Review of new medical technology
   • Review of emergency services
   • Review of case management
   • Follow up documentation to identified issues
   • Member and practitioner satisfaction with UM process
   • Evidence of appropriate communication to all contracted providers/practitioners and members
   • Review of any delegated functions
   • Identification of issues, corrective action plan formulation, follow-up and reevaluation as applicable
The regularly scheduled UMC meeting was held on Thursday, June 10, 2011 at 8:00 AM. The following committee members were in attendance: Dr. Healthy, M.D., UM Chairman, Dr. Surgeon, M.D., Dr. PCP, M.D., Dr. Smith, Behavioral Health, M.D., Dr. Jones, D.O., Nancy Nurse, R.N., UM Director. Guests: Dr. Heartfelt, Keystone BH (via teleconference), Health Plan representative attendees. The following committee members were absent: Dr. PCP-2, M.D, Jenny Nurse, R.N.

### Agenda

<table>
<thead>
<tr>
<th>Agenda</th>
<th>Discussion/Findings/Recommendations</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction &amp; Confidentiality Agreements</td>
<td>1. Guests introduced. Confidentiality Agreements distributed and signed (Confidentiality Agreements may be kept on file for each committee member. Guests should sign each time. Guests may be excluded upon recommendation of the committee for sensitive issues.)</td>
<td>1. None</td>
</tr>
<tr>
<td>2. Review of Previous Minutes</td>
<td>2. Minutes of previous UMC meeting, May 12, 2011, reviewed. Minutes accepted with the following revision to Item #3; wording changed from &quot;Dr. Health presented...&quot; to &quot;Dr. Surgeon presented..&quot;</td>
<td>2. None</td>
</tr>
<tr>
<td>3. Old Business</td>
<td>3. (Discussion of items/issues requiring F/U from last meeting. Brief narrative required to provide meaningful information to committee members. De-identify physician and patient names.)</td>
<td>3. Continue to evaluate UM Reports, monitor for patterns and trends. No action required this month.</td>
</tr>
<tr>
<td>a. Case Management Case #9876-5678-3214: 24 yr old female diagnosis leukemia, with history of paranoid schizophrenia</td>
<td>a. Case Manager maintains close contact with member. Referred to Health Plan Centers of Medical Excellence. Specialist currently reviewing case for bone marrow transplant. Member continues to deteriorate following chemo treatments and refuses to take her psych meds due to delusional thoughts. Pt believes the meds are putting cancer cells back into her body. Claims approaching $50,000; stop loss notification forms filed. In the event out of network resources are required, contract will need to be negotiated.</td>
<td>a. Contact the member's home health agency to inquire about mental health RN services for a better evaluation of the member's delusional thoughts.</td>
</tr>
</tbody>
</table>
| 5. Adjournment | Authorization Report. **Findings:** Significant increase in allergy referrals, no trend noted by PCP, may be seasonal pattern. Continue to monitor. Drug utilization report indicates 5% decrease in PMPM. One member noted on Concurrent Review Report with 15 day stay, member is being monitored by Case Manager. No significant findings in remaining Utilization Reports.  
5. All business for UMC meeting concluded and adjourned at 9:00 AM |

UMC Chairperson Name: _____________________________________

UMC Chairperson Signature: ________________________________

Date: __________________
Confidentiality Statement – UMC Member

As a member of the Utilization Management Committee, involved in the evaluation and improvement of quality of care and service, I recognize that confidentiality is vital to the utilization management process. Therefore, I agree to respect and maintain the confidentiality of all discussions, records, and information generated in connection within the Utilization Management Committee activities, and will not disclose such information except to persons authorized to receive it.

Date: ____________________ Signed: ____________________

Print Name: ____________________________________________
SAMPLE

Confidentiality Statement – Health Plan Representative Attendee

I, ____________________ hereby represent and warrant that I am an authorized representative of _______________________________ Health Plan. I acknowledge and agree that I have been granted permission by __________________________ to attend the meeting on __________________________, subject to the following terms and conditions:

1. I agree to respect and maintain the confidentiality of all discussions, records, and information generated in connection with the meeting and agree not to disclose such information except to authorized representatives of the Health Plan for use in peer review activities of the health plan or as is otherwise required by state or federal laws or regulations.

2. I further acknowledge and agree that I shall not testify or provide any written statements or information of any kind or nature relating to the meeting in any discovery process, (including but not limited to depositions and interrogations) or any administrative or court hearing or proceeding unless compelled to do so by a court of competent jurisdiction.

3. I further agree to raise all legal defenses, privileges and immunities which may be available at law or in equity to preserve the confidentiality of and to prevent the disclosure of all records and information generated in connection with the meeting.

Health Plan Representative Signature: ________________________________

Date: ________________
Conflict of Interest Agreement

As a member of the Utilization Management Committee, I agree to report any conflict of interest with respect to matters under review to the chairperson of the committee and refrain from completing the review.

Conflict of interest is defined as having any involvement with the beneficiary involved in the review, having any fiduciary relationship with the provider in question, or having any other involvement in the case which impairs judgment in performing the review.

I have read and understand the above Conflict of Interest Agreement, and promise to abide by its terms.

Date: ____________________ Signed: _________________________

Print Name: _________________________
**Affirmative Statement**

I, ___________________ understand that UM decision making is based on appropriateness of care and service and existence of coverage. The Provider Organization does not compensate practitioners or individuals for denials, does not offer incentives to encourage denials, and does not encourage decisions that result in under utilization.

The Provider Organization ensures independence and impartiality in making referral decisions that will not influence hiring, compensation, termination, promotion and any other similar matters.

I have read and understand the affirmative statement and promise to abide by its terms.

Date: ____________________ Signed: _________________________

Print Name: _________________________
SAMPLE

Agreement Regarding Confidential or Proprietary Information

As a condition of my employment at “X” Provider Organization, I agree to the following:

1. I will not disclose or use at any time, either during or subsequent to my employment, any confidential or proprietary information of “X” Provider Organization of which I have become aware during my employment, except as required in performing my duties as an employee of “X” Provider Organization. I further agree that I will not appropriate any such confidential or proprietary information for my own use, or use in any way inconsistent with the interest of “X” Provider Organization.

2. I understand that confidential or proprietary information may be available to me in order that I may perform the duties of my job. I agree not to seek to acquire confidential or proprietary information beyond that which is reasonably necessary for me to effectively perform my job.

3. I agree that confidential and proprietary information includes, but is not limited to, the following:
   - Medical information, personal information regarding members, employees, practitioners, providers, patient accounting, billing or payroll information.
   - Information that “X” Provider Organization is required by law, regulation, or policy to maintain as confidential.
   - All financial information concerning “X” Provider Organization, its members, practitioners, or providers, disseminated solely for internal use.
   - Personnel records and information contained in those records.
   - Information which could aid others to commit fraud, sabotage, or otherwise misuse “X” Provider Organization’s products or services, or damage their business.
   - Trade secrets such as product design, computer hardware/software, computer systems and programs, processing techniques and generated outputs, and all information received that is marked “Confidential – Do Not Copy.”

4. I agree that all “X” Provider Organization files and other records or data in any form are the exclusive property of “X” Provider Organization, even if I have written, created or otherwise been involved in the development of such information. I agree that upon termination of my employment, I will return to my employer all manuals, letters, notes, notebooks, reports, lists, data, information, or files which were in my possession or control during the term of my employment. I agree that any and all work product, materials, software and programs, including any intellectual property I develop in the course of my employment at “X” Provider Organization shall be the sole and exclusive property of my employer.

5. I agree that I will not engage in any outside activities from which I or a third party may gain at the expense of “X” Provider Organization, or otherwise have an adverse impact on “X” Provider Organization. I agree to fully disclose to “X” Provider Organization any potential conflicts of interest and to fully and truthfully respond to any questions concerning possible conflicts of interest.

6. I agree to report any apparent violation of terms of the Agreement by another employee to appropriate management.

7. I understand this Agreement is a condition of my employment, and if I violate the terms of this Agreement my employment may be immediately terminated. Such remedy shall not be exclusive but shall be cumulative with all other remedies at law or in equity.

8. I have read this Agreement and I understand its contents. I agree to be bound by this Agreement and have signed it below to signify my agreement.

__________________________________________  _______________________________________
Employee Name                                    Employee Signature
__________________________________________  _______________________________________
Employee ID Number                                Date

Revised 10/29/2015 - 41 -
DELEGATION OF UTILIZATION MANAGEMENT
Delegation

What is delegation?
Delegation occurs when the Provider Organization gives another entity the authority to carry out a function that it would otherwise perform. This authority includes the right to decide what to do and how to do it, within the parameter agreed on by the Provider Organization and the other entity. When delegation exists, the health plan requires the presence of a mutual agreement between the delegating organization and its delegate that is performing specific functions related to its own standards, governmental agency (CMS and DMHC), URAC and NCQA standards. Although the Provider Organization does not directly perform delegated functions, it must oversee them to ensure that the delegate is properly performing the functions. The Provider Organization may reclaim the right to carry out its delegated functions at any time.

The Provider Organization’s responsibility:
The Provider Organization is ultimately accountable for all functions performed within its purview, whether they are performed by the Provider Organization, by a delegate or by a sub-delegate. A Provider Organization that delegates activities associated with any of the five categories of NCQA standards must demonstrate that it can evaluate performance and implement improvements, as needed, across its network and membership.

What is Sub-Delegation?
Sub-delegation occurs when the Provider Organization’s delegate gives a third entity the authority to carry out a delegated function. For example, the Provider Organization may delegate credentialing (CR) activities to a Management Services Organization (MSO), which then delegates some of those activities to a Credentialing Verification Organization (CVO). In this case, the CVO is the sub-delegate.

Oversight of sub-delegates:
When a delegate sub-delegates to a third entity, either the delegate or the organization oversees the sub-delegate’s work. The delegation agreement between the organization and the delegate specifies the entity responsible for overseeing sub-delegates. If the delegate oversees the sub-delegate, it must report to the organization regarding the sub-delegate’s performance. The Provider Organization must ensure that work performed meets the Provider Organization standards, governmental agency (CMS and DMHC), URAC and NCQA standards. The Provider Organization is ultimately accountable for all activities performed by both the delegate and sub-delegate on its behalf.

Types of Delegation Arrangements
The most common delegation arrangements are between organizations and primary, specialty and multi-specialty medical groups, IPAs, credentialing verification organizations (CVO) and disease management (DM) organizations.
### Guide to Delegation

<table>
<thead>
<tr>
<th>Ownership issues</th>
<th>Delegation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSO and group wholly owned by the same organization (e.g., hospital, integrated health system, business corporation)</td>
<td>Activities conducted by 'sister' organizations does not constitute a delegation arrangement</td>
<td>Wholly owned means 100%, anything less is not wholly owned</td>
</tr>
<tr>
<td>MSO wholly owns medical group</td>
<td>No delegation</td>
<td></td>
</tr>
<tr>
<td>Medical group wholly owns MSO</td>
<td>No delegation</td>
<td></td>
</tr>
<tr>
<td>MSO partially owned by medical group</td>
<td>Delegation</td>
<td></td>
</tr>
<tr>
<td>Medical group partially owned by MSO</td>
<td>Delegation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product</th>
<th>Activity</th>
<th>Delegation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSO</td>
<td>P&amp;P development, approved by group</td>
<td>No delegation</td>
<td>No delegation agreement or oversight required</td>
</tr>
<tr>
<td></td>
<td>P&amp;P development, not approved by group</td>
<td>Delegation</td>
<td>Delegation agreement and oversight required (annual review for compliance with MCO requirements)</td>
</tr>
<tr>
<td></td>
<td>Collection of information needed to make a decision</td>
<td>No delegation</td>
<td>No delegation or oversight required</td>
</tr>
<tr>
<td></td>
<td>Any decision made by MSO – either an approval or a denial</td>
<td>Delegation</td>
<td>Delegation agreement and oversight required</td>
</tr>
</tbody>
</table>
Delegating to an NCQA-Accredited or NCQA-Certified Entity

When a Provider Organization delegates defined activities to an NCQA-Accredited or NCQA-Certified organization, the expectation of a formal pre-delegation evaluation, annual evaluation and annual audit, as applicable, and the determination of meeting NCQA standards are satisfied for activities covered within the delegate’s NCQA-Accreditation or NCQA-Certification survey.

The Health Plan waives the pre-delegation assessment and annual oversight requirements of NCQA-Accredited or NCQA-Certified delegates. Oversight relief is not available for activities that are not covered—including NA activities, within the scope of a delegate’s NCQA-Accreditation or NCQA-Certification survey.

Oversight relief is only available for elements and categories (certification options) in which an NCQA certified organization received certification. For example, a CVO may elect not to seek or may not receive certification for Ongoing Monitoring of Sanction Information. If the CVO has certification in all other certification options and the Provider Organization delegates ongoing monitoring to the CVO, it does not receive oversight relief for delegated ongoing monitoring activities and is required to conduct pre-delegation and annual evaluation of the delegates. The Health Plan will give the Provider Organization 100% score on specific delegation oversight elements for NCQA-Accredited or NCQA-Certified delegates.

NCQA Accreditation programs

NCQA Certification Programs
- Organization Certification in Disease Management (DM)  http://www.ncqa.org/tabid/98/default.aspx
Utilization Management Delegation Example

Does someone other than the treating physician make decisions about what care the Provider Organization pays for or what care a patient may have including pre-certifying services (e.g. inpatient care procedures pharmaceutical)?

Yes

Delegation

No

Does an entity other than the Provider Organization have the authority to perform some or all UM functions (e.g. another entity provides communication or pharmaceutical services for members and practitioners, etc)?

Yes

Delegation

No

No Delegation
Utilization Management Definitions and Formulas

Click on the Hyperlink below:

UM Definitions and Formulas

Updates will be posted to that site as well.
Sample Policies and Procedures
and
Informational Attachments - Commercial

The following templates may be utilized by the Provider Organization to assist with the development of policies. The templates are based on Anthem requirements and may not be specific to other health plan requirements, including the ICE Credentialing Shared Audit.
Anthem Commercial
Case Management Information Sheet

The Case Management program at Anthem is responsible for evaluating and monitoring the efficiency, appropriateness and quality of all aspects of health care for Anthem members who have accepted the Case Management Program. Anthem’s case managers handle medically complex, surgically complex, and high level care coordination needs type cases. The Case Management program accepts referrals from internal and external sources to include and not limited to data mining, system triggers, live referrals from the Utilization Management team, customer service, physician referrals, and client groups.

The Case Management Program works in partnership with integrated teams that includes member, their caregivers as appropriate, physicians, Case Management Medical Directors, pharmacists, behavioral health case managers, and others to support a member centric plan of care. The Case Management program targets and addresses gaps in care and care transitions issues with implementation of interventions that support appropriate use of member benefits and community resources. The Case Management program also includes programs with specialty focus such as:

- The NICU program provides UM to all members admitted to the NICU and CM to all members being discharged from the NICU with complex needs.
- Post discharge calls to members recently discharged from a hospital to ensure members understanding and compliance with their discharge instructions. Case Managers will complete an assessment to identify gaps in care and care transitions issues that include medication reconciliation, physician follow up appointments, self-management plan of care, and implement interventions addressing barriers to care.

The Case Management Department is committed to supporting our Provider Organization partners. If you would like to refer your patient for case management or need assistance in managing a commercial member, please feel free to call the number listed on our referral guidelines.
Referrals to Case Management

Scope: CA Commercial UM (PPO and HMO)

Predictive Modeling software automatically identifies members at the highest risk for possible readmission for PPO member population. However, there are circumstances that require a UM/UM CDC Nurse to manually refer PPO and HMO members to Case Management for direct member outreach.

Referral Criteria

Refer members to Case Management based on the following criteria:

- 10 day inpatient LOS (i.e. 10 day mandatory referral)
- Direct request for CM referral from
  - Member
  - MD/Provider
  - Client/Employer group
  - Account Managers/Directors
- Benefit Substitution
- Known barriers to discharge or access to care issues
  - Psychosocial
  - Financial
  - Transportation
- Identification of limited and/or complex benefit issues
- NICU and High Risk OB (see criteria below for CM and DM)

Specific to HMO Members

Participating medical group (PMG) consent is required for HMO members prior to CCM referral when the member is in the service area of the PMG; this is called “PMG outreach”. PMG outreach is NOT required if the member is NOT within the PMG service area (i.e. out of area).

NICU/Maternity/High Risk OB Referral Criteria to CM

**Neonatal/Complex Newborn Criteria**

Refer any of the following conditions to CM, at time of identification or timeframe listed, via Medical Level I Screening:

- Every newborn baby in hospital for 30 days or more, or discharged from NICU with any complex needs
- Congenital or chromosomal anomalies
- Neurological issues such as: Asphyxia, Hydrocephalus, or Seizures... if discharged home with medication
- Social issues
- Blood disorders
- Cancer
- Long term chronic illness
- Any baby who is discharged from the NICU and is readmitted
- Any baby readmitted within 1 month of discharge from NICU, PICU, or Pediatrics

**Maternity/High Risk OB Criteria**

Refer any of the following conditions to CM, at time of identification or timeframe listed, via Medical Level I Screening:
Any pregnant patient in hospital for 7 days or more and is less than 35 weeks pregnant (with any diagnosis)
Fetal anomalies
Mother with a chronic illness (i.e. - cardiac, Sickle Cell, etc.)
Multiple admissions- 2 or more admissions for Pre Term Labor with this pregnancy
Poor OB history (e.g. prior still born, fetal demise, preterm delivery @ 28 weeks or less) and is currently between 24 and 34 weeks pregnant
3 or more home or outpatient services (e.g. HUAM, HIT, Progesterone)
Hyperemesis with 2 or more hospital admissions (regardless of how many weeks currently pregnant)

**Maternity/High Risk OB Referral Criteria to DM Maternity Program**

- Any pregnant member under 36 week gestation who does not meet criteria for case management
- Send referral via email (see example form on next page):
  - Case.management@wellpoint.com
  - Call the Case Management Toll Free number 888 613 1130, press option 2, then, press option 2 for all other CM referrals.

**Review/Revision Log**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tr>
<td>9/20/11</td>
<td>Created and Adopted</td>
</tr>
<tr>
<td>9/28/11</td>
<td>Added NICU and High Risk OB; added HMO</td>
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<tr>
<td>10/11/11</td>
<td>Added NICU/High Risk OB referral criteria</td>
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<tr>
<td>10/18/11</td>
<td>Added NICU/High Risk OB DM referral criteria and process</td>
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<td>07/10/205</td>
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Case Management Referral Criteria:
- Known barriers to discharge or access to care issues
- Benefit Substitution
- Identification of limited and/or complex benefit issues
- Newly diagnosed complex chronic conditions not managed by PMG/IPA CM
- Services for non-participating providers (Inpatient and Outpatient services)
- Unexpected change in discharge plan that may have negative impact to member
- NICU and High Risk OB
- Direct request for CM referral from Member, MD/Provider, PMG/IPA, Client/Employer Group

Case Management for HMO members is handled at Anthem Blue Cross in the Commercial HMO Co-
Management Department. Please refer members who may benefit from Case Management, as described
below.

NOTE: Anthem Blue Cross also provides Case Management for Federal Employee HMO members (may
also be referred to as FEHBP, FEP or Federal Employees).

Please Complete and Return to Anthem Blue Cross HMO Co-Management via:
Email: case.management@wellpoint.com
Phone: Case Management Toll free number: 888 613 1130, press option 2, then press option 2 for
all other CM referrals

Member Name: 

Member ID: 

Current level of care:
- Acute Care
- SNF
- ARU
- LTAC
- at home under care of PCP/Specialist
- Other

Reason for referral to CM: (Insert Free Form Text)

Phone Number and contact information:
(Insert Name and Title)
(Insert Phone Number and Extension)
Fax number:
PMG Medical Director contact:

Clinical history:
☐ Primary diagnosis
☐ Co-morbid diagnosis

Check all that apply and provide a short description of the assessed Case Management needs?

☐ HHC
☐ DME
☐ SNF
☐ Long term acute care
☐ Acute Rehab
☐ Outpatient Rehab
☐ Tertiary Care
☐ Psychosocial Issues
☐ Access to Care issues
☐ Compliance issues
☐ Long term / life care planning
☐ Disease Management Resources
☐ OOA notification

Other Issues / please describe
☐ Disputed assignment of member
☐ Disenrollment request
Affirmative Financial Statements Regarding Incentives

Provider Organizations must distribute a statement every 2 years to all participating practitioners, providers and staff who make UM decisions regarding its incentives to encourage appropriate utilization and discourage underutilization. The statement must affirm the following:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- The Provider Organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
- Practitioners are ensured independence and impartiality in making referral decisions that will not influence:
  - Hiring
  - Compensation
  - Termination
  - Promotion
  - Any other similar matters

**URAC Accredited Provider Organizations Only in Addition**

- *Staff confirmation that consumer healthcare is not compromised.*

- The affirmative statement may be distributed via memos, signed statements, meeting minutes, practitioner contract, practitioner manual, program/plan, policies and procedures, clinic fliers or postings, member or practitioner newsletters, and the Internet. If the Internet is the mode of distribution, the Provider Organization must also send written notification to all participating practitioners of the availability of the information on the Provider Organization’s Web site and provides paper copies of the information upon request.

**Reference Sources:**
NCQA UM 4.F; URAC Core 33; 29 CFR 2590.715-2719(b)(2)(ii)(D)
Consistency in Applying Criteria (Interrater Reliability)

At least annually, a 12 month period with a 2 month grace period, the Provider Organization must evaluate the consistency with which health care professionals involved in Utilization Management apply criteria in decision making. Consistency of applying criteria is evaluated on all physician reviewers and on all non-physician reviewers. A minimum of 2 physician reviewers must be included in the study. The Provider Organization must also act on opportunities to improve consistency with evidence of corrective action.

- Methods utilized to ensure interrater reliability may include side by side comparisons of different UM staff members managing the same cases, weekly UM rounds attended by UM staff members and physicians to evaluate determinations and problem cases, or periodic audits of determinations against criteria, or an annual review of a sample of UM determinations.
- Assessment methodology and results should be documented and reported to the appropriate oversight committee and the physician and non-physician reviewers.
- Problem identification, corrective action, intervention/education, re-measurement must be conducted as applicable.

Attachments:
- Sample Interrater Reliability Assessments

Reference Sources:
NCQA UM 2.C 1-2; CA Health & Safety Code § 1367.01(b)
Physician Interrater Reliability Audit
Consistency of Application of Criteria

Purpose: To provide a mechanism for evaluating the consistency with which health care professionals involved in utilization review, apply criteria in decision making.

Date: ________ Case ID #: __________________________

Physician Reviewer Name/ID #: __________________________

Physician Reviewer Specialty: _____________ Board Certified? Yes ___ No____

Brief Summary of Case:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Physician Reviewer's Recommendation:

☐ Approve
☐ Refer to Utilization Management Committee
☐ Pend/Defer (If referral is pended or deferred, complete section III.)
☐ Deny (If referral is denied, complete section III.)

Physician Reviewer's Reason and Criteria for Decision:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Physician Reviewer's Signature: ________________________________________________________

Analysis conducted by: ________________ Title: ______________ Date: ____________

Improvement intervention necessary:  ☐ Yes  ☐ No

CAP necessary: ☐ Yes  ☐ No

Re-assessment date: ________________ ☐ N/A

Date reviewed by Oversight Committee: ____________
Physician Interrater Reliability Audit Instructions

Procedure:

- The assessment mechanism may take several forms: a supervisor's periodic review of determinations (which could be side-by-side comparisons of how different UM staff members manage the same cases), weekly UM "rounds" attended by UM staff members and physicians to evaluate determinations and problem cases, hypothetical UM test cases, periodic audits of determinations against criteria, or annual review of a sample of UM determinations using the 5 percent or 50 of UM determination files, whichever is less or the 8/30 scoring methodology.
- UM Director sends the audit to all MD reviewers along with appropriate documentation and timeline for completion (i.e. prior to next UMC meeting)
- A minimum of 2 physician reviewers must be included in the IRR study
- All assessments should be reviewed/scored by the Medical Director and UM Director
- Results and education (if applicable) should be discussed at the appropriate oversight committee
- Issues should be identified and corrective action implemented as applicable
- Re-assessment must be conducted to measure outcomes of corrective action interventions
- Results and education (if applicable) are discussed at the appropriate oversight committee
Non-Physician RN/LVN Interrater Reliability Audit
Consistency of Application of Criteria

Date: ___________________ RN/LVN Reviewer Name/ID#: ___________________

Title: ___________

Reviewer Licensure: _______________________________________________

Reviewer Signature: _______________________________________________

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Analysis conducted by Name: ___________________ Title: ___________________ Date: ___________

Improvement intervention necessary: ☐ Yes ☐ No

CAP necessary: ☐ Yes ☐ No

Re-assessment date: _______________ ☐ N/A

Date reviewed by Oversight Committee ___________
Purpose:
To ensure compliance with Anthem ReadyAccess Program

Responsibility:
Utilization Management Staff

Policy:
Per contract with Anthem, in relation to the Speedy Referral Program, it is the policy of “X” Provider Organization to authorize the PCP to immediately refer to the following: Allergy, Cardiology, Dermatology, Ear/Nose/Throat, Endocrinology, Gastroenterology, General Surgery, Hematology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Podiatry, Routine Laboratory, Routine X-ray, Urology.

Per contract with Anthem, in relation to the Direct Access Program, the member must have direct access without PCP referral to the following: Allergy, Dermatology, Ear/Nose/Throat. Anthem members should expect to receive at minimum an evaluation and consultation from the physician during the direct access visit(s).

Direct member access to an OB/GYN is required under Federal law without any requirement for authorization.

Specialist/Ancillary Providers may provide more services in addition or subsequent to the evaluation/consultation and are subject to “X” Provider Organization protocol and procedure with regard to referrals authorizations and treatment.

Attachment(s):
None

Reference Sources:
42 USC 300gg-19b
Purpose:
“X” Provider Organization has a process to ensure cooperation and compliance with our contracted Health Plan’s Language Assistance Program (LAP) translation services for non-standardized vital documents, applicable LAP education and training including cultural competency, and provision of interpretation services is in accordance with state and federal regulatory and accrediting agency standards.

Policy:
• It is the policy of “X” Provider Organization to ensure that all requests for translation services are forwarded to the Health Plan in a timely fashion and that these requests are tracked.
• All “X” Provider Organization administrative and medical staff that have contact with Limited English Proficiency (LEP) members will have education regarding Health Plan offered LAP services, and cultural competency.
• All “X” Provider Organization administrative and medical staff will be provided a list of contracted Health Plans and their contact numbers for interpretive services.

Responsibility:
Utilization Management, Quality Management and all staff having contact with Limited English Proficiency (LEP) members

Procedure:
• “X” Provider Organization’s process for the provision of Language Assistance Program (LAP) translation services for non-standardized vital documents is, as follows:
  ➢ The LAP Notice of Translation, approved by DMHC, will accompany the following Non-standardized Vital Documents when issued in English:
    ▪ UM denial notifications, including modifications
    ▪ UM delay notifications for additional information or expert review
    ▪ Specialist termination letters to members
• “X” Provider Organization forwards all translation requests to the Health Plan. Member requests for translation may include Provider Organization issued non-standard vital documents and Health Plan issued documents.
• “X” Provider Organization tracks member requests (e.g., log, electronic monitoring, and copy retention) for translation services including:
  ➢ Date and time the request for translation or vital document was received
  ➢ Date and time the member request and/or vital document was forwarded to the Health Plan
    ▪ “X” Provider Organization includes any attachments that are provided with the letter to the member (e.g., clinical guidelines or medical policy) when copy retention is used as the tracking mode.
• “X” Provider Organization follows timeliness standards for forwarding the translation requests or supporting documents to the Health Plan including:
  ➢ Requests related to urgent health care services will be forwarded within one business day of receipt of request.
- Requests related to non-urgent health care services will be forwarded within two business days of receipt of request.

- **“X” Provider Organization** provides education and training including the Health Plan’s LAP materials, to persons who have routine contact with Limited English Proficiency (LEP) members. Staff may include the following: Provider Organization staff, contracted and employed providers/practitioners and provider office staff.

- **“X” Provider Organization** ensures Health Plan LAP materials, (i.e., Anthem HMO Provider Operations Manual, ICE Health Plan LAP contact sheet, cultural diversity and sensitivity materials and any Anthem generated LAP educational materials) are disseminated by documenting LAP education was conducted for all persons identified as having routine contact with Limited English Proficiency (LEP) members.

- **“X” Provider Organization** provides a list of the contracted Health Plans responsible for interpretation services at all points of contact, including the appropriate phone number and the name of Health Plan department responsible for coordinating interpretation services.

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**Web Links:**


**Attachments:**
See Commercial Attachments: Language Assistance Program (LAP) Template Information

**Reference Sources:**
CA Health & Safety Code § 367.04(b)(1)(C)(ii); 28 CCR § 1300.67.04(c)(2)(H)(3), § 1300.67.04(c)(2)(C)(i),(e), § 1300.67.04(c), § 1300.67.04(c)(2)(C)(i),(e)
Purpose:
Applicable only to Provider Organizations who are delegated for Language Assistance and/or provide services as self-funded plans. “X” Provider Organization has a process to ensure Limited English Proficiency (LEP) members are notified that translation services for adverse determinations are available upon request. Further, applicable LEP education and training including cultural competency, and provision of interpretation services are in accordance with federal regulatory and accrediting agency standards.

Policy:
• It is the policy of “X” Provider Organization to ensure that all adverse determinations include the offer of translation in threshold languages as determined by contracted health plan, state regulatory body as applicable and U.S. Census data.
• All “X” Provider Organization administrative and medical staff that has contact with LEP members will have education regarding translation and interpretive services, and cultural competency.
• All “X” Provider Organization administrative and medical staff will be provided a list of contracted providers for translation and interpretive services.

Responsibility:
Utilization Management, Quality Management and all staff having contact with LEP members

Procedure:
• “X” Provider Organization’s initial process will be to determine the applicable plan jurisdiction and notice requirements. For members of DMHC managed care plans, “X” Provider Organization’s process for the provision of Language Assistance Program (LAP) translation services for non-standardized vital documents is, as follows:
  ➢ The LAP Notice of Translation, approved by DMHC, will accompany the following Non-standardized Vital Documents when issued in English:
    ▪ UM denial notifications, including modifications
    ▪ UM delay notifications for additional information or expert review
    ▪ Specialist termination letters to members
• For members of self-funded plans which are not under a DMHC managed care plan and the Federal Notice of Language Assistance will be used as applicable:
  ➢ California addressee: English, Spanish and Chinese
  ➢ Alaska addressee: English, Spanish and Tagalog
  ➢ Arizona, New Mexico or Utah addressee: English, Spanish and Navajo.
  ➢ All other state addresses receive English and Spanish only.
“X” Provider Organization may receive member requests for translation for Provider Organization and Health Plan documents. For DMHC managed care plans, “X” Provider Organization is responsible for providing translation of Provider Organization issued documents within 21 calendar days of the member’s request. Member requests for translation of Health Plan issued documents should be forwarded to the Health Plan.

“X” Provider Organization tracks member requests of Health Plan issued documents (e.g., log, electronic monitoring, and copy retention) for translation services including:
- Date and time the request for translation or vital document was received
- Date and time the member request and/or vital document was forwarded to the Health Plan

“X” Provider Organization follows timeliness standards for forwarding the translation requests or supporting documents to the Health Plan including:
- Requests related to urgent health care services will be forwarded within one business day of receipt of request.
- Requests related to non-urgent health care services will be forwarded within two business days of receipt of request.

“X” Provider Organization provides education and training, including the offers of translation materials, to persons who have routine contact with LEP members. Staff may include the following: Provider Organization staff, contracted and employed providers/practitioners and provider office staff.

“X” Provider Organization ensures translation and interpretive service materials, (i.e., Anthem HMO Provider Operations Manual, ICE Health Plan LAP contact sheet, cultural diversity and sensitivity materials and any Anthem generated LEP educational materials) are disseminated by documenting education was conducted for all persons identified as having routine contact with LEP members.

“X” Provider Organization provides a list of the responsible department or vendor for interpretation services at all points of contact, including the appropriate phone number and the department responsible for coordinating interpretation services.

Attachments:
None

Reference Sources:
CA Health & Safety Code § 367.04(b)(1)(C)(ii); 28 CCR § 1300.67.04(c)(2)(F)(v); 28 CCR § 1300.67.04(c)(2)(H)(3); 28 CCR § 1300.67.04(c)(2)(C)(i),(e); 28 CCR § 1300.67.04(c); 28 CCR § 1300.67.04(c)(2)(C)(i),(e)
**Purpose:**
To ensure timely and appropriate Commercial Utilization Management (UM) Referral processing for HMO and PPO members governed by Knox Keene Act in California.

**Policy:**
It is the policy of “X” Provider Organization that Commercial UM Referrals will be processed per Health Plan criteria and that the process will not interfere with or cause delay in service, or preclude delivery of services. It is the policy of “X” Provider Organization that the Commercial UM Referral process will be documented according to federal and state requirements. It is the policy of “X” Provider Organization to follow the most current ICE Commercial UM timeliness standards to meet federal and state requirements for decision and notification timeliness.

**Responsibility:**
Medical Director, Utilization Management Staff

**Procedure:**

**UM Referral Processing**
- A tracking system will be implemented for all UM Referrals for documentation/identification of request status.
- Tracking will also include periodic audits for UM Referral time frame compliance monitoring. If UM Referral time frame audits indicate poor compliance, “X” Provider Organization will take action to improve performance.
- Denial decisions will be made in accordance with state licensure requirements.

**UM Referral Documentation**
- Denials will include clinical information documented on the authorization request form or on attached medical record copies. Determinations related to benefit limitations/exclusions must evidence consultation with appropriate resources (e.g., consultation with Health Plan, Health Plan criteria, medical policy).
- UM Referral requests, decisions, notifications and all pertinent related actions will be documented in the applicable UM file.
- Practitioner notification of the availability of physician and behavioral health reviewers to discuss decisions will ensure that practitioners receive information sufficient to understand and discuss with the member about appealing a decision to deny care or coverage.
- Communications regarding decisions to approve requests by practitioners will specify the specific health care service approved.
- For all telephonic notifications, practitioner/provider/member name, the time, date, and signature of the person who spoke with the practitioner/provider/member will be documented.

**UM Referral Process Timeliness**
- “X” Provider Organization will follow the current Commercial ICE Timeliness Standards located on the ICE Web site at www.iceforhealth.org.
- Urgent Pre-Service Requests
  - Decisions are made in a timely fashion as appropriate for the member’s condition, not to exceed 72 hours of receipt of the request.
  - Practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision, not to exceed 72 hours of receipt of request.
  - Member is notified of approvals within 72 hours of receipt of the request.
  - Practitioner is sent written or electronic notification of denial decisions within 72 hours of receipt of the request.
  - Member is sent written or electronic notification of denial decisions within 72 hours of receipt of the request.
  - If verbal notification of denial decision is given to practitioner and member within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial verbal notification.

- Urgent Pre-Service – Additional Information Required
  - Practitioner and Member are notified within 24 hours of receipt of the request.
  - Practitioner and member are provided 48 hours for submission of requested information.
  - If requested information is received, complete or not, decision is made within 48 hours of receipt of additional information.
  - If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours.
  - If additional information is received or incomplete, practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision, not to exceed 48 hours of receipt of the requested information.
  - If additional information is received or incomplete, member is notified of approvals within 48 hours after receipt of the requested information. Notification may be verbal, electronic or written.
  - If information is not received, practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner and member to supply the information.
  - If information is not received, member is given verbal, electronic or written notification of approval decisions within 48 hours after the timeframe given to the practitioner and member to supply the information.
  - If additional information is received or incomplete, practitioner and member are sent written or electronic notification of denial decisions within 48 hours after receipt of the requested information.
  - If additional information is not received, practitioner and member are sent written or electronic notification of denial decisions within 48 hours after the timeframe given to the practitioner and member to supply the information.
  - If verbal notification of denial decision is given, written or electronic notification to practitioner and member must be given no later than 3 calendar days after the initial verbal notification.

- Non-Urgent Pre-Service Requests
  - Decision is made within 5 business days of receipt of the request.
  - Practitioner is given initial notification of approval and denial via telephone, fax, e-mail, or online within 24 hours of making decision.
  - Member is notified of approval within 2 business days of the decision. Notification may be verbal, electronic or written.
  - Practitioner is sent written or electronic notification of denial decision within 2 business days of making the decision.
- Member is sent written or electronic notification of denial decision within 2 business days of making the decision.

- **Non-Urgent Pre-service – Additional Information or Expert Review Required**
  - Practitioner and Member are notified within 5 business days of receipt of the request.
  - Member and practitioner are provided at least 45 calendar days for submission of requested information.
  - If a consultation by an expert reviewer is required, upon expiration of the 5 business days or as soon as it is known that the 5 business day timeframe will not be met, whichever occurs first, the practitioner and member must be notified of the type of expert reviewer required and the anticipated date on which decision will be rendered (no more than 15 calendar days from the date of the pended notification).
  - If requested information is received, complete or not, decisions are made within 5 business days of receipt of additional information.
  - If no information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 5 business days.
  - If a consultation by an expert reviewer is required, decision is made within 15 calendar days from the date of the pended notification.
  - Practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision.
  - Member is notified of approvals within 2 business days of making the decision. Notification may be verbal, electronic or written.
  - Practitioner and Member are sent written or electronic notification of denial decisions within 2 business days of making the decision.
  - If a consultation by an expert reviewer is required, practitioner and member are given written/electronic notification of denial decision within 2 business days of making the decision.

- **Urgent Concurrent Requests (e.g., inpatient, ongoing ambulatory services)**
  - Urgent concurrent requests involve both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. (Exceptions: When request is not received at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to the Urgent Pre-Service category. When the request to extend a course of treatment beyond the period of time or number of treatments previously approved does not involve urgent care, default to the Non-Urgent Pre-Service category.)
  - Care cannot be discontinued until the member’s treating practitioner has been notified of the decision and a care plan has been agreed to by the treating practitioner.
  - Decision is made within 24 hours of receiving request.
  - Practitioner is given initial notification of approval and denial decisions via telephone, fax, e-mail, or online within 24 hours of receiving request.
  - Member is notified of approvals within 24 hours of receipt of request. Notification may be verbal, electronic or written. (Hospitalist programs are not required to provide notifications of approvals or denials.)
  - Practitioner is sent written or electronic notification of denial decisions within 24 hours of receipt of request.
  - Member is sent written or electronic notification of denial decisions within 24 hours of receipt of the request. If verbal notification of denial decision is given within 24 hours of receipt of the request, then written or electronic notification to practitioner and member must be given no later than 3 calendar days after the initial verbal notification.
Post-Service Requests
- Decision is made within 30 calendar days of receipt of the request.
- Practitioner is sent written or electronic notification of denial decision within 30 calendar days of receipt of request.
- Member is sent written or electronic notification of denial decision within 30 calendar days of receipt of request.

Post-Service – Additional Information or Expert Review Required
- Practitioner and Member are notified within 30 calendar days of receipt of the request.
- Practitioner and member are provided at least 45 calendar days for submission of requested information.
- If a consultation by an expert reviewer is required, upon expiration of the 30 calendar days or as soon as it is known that the 30 calendar day timeframe will not be met, whichever occurs first, the practitioner and member must be notified of the type of expert reviewer required and the anticipated date on which a decision will be rendered (decision will be rendered no more than 15 calendar days from the date of the pended notification).
- If additional information is received, complete or not, decisions are made within 15 calendar days of receipt of requested information.
- If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information available within an additional 15 calendar days.
- If a consultation by an expert reviewer is required, decision is made within 15 calendar days from the date of the pended notification to the practitioner and member.
- If additional information was received or incomplete, practitioner and member are sent written or electronic notification of denial decisions within 15 calendar days of receipt of requested information.
- If no additional information is received, practitioner and member are sent written or electronic notification of denial decisions within 15 calendar days after the timeframe given to the practitioner and member to supply the information.
- If a consultation by an expert reviewer was required, practitioner and member are given written or electronic notification of denial decision within 15 calendar days from the date of the pended notification.

Attachments:
None

Reference Sources:
Purpose:
To ensure that criteria used to make UM decisions are appropriate

Policy:
It is the policy of “X” Provider Organization that established utilization review (UR) criteria will be utilized in the UM Referral process.

Responsibility:
Utilization Management Staff

Procedure:
- Written or electronic UR criteria (used to authorize, modify, or deny healthcare services), and procedures for applying them, must be developed, reviewed at least annually and updated as necessary utilizing and referencing established UR criteria standards (MCG, InterQual, or Health Plan and for behavioral health - DSM-IV or VI-TR or Health Plan).
- UR protocols include appropriate setting, LOS, practitioner type, and indications/contraindications for requested service. Criteria will be objective, measurable, based on sound clinical evidence, and the individual needs of the members and characteristics of the local delivery system.
- The criteria hierarchy is as follows:
  o Federal or State Mandate
  o Benefit coverage
    - Anthem adopted AIM Specialty Health Radiology and Sleep Disorder Management, Diagnostic and Treatment Guidelines
    - Anthem Medical Policy or Anthem UM Clinical Guidelines, if available
  - Standardized Criteria (e.g., MCG, InterQual, DSM-IV or VI-TR)
  o Provider Organization Criteria or Guideline
  o Resources may include MCG™ (formerly Milliman Care Guidelines), McKesson’s InterQual, Apollo Managed Care, Hayes Inc., Medicare Coverage Guidelines, DSM-IV, Health Plan and generally accepted standards of medical practice based on medical necessity
- The following factors will be considered when applying criteria to the given individual: age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable.
- Appropriate actively practicing health care practitioners will be involved in the development, adoption, and application of medical and behavioral health care standardized criteria.
- Standardized criteria at a minimum are:
  o in accordance with generally accepted standards of medical practice; and
  o clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and
  o not primarily for the convenience of the covered individual, physician or other health care provider; and
not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

- **Written or electronically maintained operational policies, procedures and clinical support tools are provided to UM staff to use as appropriate to their job.**
- **Initial screening scripts and algorithms are developed to support UM staff including non-clinical staff and are approved by the medical director or Clinical Director (designee), upon request.**
- A description should be included explaining how UM policies/procedures and UR criteria will be distributed to practitioners and providers.
- Upon request, UM policies/procedures and UR criteria will be disclosed to providers, members, and/or member representatives. Commercial members may be charged a copying/postage fee, however, MediCal members will not be charged.
- **“X” Provider Organization’s dissemination of UM policies/procedures and UR criteria to requesting members and the public will include the following disclosure notice: “The materials provided to you are guidelines used by this Provider Organization to authorize, modify or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.”**

**Attachments:**
None

**Reference Sources:**
NCQA UM 2; URAC Core 28, HUM 1(a-d), HUM 4(b); 42 CFR § 422.202(b)(1)(i, iii, iv), § 422.202(b)(2); CA Health & Safety Code § 1363.5(a), § 1363.5(b)(1-3), 1367.01(b)
To ensure the collection and review of the minimum information required for referral requests.

**Policy:**
It is the policy of “X” Provider Organization that appropriate clinical information will be reviewed as part of the decision process. The review process must not interfere with or cause delay in service or preclude delivery of services.

**Responsibility:**
Utilization Management Staff

**Procedure:**
- When making a determination of coverage based on medical necessity, “X” Provider Organization will obtain and document in the file, relevant clinical information (only the information which is reasonably necessary to make a determination) and consult with the treating physician, as necessary.
- Referral review and decision processes will be based on eligibility, plan benefits, review of member medical record, and review of UM criteria to determine medical necessity (using the UM criteria hierarchy:, Federal law, State law, Benefit coverage, Health Plan criteria, “X” Provider Organization specific adopted criteria, e.g.MCG, Interqual, Apollo, etc.then, “X” Provider Organization own guidelines; if none apply, professional judgment is used in lieu of UM criteria).
- Only the information necessary to approve the admission, procedure, or treatment, length of stay or frequency or duration of services is collected.
- Information is accepted from any reasonably reliable source that will assist in the approval process
- Peer clinical review is conducted for all cases where approval is not issued through initial clinical review or screening.
- Hospitals, physicians, and other providers are not routinely required to numerically code diagnoses or procedures to be considered for approval but may request such codes if available.
- Approval determinations are not reversed unless new information received is relevant to the approval that was not available at time of original approval and the service has not yet been rendered
- Communication of approval includes:
  - Notification to the attending physician or other ordering provider, facility rendering service and member
  - Tracking information (such as reference number) for the approval
  - Upon request from the attending physician or other ordering provider, facility rendering service, or member, written notification of any approval is provided.
  - Confirmation of approval for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services
- Ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the member’s condition or on necessary treatment and discharge planning activity (e.g., not routinely conducted on a daily basis).
- Does not routinely request copies of all medical records on all patients reviewed, and only the section(s) of the medical records necessary in that specific case to determine medical necessity or appropriateness of admissions or extension of stay, frequency or duration of service, or length of anticipated inability to return to work is required.
• **Process for sharing all clinical and demographic information on individual patients among various clinical and administrative departments that have a need to know to avoid duplicate requests for information from members or providers.**

• **For pre-service and concurrent review, review of determinations is based solely on the medical information obtained by “X” Provider Organization at the time of the review determination.**

• **For post-service review, review of determinations is based solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.**

• **Denials are not issued based on initial screening.**

• **Denials are not issued based on initial clinical review.**

  Written notification of the denial decision to the member and the attending physician or other ordering provider or facility rendering service includes:

  • **The principal reasons for the determination to deny**
  • **A statement that the clinical rationale used in making the denial decision will be provided in writing, upon request**
  • **Instructions for initiating an appeal and requesting a clinical rationale of the denial decision, including concurrent review**

**Attachments:**

None

**Reference Sources:**

NCQAUM 1.A.5, UM 6.A; URAC HUM 9, HUM 12,13 HUM,22-25.HUM 27-32; CA Health & Safety Code§ 1367.01(g)
Denial Letter Content

Provider Organizations must clearly document and communicate the reasons for each denial. Members and practitioners must receive sufficient information to understand and decide to appeal a decision to deny care or coverage.

Denial notifications must include the following:

- Denials to physicians/healthcare practitioners must include an opportunity to discuss any UM denial decision with a physician reviewer/healthcare practitioner reviewer including the name and phone number of the denying physician.
- Medical necessity denial notifications must include the specific reason for the denial and an easy-to-understand summary of the UR criteria on which the denial decision was based in relation to the member’s medical condition.
- Benefit denial notifications must include a reference to the specific benefit provision that excludes the health care service requested.
- Denial notifications must state that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
- Denial notifications must instruct the member to contact the requesting practitioner/provider for explanation of diagnosis and treatment codes.
- Denials must include standard/expedited appeals rights/process including the following:
  - An explanation of the appeal process and instructions for referral of all appeals to Anthem’s Grievance and Appeals Department
  - Right to submit written comments, documents or other relevant appeal information
  - Right to member representation
  - Timeframes for appeal resolution
  - Appropriate Health Plan demographic/contact information:
    - Anthem Blue Cross
    - Attention: Grievance and Appeals Department
    - P.O. Box 4310
    - Woodland Hills, CA91365
    - Phone: 1-800-365-0609
    - TDD: 1-866-333-4823
    - FAX: 1-818-234-1089
    - Internet: www.anthem.com/ca
  - The following paragraph (phone numbers and Web site address will be printed in 12-font bold face type):
    - The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Health Plan, you should first telephone your Health Plan at 1-800-365-0609 or TTY/TDD users may call 1-866-333-4823, and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage
decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

- Denials must include the following statement of the member’s right to bring a civil action:
  “You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your health plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employer’s benefit plan administrator to determine if your employer’s benefit plan is governed by ERISA. Additionally, you and your health plan may have other voluntary alternative dispute resolution options, such as mediation.”

- Denials must include an offer of consumer assistance:
  **Other resources to help you:** Do you have questions about your appeal rights or this notice? Need help with an appeal? You can get help from the Consumer Assistance Program (CAP) in California.
  California Department of Managed Health Care Help Center
  Toll Free: 1-888-466-2219   TDD/TTY 1-877-688-9891
  http://www.healthhelp.ca.gov

- Denial notifications must also include the following:
  - De-identification of the member’s social security number.
  - Names of copied practitioners
  - Anthem approved LAP Notice of Translation.

- It is recommended to use the health plan specific ICE Commercial Service Denial Notification (CSDN) template that may be downloaded from the ICE Web site:
  http://www.iceforhealth.org/library.asp?sf=&scid=702#scid702
NOTE: This policy is only applicable to PPO Provider Organizations that are fully funded and are not governed by the Knox Keene Act in California.

Purpose:
To ensure timely and appropriate Commercial Utilization Management (UM) Referral processing for PPO members.

Policy:
It is the policy of “X” Provider Organization that Commercial UM Referrals will be processed per Health Plan criteria and that the process will not interfere with or cause delay in service, or preclude delivery of services. It is the policy of “X” Provider Organization that the Commercial UM Referral process will be documented according to federal and state requirements. It is the policy of “X” Provider Organization to follow timeliness standards to meet federal and state requirements for decision and notification timeliness.

Responsibility:
Medical Director, Utilization Management Staff

Procedure:
UM Referral Processing
- A tracking system will be implemented for all UM Referrals for documentation/identification of request status.
- Tracking will also include periodic audits for UM Referral time frame compliance monitoring. If UM Referral time frame audits indicate poor compliance, “X” Provider Organization will take action to improve performance.
- Denial decisions will be made in accordance with state licensure requirements.

UM Referral Documentation
- Denials will include clinical information documented on the referral request form or on attached medical record copies. Determinations related to benefit limitations/exclusions must evidence consultation with appropriate resources (e.g., consultation with Health Plan, Health Plan criteria, medical policy).
- UM Referral receipts, decisions, notifications and all pertinent related actions will be documented in the applicable UM file.
- Practitioner notification of the availability of physician, behavioral health and pharmacist reviewers to discuss decisions will ensure that practitioners receive information sufficient to understand and discuss with the member about appealing a decision to deny care or coverage.
- “X” Provider Organization communication of denials will include:
  - Written notification of the denial decision to the member and the attending physician or other ordering provider or facility rendering the service
  - The principal reasons for the determination to deny
  - A statement that the clinical rationale used in making the denial decision will be provided in writing, upon request
Instructions for initiating an appeal of the decision, including concurrent review
Process by which “X” Provider Organization issues an administrative denial due to lack of information

“X” Provider Organization communication of approvals includes:
- Notification to the attending physician or other ordering provider, facility rendering service and member
- Tracking information (such as reference number) for the approval
- Upon request from the attending physician or other ordering provider, facility rendering service, or member, “X” Provider Organization provides written notification of any approval
- Confirmation of approval for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

Communications regarding decisions to approve requests by practitioners will specify the specific health care service approved.
For all telephonic notifications, practitioner/provider/member name, the time, date, and signature of the person who spoke with the practitioner/provider/member will be documented.

UM Referral Process Timeliness

“X” Provider Organization will follow the current Commercial ICE Timeliness Standards. (See ICE Timeliness Standards located on the ICE Web site at www.iceforhealth.org.

**Urgent Pre-Service Requests**

- Decisions are made in a timely fashion for the member’s condition not to exceed 72 hours of receipt of the request.
- Practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision, not to exceed 72 hours of receipt of request.
- Member is notified of approvals within 72 hours of receipt of the request. Notification may be verbal, electronic or written.
- Facility rendering service is given notification of approvals and denials via telephone, fax, email, written or online.
- Practitioner is sent written or electronic notification of denial decisions within 72 hours of receipt of the request.
- Member is sent written or electronic notification of denial decisions within 72 hours of receipt of the request. If verbal notification of denial decision is given to practitioner and member within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial verbal notification.

**Urgent Pre-Service – Additional Information Required**
- Practitioner and Member are notified within 24 hours of receipt of the request.
- Member and practitioner are provided 48 hours for submission of requested information.
- If requested information is received, complete or not, decisions are made within 48 hours of receipt of additional information.
- If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours.
- If additional information is received or incomplete, practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision, not to exceed 48 hours of receipt of the requested information.
- If additional information is received or incomplete, member is notified of approvals within 48 hours after receipt of the requested information. Notification may be verbal, electronic or written.
If additional information is received or incomplete, facility rendering service is notified of approvals and denials. Notification may be verbal, electronic or written.

If information is not received, practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner and member to supply the information.

If information is not received, member is given verbal, electronic or written notification of approval decisions within 48 hours after the timeframe given to the practitioner and member to supply the information.

If information is not received, facility rendering service is given verbal, electronic or written notification of approvals and denials.

If additional information is received or incomplete, practitioner and member are sent written or electronic notification of denial decisions within 48 hours after receipt of the requested information.

If additional information is not received, practitioner and member are sent written or electronic notification of denial decisions within 48 hours after the timeframe given to the practitioner and member to supply the information.

If verbal notification of denial decision is given, written or electronic notification to practitioner and member must be given no later than 3 calendar days after the initial verbal notification.

Non-Urgent Pre-Service Requests

- Decisions are made within 5 business days of receipt of the request.
- Practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision.
- Member is notified of approvals within 2 business days of the decision. Notification may be verbal, electronic or written.
- Facility rendering service is given notification of approvals and denials via telephone, fax, e-mail, or written, or online.
- Requesting practitioner is sent written or electronic notification of denial decisions within 5 calendar days of receipt of request.
- Requesting member is sent written or electronic notification of denial decisions within 5 calendar days of receipt of request.

Non-Urgent Pre-service – Additional Information or Expert Review Required

- Within 15 calendar days from receipt of request, “X” Provider Organization will provide written notification to the practitioner that it is unable to make a decision due to lack of information, the specific information needed, and the 45 calendar day time frame given to the member to provide the information.
- Within 15 calendar days from receipt of request, “X” Provider Organization will provide written notification to the member that it is unable to make a decision due to lack of information, the specific information needed, and the 45 calendar day time frame given to the member to provide the information.
- If a consultation by an expert reviewer is required, upon expiration of the 15 business days or as soon as it is known that the 15 business day timeframe will not be met, whichever occurs first, the practitioner and member must be notified of the type of expert reviewer required and the anticipated date on which decision will be rendered (no more than 15 calendar days from the date of the pended notification).
- If requested information is received, complete or not, decisions are made within 15 business days of receipt of additional information.
- If no information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 business days.
- If a consultation by an expert reviewer is required, decision is made within 15 calendar days from the date of the pended notification.
- Practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision.
- Member is notified of approvals within 2 business days of making the decision. Notification may be verbal, electronic or written.
- Facility rendering service is given notification of approvals and denials via telephone, fax, e-mail, written, or online.
- Practitioner and Member are sent written or electronic notification of denial decisions within 2 business days of making the decision.
- If a consultation by an expert reviewer is required, practitioner and member are given written/electronic notification of denial decision within 2 business days of making the decision.

#### Urgent Concurrent Requests (e.g., inpatient, ongoing/ambulatory services)
- Urgent concurrent requests involve both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. (Exceptions: When request is not received at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to the Urgent Pre-Service category. When the request to extend a course of treatment beyond the period of time or number of treatments previously approved does not involve urgent care, default to the Non-Urgent Pre-Service category.)
- Decisions are made within 24 hours of receiving request.
- Practitioner is given initial notification of approval and denial decisions via telephone, fax, e-mail, or online within 24 hours of receiving request.
- Member is notified of approvals within 24 hours of receipt of request. Notification may be verbal, electronic or written. (Hospitalist programs are not required to provide notifications of approvals or denials.)
- Facility rendering service is notified of approvals and denials via telephone, fax, e-mail, written, or online.
- Practitioner is sent written or electronic notification of denial decisions within 24 hours of receipt of request.
- Member is sent written or electronic notification of denial decisions within 24 hours of receipt of the request. If verbal notification of denial decision is given within 24 hours of receipt of the request, then written or electronic notification to practitioner and member must be given no later than 3 calendar days after the initial verbal notification.

#### Ongoing Ambulatory - (see above)

#### Post-Service Requests
- Decisions are made within 30 calendar days of receipt of the request.
- Requesting practitioner and member are given verbal or electronic notification of approval decisions within 30 calendar days of receipt of request.
- Facility rendering service is notified of approvals and denials via telephone, fax, e-mail, written, or online.
- Practitioner is sent written or electronic notification of denial decision within 30 calendar days of receipt of request.
- Member is sent written or electronic notification of denial decision within 30 calendar days of receipt of request.

#### Post-Service – Additional Information or Expert Review Required
- Practitioner and Member are notified within 30 calendar days of receipt of the request.
- Member and practitioner are provided at least 45 calendar days for submission of requested information.
- If a consultation by an expert reviewer is required, upon expiration of the 30 calendar days or as soon as it is known that the 30 calendar day timeframe will not be met, whichever occurs first, the practitioner and member must be notified of the type of expert reviewer required and the anticipated date on which a decision will be rendered (decision will be rendered no more than 15 calendar days from the date of the pended notification).
- If additional information is received, complete or not, decisions are made within 15 calendar days of receipt of requested information.
- If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information available within an additional 15 calendar days.
- If a consultation by an expert reviewer is required, decision is made within 15 calendar days from the date of the pended notification to the practitioner and member.
- Approval notification is given to attending physician or requesting provider, facility rendering service, and member within 15 calendar days of receipt of request.
- If additional information was received or incomplete, practitioner and member are sent written or electronic notification of denial decisions within 15 calendar days of receipt of requested information.
- If no additional information is received, practitioner and member are sent written or electronic notification of denial decisions within 15 calendar days after the timeframe given to the practitioner and member to supply the information.
- If a consultation by an expert reviewer was required, practitioner and member are given written or electronic notification of denial decision within 15 calendar days from the date of the pended notification.

Attachments:
None

Reference Sources:
Purpose:
To ensure that emergency services are arranged for or otherwise facilitated, including appropriate coverage of cost.

Policy:
It is the policy of “X” Provider Organization that emergent requests will be reviewed retrospectively for appropriateness and necessity.

Responsibility:
Medical Director, Utilization Management Staff

Procedure:
- Emergency services are covered if an authorized representative, acting on behalf of “X” Provider Organization, has authorized the provision of emergency services.
- “X” Provider Organization will authorize continued care for members who have received emergency services and care is stabilized, but the treating practitioner believes that the member may not be discharged safely.
- Emergency services are covered to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
  - For purposes of applying this standard, a prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.
  - A prudent layperson is considered to have acted “reasonably” if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.
- ER criteria are utilized and denial decisions will take into consideration presenting symptoms and not be based solely on discharge diagnoses.
  - Requests cannot be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the claimant (e.g., the member is unconscious and in need of immediate care at the time medical treatment is required).

Attachments:
None

Reference Sources:
- Emergency services are covered if an authorized representative, acting for the PO, has authorized the provision of emergency services.
  - An authorized representative may be an employee or contractor of the PO who directs the member to seek services. For example, an advice nurse, network physician, physician assistant, or customer service representative may act as the PO’s authorized representative.
NCQA UM 12.A; 29 CFR § 2560.503-1(b)(3); CA Health & Safety Code § 1371.4(a)
Purpose:
To notify practitioner and member when decisions cannot be made within the appropriate time frame.

Policy:
It is the policy of “X” Provider Organization that the pend process will be used if additional information is required or if an expert reviewer is necessary as allowed by the standards. The pend process will not be used for contractual or benefit questions.

Responsibility:
Medical Director, Utilization Management Staff

Procedure:
- If a decision to approve, modify or deny a referral cannot be made within the appropriate time frame, a pend notification will be sent to the practitioner and member in accordance with the timeframes specified in the most current ICE UM Commercial Timeliness Standards located on the ICE Web site at www.ice.org
- Notification will include all of the following:
  - Reason for pending (e.g., information was requested but not received, consultation by an expert reviewer is required, or additional examinations or tests are required).
  - Specific information needed
  - Time frame for submission of additional information
  - Expected date of decision
  - Type of expert reviewer required, if applicable
  - Physician reviewer’s name and direct phone number
  - Health plan specific language assistance program offer of translation (member’s copy only).
- Pended referrals will be tracked to ensure that decisions are made timely.
- Decision will be made in accordance with the ICE UM Commercial Standards and in the UM Referral policy.

Attachments:
None

Reference Sources:
; URAC HUM 19(c)(ii-iii); ; CA Health & Safety Code § 1367.01(h)(5); 29 CFR § 2560.503-1(b)(i), (f)(2)(iii)(A)
Purpose:
To ensure compliance with the Second Opinion process

Policy:
It is the responsibility of the UM department of “X” Provider Organization to appropriately review and process Second Opinion requests per health plan criteria.

Responsibility:
Utilization Management Staff

Procedure:
- Reasons for a second medical opinion to be provided or authorized will include the following:
  - If the member questions the reasonableness or necessity of recommended surgical procedure.
  - If the member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, but not limited to a serious condition.
  - If clinical indications are not clear or are complex, a diagnosis is in doubt due to conflicting tests, or the treating practitioner is unable to diagnose the condition, and the member requests an additional diagnosis.
  - If the treatment plan in progress is not improving the medical condition within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
  - If the member has attempted to follow the plan of care or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.
- Second medical opinion will be authorized or denied within a period of time appropriate for the member’s circumstances, but within no more than 72 hours from receipt of the request when the member’s condition poses an imminent and serious health threat, including potential loss of life, limb, or other major bodily function, or if lack of timeliness would be detrimental to member’s ability to regain maximum function.
- The second medical opinion will be rendered by a PCP or SCP acting within the scope of practice and who possess clinical background including training and expertise related to the particular illness or condition.
- Authorization process takes into account the member’s ability to travel to the practitioner rendering the second medical opinion.
- If the member requests a second opinion about care from a PCP, the second medical opinion may be obtained within the Provider Organization’s network. If the member requests a second opinion about care from a SCP, the second medical opinion may be obtained within the health plan’s entire network, and the health plan will incur costs beyond the member’s co-pay.
- If there is no participating plan provider within the Provider Organization’s network or if the member requests a second medical opinion outside of the Provider Organization’s network, the member will be instructed to call the Anthem Customer Service number on the back of the member’s ID card and not deny the request.
- The practitioner rendering the second opinion will provide the member and requesting practitioner with a consultation report including any recommended procedures or tests.
Attachments:
None

Reference Sources:
CA Health & Safety Code § 1383.15(a)(1-5), § 1383.15 (b)(c)(f)(g)(h)
SECOND OPINION REQUEST
Transition Assistance Department
URGENT/EMERGENT

FAX To: (877) 214-1781 Or Phone: (888) 486-4227

Date: ________________________________

Time: ________________________________

Call taken by: _________________________ Phone: _________________________

Circle One: C.S.R Account Manager Other: _________________________

Patient Name: __________________________

Subscriber Name: ______________________ Home phone: ____________________

Anthem Blue Cross ID Number: __________ PMG: _______________________

First Opinion Provider: __________________ Phone number: ____________________

Specialty: _____________________________ Date of last visit: ________________

Diagnosis/condition: ________________________________

REASON FOR REFERRAL:

- Member Requests to see specific provider

   Name: ________________________________

   Specialty: ____________________________

   Phone number: ________________________

- Member requesting assistance in locating a second opinion provider

________________________________________

________________________________________

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Revised 03/09/09
Purpose:
To ensure compliance with the Investigational/Experimental request process.

Policy:
It is the responsibility of the UM department of “X” Provider Organization to appropriately review and process Investigational/Experimental request per the health plan’s process.

Responsibility:
Utilization Management Staff

Procedure:
- “X” Provider Organization will immediately refer all commercial requests for experimental or investigational treatments, including clinical trials, to the health plan for initial determination, regardless of benefit exclusion.
  - The fully completed “Request for Health Plan Initial Determination Investigational/Experimental (I/E) Treatment Form” and all pertinent medical records and related documentation in the possession of the Provider Organizations or its contracted provider(s) must be faxed to the Anthem Investigational and Clinical Trials unit at Fax # 1-866-461-2401 Attn: Investigational Review Nurse within 24 hours of the receipt of the request. For questions contact the Investigational Review Nurse at 1-866-757-8211. Expedited requests must be completed and faxed on the same day of member or physician request.
  - Provider Organizations with Medicare contracts may deny services related to experimental or investigational treatments for Medicare members only.
  - If the request is related to transplants, the information must be sent directly to the Anthem Case Management Transplant Department.
  - No denial of services considered experimental or investigational will be issued by the Provider Organization for commercial members.
  - Per Department of Managed Health Care (DMHC) regulations, members must be notified in writing within 5 business days of the initial denial of an experimental or investigational treatment of the right to seek an independent medical review, coordinated through the (DMHC), and be provided at minimum with an Independent Medical Review (IMR) application, instruction sheet, physician certification form, and envelope addressed to the DMHC.
  - When members have urgent conditions, they can bypass the Anthem appeal process and apply directly to the DMHC for an IMR.
  - When Anthem has denied, modified, or delayed service and the decision was substantially based in whole or in part on a finding that the proposed services are not medically necessary, are considered non-emergent (for in-area emergency services) or non-urgent (for out-of-area services), Anthem will communicate its appeal decision to the member and provider/practitioner and if coverage is denied, will notify the member of their right to an IMR and provide the IMR forms and envelope.
  - All transplant related investigational/experimental services for members will be referred to the Health Plan and not approved or denied by the Provider Organization.
    - All clinical trials are considered investigational/experimental.
**Attachments:**
Request for Health Plan Initial Determination Clinical Trial-Initial and Extension Requests
Investigational/Experimental (I/E) Treatment Form

**Reference Sources:**
CA Health & Safety Code § 1370.4
**REQUEST FOR HEALTH PLAN INITIAL DETERMINATION**

**CLINICAL TRIAL - INITIAL AND EXTENSION REQUESTS**

**INVESTIGATIONAL/EXPERIMENTAL (I/E) TREATMENT FORM for HMO DELEGATED Members**

If provider is requesting an **EXPEDITED REVIEW**, please complete this form and FAX it on the same day the request is received to:

Anthem Blue Cross HMO Co-Management Department  
FAX #: 866-461-2401  
Attention: Investigational/Clinical Trial Nurse  
For Questions Call: 1-866-757-8211 and ask to speak with a Clinical Trial or Investigational Review Nurse

### Clinical Trial Request

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<th>Type of Request:</th>
<th>Cancer ☐ Non-Cancer ☐</th>
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<td>Consult:</td>
<td>Initial Trial: ☐ Extension: ☐</td>
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<th>Trial Coordinator:</th>
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<tr>
<th>Principle Investigator:</th>
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<td>________________________</td>
<td>MD</td>
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**Is the member currently in the hospital? ☐ Yes ☐ No**

### Investigational Request

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<tr>
<th>Requesting Provider Name:</th>
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<th>Service(s) requested for Investigational Review:</th>
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<th>Date submitted to PMG:</th>
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| Is the member currently in the hospital? | ☐ Yes ☐ No |

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<thead>
<tr>
<th>Member Name:</th>
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<tr>
<td>Name of PMG:</td>
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<th>UR Contact:</th>
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| Is provider asking for an expedited review?: | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | YES ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | NO |

**INVESTIGATIONAL/EXPERIMENTAL REQUESTS**

Please Attach Medical Records, Including Record of Initial Assessment: (records must include relevant progress notes or consult who assessed member for the requested treatment/service)

<table>
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<tr>
<th>RECORDS ATTACHED:</th>
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Comments:

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Purpose:
“X” Provider Organization shall utilize and accept only the DMHC approved standardized Prescription Drug Prior Authorization form (Form No 61-211).

Policy:
“X” Provider Organization will maintain an expeditious process by which prescribing practitioners may obtain authorization for any medically necessary prescription drug, including injectable/infusion drugs for which the Provider Organization requires prior authorization.

Responsibility:
Providers, Medical Director, Utilization Management Staff

Procedure:
- Form 61-211: Prescription Drug Prior Authorization Request Form is available electronically on the Provider Organization’s Web site.
  - Requesting practitioner may, but is not required to, electronically submit the form.
- Requests for Prescription Drug Prior Authorization are submitted using Form 61-211: Prescription Drug Prior Authorization Request Form
  - Only the minimum amount of material information necessary to complete the form is required.
  - Provider Organization may NOT REQUIRE the requesting practitioner to submit additional forms other than Form 61-211; however, the requesting practitioner may CHOOSE to submit additional attachments to the form.
- Requesting practitioner is notified of the following:
  - Request is approved
  - Request is denied as not medically necessary
  - Request is denied as not a covered benefit
  - Request is denied as missing clinical information
  - Patient is no longer eligible for coverage
  - Request was not submitted on the required form (Form No 61-211)
- Notification is communicated to the requesting practitioner within 2 business days of receipt of request.
- Notification is delivered in the same manner as the request was submitted, or another mutually agreeable accessible method of notification.
- If the requesting practitioner is not notified within 2 business days that a request was denied or submitted using a form other than Form No 61-211, the request is deemed approved (e.g. Administrative Approval).
- Denial notices for medical necessity, benefit exclusion or missing clinical information will include an accurate and clear written explanation of the specific reasons for denying the request.
  - Requests may not be pended if additional information is required. The request must be denied on the basis that additional information is needed.
  - ICE CSDN may be used.
- Notifications of prescription drug prior authorization requests submitted using the incorrect form state the request must be resubmitted using the correct form and include a copy of Form No 61-211 with the notification
Reference Sources: 28 CCR 1300.67.241(c)(1)
Purpose:
To ensure that all UM decisions are conducted under the supervision of appropriate health care professionals.

Policy:
It is the policy of “X” Provider Organization that qualified, licensed health care professionals oversee unlicensed staff and assess clinical information received in support of a request for services.

Responsibility:
Medical Director, Utilization Management Staff

Procedure:
- Referrals will be evaluated and authorized by a person with a defined level of responsibility, for clinical and non-clinical, based on the necessary protocols and within the parameters of the requested service.
- Qualified appropriately licensed health care professionals will supervise all medical necessity decisions (an LVN is the minimal level of training and licensure allowed to supervise). Non-licensed personnel may have the authority to approve, but not deny, services for which there are explicit approval criteria. Benefit clarifications do not require a licensed health care professional.
  - Staff members who are not qualified health care professionals may collect data for preauthorization and concurrent review under the supervision of appropriate licensed health care professionals.
- For initial screening, “X” Provider Organization limits use of non-clinical administrative staff for:
  - Review of service request for completeness of information
  - Collection and transfer of non-clinical data
  - Acquisition of structured clinical data
  - Activities that do not require evaluation or interpretation of clinical data
- Licensed health care professionals monitor non-clinical administrative staff performing initial screening
- Individuals who conduct peer clinical review:
  - Are appropriate health care professionals
  - Are qualified, as determined by the medical director or clinical director, to render a clinical opinion about the medical condition, procedures and treatment under review
  - Hold a current, valid license in the same licensure category as the ordering provider, or as a doctor of medicine or doctor of osteopathic medicine
- Individuals who conduct initial clinical review:
  - Are appropriate health care professionals
  - Possess an active professional license
- Individuals who conduct initial review have access to consultation with a:
  - Licensed doctor of medicine or doctor of osteopathic medicine
  - Licensed health care professional in the same licensure category as the ordering provider
Health care professional with the same clinical education as the ordering provider in clinical specialties where licensure is not issued.

- All denial decisions based on medical necessity will be reviewed by a physician, dentist, pharmacist, chiropractor, or behavioral health practitioner (e.g., doctoral-level clinical psychologist or certified addiction-medicine specialist), as appropriate.
- Only California licensed physicians who are competent to evaluate specific clinical issues may deny or modify requests for services based on medical necessity.
- Behavioral health care practitioners are available to review cases pertaining to their specialty.
- Board certified physicians from appropriate specialty areas will be utilized to assist in making determinations of medical necessity.
- Written job descriptions specify the qualifications for practitioners (physicians, behavioral health practitioners, dentists, and pharmacists) who review medical necessity denials. The description must include the following: education, training, or professional experience in medical or clinical practice and current license to practice without restriction.
- At a minimum, licensure is in the same licensed category as the ordering provider, or as a doctor of medicine or doctor of osteopathic medicine.
- The scope of roles and responsibilities for reviewers should include maintenance of professional competencies.

Attachments:
None

Reference Sources:
Purpose:
To ensure that on-site utilization review services are conducted in accordance with facility procedures.

Policy:
It is the policy of “X” Provider OrganizationOrganizationGroup that all utilization review (UR) staff who conducts reviews on-site at facilities follow all procedures, rules and processes.

Responsibility:
Utilization Management Review Staff

Procedure:
- “X” Provider OrganizationOrganizationGroup staff who provide on-site UR services are expected to wear appropriate identification
  - On-site reviewers will display a picture ID with full name and the name of “X” Provider OrganizationOrganizationGroup.
- Staff will schedule the on-site review in advance, unless otherwise agreed.
  - Reviews are scheduled at least one business day in advance, unless alternate arrangement has been accepted.
- Staff are informed of the facility rules prior to on-site review.
  - Process for ensuring that staff follows facility rules.
  - The contract between “X” Provider OrganizationOrganizationGroup and the facility specifies the method for informing staff of facility rules.

Attachments:
None

Reference Sources:
URAC HUM 5
Purpose:
To ensure practitioners/providers, facilities and members are able to contact “X” Provider OrganizationGroup regarding referrals or other UM issues.

Policy:
It is the policy of “X” Provider OrganizationGroup that UM representatives will be available by telephone during normal business hours. Inbound and outbound communications may include directly speaking with practitioners and members, fax, electronic, or telephone communications (e.g., sending email messages or leaving voice mail messages). Physician reviewers are available to discuss UM decisions and/or process. “X” Provider OrganizationGroup will provide complete written or telephonic notifications to practitioners and members regarding UM decisions.

Responsibility:
Medical Director, Utilization Management Staff

Procedure:
- Provider OrganizationGroup must maintain telephone access for providers/practitioners to request authorizations for health services.
- TDD/TTY services for the deaf are offered to members.
- Staff will be available at least 8 hours/day during normal business days for inbound calls regarding UM issues via a toll free number.
- At a minimum, “X” Provider OrganizationGroup is available from 9 am to 4 pm of each normal business day.
- “X” Provider OrganizationGroup will maintain staff availability to receive inbound communication after normal business hours regarding UM issues.
- “X” Provider OrganizationGroup will maintain outbound communication from staff regarding inquiries about UM during normal business hours.
- Staff will respond to communications within one business day.
- Staff will identify themselves by name, title and Provider OrganizationGroup name when initiating or returning calls regarding UM issues.
- “X” Provider OrganizationGroup physician reviewers will be available by telephone to physicians to request authorization for health care services and discuss determinations.
- “X” Provider OrganizationGroup will provide the following written information to practitioners, staff, and members:
  - A toll free number or available staff who accepts collect calls regarding UM issues during normal business hours.
  - Access to staff for callers with questions about the UM process

Attachments: None

Reference Sources:
NCQA MEM 5.B.1; UM 3.A.1-75; URAC HUM 2-4;5(c); CA Health & Safety Code § 1367.01(i)
Purpose:
To ensure that centralized triage and referral of Behavioral Healthcare (BH) services are provided in accordance with established protocols and by appropriate practitioners.

Policy:
It is the policy of "X" Provider Organization that protocols will be used to make triage and referral decisions related to mental health and substance abuse care, including urgency and appropriate setting. All triage and referral decisions are made by licensed and qualified practitioners; supervision and oversight are performed by a licensed and experienced practitioner.

Responsibility:
Behavioral Healthcare Director, Utilization Management Staff

Procedure:
- "X" Provider Organization will maintain a toll-free number for Behavioral Healthcare triage and referral.
  - "X" Provider Organization will operate a 24 hour crisis line where crisis line staff assesses the level of care, urgency or response or type of practitioner need prior to arranging an appropriate BH appointment.
- BH triage and referral decisions are made according to protocols for mental health and substance abuse that define the urgency and appropriate setting of care.
- BH protocols are based on sound clinical evidence and currently accepted practices within the industry and are reviewed and revised as necessary every 2 years.
- Triage and referral decisions requiring clinical judgment will be made by a licensed BH care practitioner with appropriate qualified experience pertaining to their specialty.
- Triage and referral staff will be supervised by a licensed BH care practitioner with a minimum of a Masters degree and 5 years of post Masters clinical experience.
- A licensed psychiatrist or an appropriately licensed Doctoral-level clinical psychologist experienced in clinical risk management will oversee triage and referral decisions.
- At least annually, "X" Provider Organization will gather information from members and practitioners regarding their satisfaction with the BH UM process and address identified sources of dissatisfaction.

Attachments:
None

Reference Sources:
NCQA UM 14 A-B
Purpose:
To ensure that appeals are handled in a timely and appropriate manner.

Policy:
It is the policy of “X” Provider Organization to forward all appeals to the health plan upon receipt and to cooperate with requests from the health plan for additional information regarding decisions.

Responsibility:
Utilization Management Staff

Procedure – Anthem:
- Anthem does not delegate appeals.
- All expedited appeals must be referred to Anthem Grievance and Appeals Department immediately. For expedited appeals, records must be sent within 24 hours or sooner.
- All standard appeals must be referred to Anthem Grievance and Appeals Department within 48 hours of receipt. For standard appeals, records must be sent within 7 calendar days.
- All Transplant appeals are referred and handled by the health plan.

Attachments:
None

None
Anthem Blue Cross Grievances and Appeals Process

DEFINITIONS

“Grievance” means a written or oral expression of dissatisfaction regarding the plan and/or provider/practitioner, including quality of care and service concerns, and includes a complaint, dispute, request for reconsideration or appeal made by a member or the member’s designated representative. When the plan is unable to distinguish between a grievance and an inquiry, it is considered a grievance.

“Medical Necessity Appeal” pertains to a health care service eligible for benefits that have been denied, modified, or delayed by a decision of Anthem or by one of its contracted providers/practitioners, in whole or in part, based on a finding that the service is not medically necessary.

“Benefit Appeal” is the denial of health care services by Anthem or by one of its contracted providers/practitioners, substantially based on a finding that the provision of a particular service is excluded as a covered benefit under the terms and conditions of the member’s benefit plan.

It is possible to have an appeal in which the member also expresses a quality of care or service concern. Each issue is addressed simultaneously through the appropriate processes. For example, a quality of care or service concern (grievance) that also involves a denial of health care services (appeal) is processed through both the grievance process and appeal process.

The Anthem Grievances and Appeals (G&A) process is designed to investigate and resolve member and physician, hospital, or other health care professional complaints expeditiously and within time frames established by regulatory and accreditation agencies.

Provider Organizations are responsible for the initial determination on requests for services and/or claims payment, and are required to provide written notification to members on the disposition of the request and appropriate appeal rights. Provider Organizations are not delegated for the review of appeals and are required to forward grievances and appeals to the Anthem G&A Department within 24 hours of receipt. G&A will process the grievance or appeal through the standard or expedited appeal process, depending on the nature of the issue.

A member, member’s designated representative or provider/facility rendering care may submit verbal or written appeals to Anthem pertaining to an adverse initial determination made by a Provider Organization or Anthem. A member may be represented at any level of the appeal process. If a representative submits the appeal on behalf of the member, the member must sign a Designation of Representation “(DOR)” form. The representative or member, as appropriate, is notified in writing and sent a DOR form, which must be signed by the member and returned to G & A. A signed DOR form is not required from a member’s practitioner acting on behalf of the member for a prospective or urgent appeal. If a member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative or other designee of the member with appropriate documentation, may submit the appeal. When an attorney is representing the member, and requests medical records, the member must sign an authorization for release of protected health information (PHI). The attorney is notified that a signed authorization from the member is required before records are released. If the attorney wishes to subpoena records, the subpoena is sent to Anthem Legal Department.

Members have up to 180 calendar days after notification of a denial to file an appeal, unless otherwise specified in their Evidence of Coverage. The appeal process allows all parties involved in a member’s care, including the member, provider or facility, the opportunity to submit additional information relating to an appeal.

Members and their representatives have the option of submitting grievances on-line to Anthem via the internet. The grievance Web site can be accessed at www.anthem.com/ca. Under the heading Customer Care, the member will see “I need to.” Under that, the member should click on File an Appeal or Grievance. Follow the instructions. The site has copies of all the forms the member can download to use. It also explains how to use them. The grievance is routed to the Grievances and Appeals Department for distribution to the appropriate grievance associate.
The Anthem Grievances and Appeals process is designed to serve the linguistic and cultural needs of its member population, as well as the needs of members with disabilities.

**Standard Appeals**

Standard appeals involve pre-service, and post-service medical necessity appeals and benefit/coverage appeals. The G&A Department is mandated to resolve standard grievances and appeals within 30 calendar days of the Anthem receipt date.

A non-covered custodial parent (evidenced by a court or administrative order) will be provided with the same correspondence sent to the covered, non-custodial parent. However, the non-covered custodial parent will not be notified in any cases where there is clear clinical/legal reason in which potential harm could come to the minor as a result of such notification (such as in cases of family violence or abuse).

Anthem sends the member an acknowledgement letter within 5 calendar days of receipt of the appeal. The acknowledgement letter will contain the following information:

a. The date the appeal was received by the Health Plan,

b. A general explanation of the appeal process and timeframe,

c. The name, address and phone number of the Health Plan representative who may be contacted about the appeal,

d. A statement that the member may submit additional comments, documents or other information relating to the appeal,

e. The appropriate regulatory language per the member’s (EOC) or applicable plan provisions.

f. Plans regulated by the CA Department of Managed Health Care (DMHC) must include the DMHC’s mandatory paragraph in the acknowledgement letter. Within this paragraph, the DMHC’s telephone number, California Relay Services’ telephone number, the Health Plan’s telephone number and TDD line, and the DMHC’s Internet address must be in 12-point boldface font.

In order to evaluate both sides of the issue, the Provider Organization will be asked via a faxed request to provide the G&A Department with a written response and medical records pertaining to the complaint within 7 calendar days of G&A’s request. The Provider Organization response should be a formal written response and include the rationale and applicable criteria used by the Provider Organization in their decision. It must be comprehensive in content, addressing all pertinent issues raised in the member’s grievance/appeal. The written response must include the title and qualifications of the reviewer(s) responsible for the decision, and any supporting documentation/medical records used as the basis for the Provider Organization’s decision. The Provider Organization response may be in the form of a written letter, memo, e-mail or fax.

Grievance and appeal adjudication is the responsibility of Anthem. Prior to Anthem issuing a denial, clinical appeals undergo one or more levels of review by an Anthem G&A Medical Director and/or peer clinical reviewer who was not involved in the initial determination and is not a subordinate of such an individual. The G&A Medical Directors are physicians with active, unrestricted California medical licenses, who are responsible for clinical oversight and final decision-making on medical necessity appeals. Peer clinical reviewers hold active, unrestricted licenses to practice medicine and are board-certified by a specialty board approved by the American Board of Medical Specialists (doctors of medicine) or the Advisor Board of Osteopathic Specialists (doctors of osteopathic medicine). Peer clinical reviewers are in the same or similar specialty that typically manages the medical condition, procedure or treatment under review.

When a decision is made to overturn a Provider Organization denial, the Provider Organization is notified in writing, and is offered the opportunity to respond and provide any additional information to the G&A Department within a specified time frame (two calendar days).

Provider Organization disputes of an overturned decision are submitted to a G&A Medical Director for consideration, and a final determination is made at that time. Provider Organizations are required to comply with the health plan and the Department of Managed Health Care (DMHC) decisions regarding grievances and appeals, and are obligated to follow the appropriate dispute resolution mechanisms for resolving disagreements with Anthem.
Appeal decisions are communicated in writing to the member and the provider/practitioner and sent within 30 calendar days of the Anthem receipt date. If a decision is communicated verbally, a written decision is sent within 2 business days of verbal notification. G & A communications regarding approvals specify in writing the exact health care services that are approved. Written approval is sent to the member and a copy is sent to the Provider Organization and involved provider/practitioner, as applicable. All appeal denial letters contain the following information, as applicable to the case:

● A statement of the reviewer’s understanding of the pertinent facts of the member’s appeal
● The titles and qualifications of the individuals who participated in the appeal review, including consultants
● Medical necessity denials have a clear explanation of the reason for the denial, and a description or reference to the documentation used as the basis for the decision, for example, Anthem clinical guidelines, Anthem Medical Policy.
● Instructions for requesting a written statement of the clinical rationale and a copy of the criteria used to make the decision, as applicable to the issue (if not attached to the letter)
● For contractual/coverage denials (not related to medical necessity), the response identifies and directs the member to the section and page in the EOC (Evidence of Coverage) where the provision is found, or provides a copy of the provision and explains in clear language how the exclusion applies to the specific benefit or health care service requested by the member.
● The signature of the Anthem Medical Director on all medical necessity denial letters
● A description of further appeal rights to include:
  ➢ The right to apply to the appropriate regulatory agency for Independent Medical Review "(IMR)" (e.g., DMHC)
  ➢ An application for IMR and instructions, including a statement that there is no cost to the member
  ➢ An envelope addressed to the DMHC
  ➢ The mandatory DMHC paragraph which explains the member’s right to contact the DMHC for assistance
  ➢ A statement of ERISA rights as applicable
  ➢ Arbitration rights as applicable to the member’s plan
  ➢ For FEHBP members, the right to contact the Office of Personnel Management in Washington, DC regarding a disputed health care service or claim. For investigational/experimental denials, the right to submit a request to Anthem for an IMR with an organization contracted with the DMHC

Under Health & Safety Code Sections 1374.30 through 1374.36, a member may seek a free independent medical review ("IMR") when dissatisfied with the Provider Organization or Anthem’s decision regarding denials for the following three categories: 1) investigational/experimental, 2) lack of medical necessity, and 3) emergency care services denied as non-urgent/emergent, within 6 months of the decision (DMHC may extend the application deadline beyond 6 months if the circumstances of a case warrants the extension). (The IMR process does not apply to the Anthem Senior Secure product.) The IMR request is made directly to the DMHC by the member if the member believes that health care services have been improperly denied, modified, or delayed by Anthem or the Provider Organization. (A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.) The member has the right to request an IMR after filing an appeal with Anthem and the denial is either upheld or the appeal remains unresolved after 30 calendar days. In the case of an appeal that requires an expedited review, the member may request an IMR immediately. An expedited review is for cases involving an imminent and serious threat to the patient's health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Expeditred Appeals
Appeals related to urgent clinical issues, prospective or concurrent inpatient services are reviewed through the Expedited Appeal Process and resolved. A decision is communicated to the requesting party verbally within 72 hours of receipt by Anthem, followed by written notification within 3 calendar days of receipt. For denials of continued inpatient stays, the denial letter is faxed to the member at the facility prior to cessation of benefits. A written notice is also sent by mail to the member and the facility.

If an appeal does not meet the criteria for an expedited review, a de-expedited acknowledgement letter is sent to the member and provider/practitioner and the letter is signed by the G&A Medical Director. The letter provides the reason for not expediting the appeal and explains the standard appeal process, including the 30 calendar day resolution timeframe. The letter includes the date the appeal was received, the name, address and phone number of the plan representative who may be contacted about the appeal, and the right to contact the DMHC.

An appeal may be received verbally or in writing. The intent of expediting an appeal is to assure that no harm comes to a member’s health. Anthem receives emergent/urgent appeals 24 hours a day, seven days a week. This process includes involving the on-call Medical Director to resolve urgent appeals during non-working hours. During normal business hours, the Anthem Medical Director responds to all DMHC requests involving urgent appeals within 1 hour from the time of initial DMHC contact. The Anthem Medical Director has the authority to resolve urgent grievances and appeals on behalf of the plan, including authority to make financial decisions for expenditure of funds without first having to obtain approval from supervisors or other superiors within the Plan. If the case involves an expedited appeal, Provider Organizations must provide a response and medical records within 24 hours of the G&A Department’s request.

Appeal files containing all information used for the appeal decision are confidentially stored by Anthem for a period of seven years. G & A maintains minutes of Committee appeal proceedings, including minutes of member conferences, as applicable, for a period of seven years.

Grievances are tracked and trended for reporting purposes. When a quality issue is identified, the G&A Medical Director may request that the Provider Organization provide a corrective action plan. The G&A Medical Director will send a written request for a corrective action plan to the PMG/IPA Medical Director. The Provider Organization is expected to comply within time frames specified by the G&A Department.

The G&A Department continually strives to improve its process and relationships with the Provider Organization. The Provider Organizations are encouraged to establish satisfactory working relationships with the G&A staff to ensure timely and appropriate resolution of member and physician issues. Provider Organizations are expected to educate their staff regarding Anthem medical policy and benefit interpretation guidelines, as well as current managed care legislation.

**Purpose:**
To ensure telephone advice is handled appropriately and follows state and regulatory requirements.

**Policy:**
It is the policy of “X” Provider Organization that licensed staff conduct telephone advice that is consistent with good professional practice.

- **“X” Provider Organization** will maintain current registration with the California Department of Consumer Affairs.

- All health professionals will be licensed, registered, or certified in the state in which they are providing the telephone medical advice services and operating consistent with the laws governing their respective scopes of practice.

- Staff members handling member calls, who are not licensed, certified, or registered as required, do not provide telephone medical advice.
• “X” Provider Organization staff who are not licensed or certified, will not use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered professional.

• A physician and surgeon are available to the telephone medical advice service on an on-call basis at all times the service is advertised to be available.

• Advice will be consistent with good professional practice.

• A grievance/complaint tracking and reporting system will be established and maintained by “X” Provider Organization. Transcripts of conversations and copies of grievances/complaints will be retained for 5 years.

Attachments:
Reference Sources:
None

Grievance and Appeals Process information may be located in the HMO Provider Manual

Health Plan Grievance Contact Information

ICE Commercial Grievance and Appeal Contact Information:
https://www.iceforhealth.org/library/documents/ICE_Commercial_GA_Contact_Information_1112.doc
Purpose:
To protect the patient’s right to access and amend their medical records. To define the guidelines for release of patient information. To ensure that any disclosures of PHI/IIHI are in accordance with HIPAA or other applicable confidentiality laws and that medical information is released after member authorization and in accordance with applicable Federal or State law.

Policy:
It is the policy of “X” Provider Organization to maintain the patient’s right to privacy and right to access their medical records in accordance with all applicable state and federal laws.

Definitions:
Individually Identifiable Health Information (“IIHI”) is information that is a subset of health information, including demographic information collected from an individual and is:
- Created or received by a health care provider, Health Plan, employer, or health care clearinghouse
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual
- Identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual

Protected Health Information (“PHI”) is individual identifiable health information that is:
- Transmitted by electronic media
- Maintained in an electronic media
- Transmitted or maintained in any other form or medium

Responsibility:
Utilization Management Staff

Procedure:
- **“X” Provider Organization** will ensure that any disclosures of PHI are in accordance with HIPAA or other applicable confidentiality laws.
- **“X” Provider Organization** will ensure establishment of security measures for PHI to the extent required under HIPAA
  - The Provider Organization has a privacy plan that includes: evidence of privacy (PHI) procedures within department policies, description of business processes that use and disclosure PHI, and training of workforce.
- **Safeguards:** **“X” Provider Organization** will protect verbal, written and electronic information across the organization
  - Physical and technical safeguards
  - Mechanism to limit access to PHI
  - Maintain the integrity of PHI in electronic systems and physical access (secure email, desk top access, etc).
- **“X” Provider Organization** will take the following steps in the event of improper use or disclosure of non-public personal health and/or financial information or personally identifiable health and/or financial information:
- “X” Provider Organization will establish procedures for reporting inappropriate or unauthorized use or disclosure of PHI, including: to the Provider Organization management/privacy officials, responding to or reporting to covered entities and government authorities, and timeframes for responding to investigations

[“X” Provider Organization to insert its own process here]

- “X” Provider Organization will document the method of notification to Anthem of violations without unreasonable delay. Reports will include the following:
  - Names of the individuals whose PHI was involved in the breach
  - Circumstances surrounding the breach
  - Date of the breach and the date of its discovery
  - Information breached
  - Any steps the impacted individuals should take to protect themselves
  - Steps taken to investigate the breach, mitigate losses, and protect against future breaches

- Contact person who can provide additional information about the breach

- Medical information is released only after member authorization and in accordance with applicable Federal or State law.
- Members/Member Representatives have the right to request restriction of use and disclosure of PHI to carry out treatment, payment or health care operations.
- Process for members to request an amendments to PHI
- Member’s right to access PHI
- Process for member’s to request an accounting of disclosure of PHI
- Internal protection of oral, written and electronic information across the entity
- Responsibilities for privacy include:
  - Designation of a privacy officer/committee
  - Description of the duties of the privacy official
  - Designation of a staff member responsible for receiving complaints/requests
  - Description of the duties of the staff member responsible for receiving complaints or requests from the plan

- “X” Provider Organization will develop and implement a contingency plan for unanticipated circumstances that includes: data backup plan, a disaster recovery plan with testing and revision procedures, notification of plan/ key contacts.

Attachments:
None

Reference Sources:
NCQA RR 5.A, B, D, F, G; URAC Core 13, 15, 16, 27; 42 CFR 422.118; 45 CFR 164.308(a)(7)(i); 45 CFR 164.314(a)(2)(i)(C); 45CFR 164.410; 45 CFR 164.508; 45 CFR 164.522;45 CFR 164.524(b)(2); 45 CFR 164.526; 45 CFR 164.528; 45 CFR 164.530 (a)(c)(1-2)(i-ii) (d)
Purpose:
To ensure compliance with the Referral Cancellation process.

Policy:
It is the policy of “X” Provider Organization that referral cancellations must be tracked, monitored, reviewed and reported so that there is no interruption, delay in patient care, or results in underutilization.

Responsibility: Department or position responsible

Procedure:
- If there is decision to cancel a utilization request, there is:
  - No interruption in patient care
  - No delay in patient care
  - Results in underutilization

- Examples of cancelled requests may include the following:
  - Already approved authorization present in the system
  - Expired referral request
  - The member terminated with the “X” Provider Organization
  - Duplicate requests not received on the same day
  - Addition or change in diagnosis or procedure codes
  - Service is part of the global period
  - For prescription injectables/infusions (practitioner didn’t use Prescription Drug Prior Authorization Request Form 61-211)

- Requesting practitioners will be notified of the cancelled request either verbally or by written notification.
- Cancelled referral requests are tracked and monitored as part of “X” Provider Organization utilization activity.
- Cancelled referral request reports are reviewed at committee as part of “X” Provider Organization utilization activity.

Reference Sources:
NCQA UM 4.F.3; 28 CCR 1300.70(b)(1)(D)

Attachments:
Cancellation Tracking log
## Cancellation Tracking Log

**Provider Organization Name:** ___________________________  **Month/Year_________**

**Provider Organization Contact Name & Phone**__________________________

<table>
<thead>
<tr>
<th>Date/Time of Request</th>
<th>Sender</th>
<th>Method</th>
<th>Health Plan</th>
<th>Member Name/ID#</th>
<th>Date of Request</th>
<th>Service or Item Requested</th>
<th>Date of Cancellation</th>
<th>Reason for Cancellation</th>
<th>Name of requesting PCP</th>
<th>Date requesting PCP is notified</th>
<th>Date Member is notified</th>
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</table>
NOTICE OF AUTHORIZATION OF SERVICES - COMMERCIAL

Date:  <Today’s Date>
<Member Name>
<Member Address1>
<Member Address 2>
<Member City, State, Zip>

DOB: <Member DOB>
Member ID: <Subscriber ID or Subscriber Dependent #>
Health Plan: <Health Plan>
Requesting Practitioner: <Requesting Practitioner Name>
Requested Provider: <Provider or Practitioner Name>
Authorization/Precertification Number: <Authorization or Referral #>

Dear <Member Name>:

The authorization referral request for the above service was reviewed by  [insert: Provider Organization name] on [insert: date], and has been approved. If these services have already been provided, this letter is your confirmation.

Authorized Service: <Service code; service description>
Number of Authorized Services: <Certified units – treatment service detail>
Authorization Valid from/to: <Certified start date – Certified end date>

Payment for services will reflect any copayment and/or insurance limitations of your benefit plan. The member is covered for this service provided that the information we have received about this service is accurate. Authorization and payment of an admission, continued stay, procedure or other services is subject to eligibility and benefits at the time the services are provided.

To be covered under this authorization, the authorized in network provider must provide these services, unless noted above and authorized as out of network. Services considered not covered by Anthem Blue Cross HMO are the member’s financial responsibility.

Your copayment is due at the time of service. You can present this authorization letter and insurance identification card at the time of your service.

If you have any questions, please contact [insert: Provider Organization name] at [insert: Provider Organization phone #]

Attention provider – Please send the consultation report to the Primary Care or Referring Provider within 30 days of visit and within 10 days of the conclusion of treatment.

Sincerely,

[insert: Provider Organization name]

CC: [Requesting Practitioner]
    [Requested Provider/Practitioner]
Language Assistance Program (LAP) Template Information

Please refer to the LAP Policy in this workbook as well as LAP Template information posted on the ICE Web site. This first site gives an explanation of the different items posted:


LAP Notice of Translation Attachment per Health Plan:

http://www.iceforhealth.org/library.asp?sf=&scid=1768#scid1768

1. Click on "Approved ICE Documents"
2. Click on "UM Templates & Tools (Commercial UM LAP Templates for LAP Regulations Effective on and after 1/1 09)"
3. Click on "Option 1- LAP Notice of Translation"
4. Pick your Health Plan for the specific notice of translation

Health Plan Specific CSDN Templates (CSDN, Commercial Delay/Extension) With LAP Notice Translation:

http://www.iceforhealth.org/library.asp?sf=&scid=1770#scid1770

1. Click on "Approved ICE Documents"
2. Click on "UM Templates & Tools (Commercial UM LAP Templates for LAP Regulations Effective on and after 1/1 09)"
3. Click on "Option 2- Health Plan Specific Templates (CSDN & Commercial Delay-Extension) with LAP Notice of Translation"
4. This site includes other Health Plan specific letters, besides the LAP
Health Plan Grievance Contact Information

ICE Commercial Grievance and Appeal Contact Information

http://www.iceforhealth.org/library/documents/ICE_Commercial_GA_Contact_Information_4-29-11.doc
Utilization Review Attestation

PG/HCO: _______________________________ Audit Year: ________

☐ Only Physicians with an active and unrestricted license to practice Medicine in the State of review make Utilization Management Decisions.

☐ Only State licensed physicians or healthcare professionals who are competent to evaluate specific clinical issues may deny or modify requests for services based on medical necessity.

☐ Substantive review, discussion and approval of Utilization Policies & Procedures were performed.

☐ UR Criteria are reviewed, revised and approved on annual basis. (Include list of approved criteria, sources, edition and year)

__________________________________________________ Date __________
Printed Name of Senior Utilization Medical Director

________________________________________________________
Signature of Senior Utilization Medical Director
UM Policy and UR Criteria Attestation

PO Name: ___________________________  Audit Year: ______

Only Check all that apply:

☐ Substantive review, discussion and approval of Utilization Policies & Procedures were performed.

☐ UR Criteria are reviewed, revised and approved annually.
  ▪ Include list of approved criteria, sources, edition, and year

_________________________________________________________________________

Date__________

Signature of Designated Senior Physician/Medical Director

_________________________________________________________________________

Printed Name of Designated Senior Physician/Medical Director
Behavioral Health
UM Policy and UR Criteria Attestation

Provider Organization Name: ____________________________
Audit Year: ______

Check all that apply:

- Substantive review, discussion and approval of Utilization Policies & Procedures were performed.

- UR Criteria are reviewed, revised and approved annually.
  - Include list of approved criteria, sources, edition, and year

________________________________________________________ Date______
Signature of Designated Behavioral Health Senior Physician/Medical Director

________________________________________________________
Printed Name of Designated Behavioral Health Senior Physician/Medical Director

**For Medicare UM and BH use only**
Sample Policies and Procedures and Informational Attachments – Medicare

The following templates may be utilized by the Provider Organization to assist with the development of policies. The templates are based on Anthem requirements and may not be specific to other health plan requirements, including the ICE Credentialing Shared Audit.
Purpose:
To ensure that all Medicare member Utilization Management (UM) referrals are processed, referred and reported per Medicare regulatory and contracted health plan requirements.

Policy:
It is the policy of “X” Provider Organization to comply with Medicare and contracted health plan requirements when processing Medicare Member UM referrals. “X” Provider Organization will notify pertinent staff of this policy.

Responsibility:
Utilization Management Department

Procedure:
- “X” Provider Organization will refer out of area pre-service requests to Anthem Senior Services.
- “X” Provider Organization will respond to the non-contracted provider of post-stabilization care services request for pre-approval within 1 hour.
- “X” Provider Organization will follow the Industry Collaborative Effort (ICE) CMS UM Timeliness Standards Grid for processing all Medicare UM referrals.
- The ICE Medicare Advantage Pre-Service Denial Reason Matrix may be utilized.

Standard Authorizations and Denials Timeframes
- “X” Provider Organization will make the determination to provide, authorize, deny or discontinue services as expeditiously as the members health condition requires but will be made within a maximum of 14 calendar days after receipt of the request.
- “X” Provider Organization will notify the requesting practitioner and member verbally, electronically or by written notification of approval decisions within 14 calendar days after receipt of the request.
- “X” Provider Organization will send the practitioner and member written or electronic notification of denial decisions within 14 calendar days after receipt of request.

Extensions
- Decision may be extended up to 14 calendar days.
- Extension is allowed only if member requests or “X” Provider Organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member. “X” Provider Organization may request an extension for information from non-contracted providers/practitioners. For contracted practitioners, an extension may be requested only for information that does not already exist (e.g., consultation, further testing, procedure) but that may be completed during the extension period.
- “X” Provider Organization will send to practitioner and member written notification of the delay within 14 calendar days of receipt of request.
- “X” Provider Organization will include in written notification the reasons for delay and the right to file an expedited grievance if practitioner or member disagrees with “X” Provider Organization’s decision to grant an extension.
• “X” Provider Organization will make the determination to provide, authorize, deny, or discontinue a service as expeditiously as member’s health condition requires no later than upon expiration of the extension.
• “X” Provider Organization will notify the requesting practitioner and member verbally, electronically or by written notification of approval decisions no later than upon expiration of the extension.
• When the timeframe is extended, practitioner and member are sent written or electronic notification of denial decisions no later than the expiration of the extension.
• If “X” Provider Organization fails to provide the member with timely notice of a determination, this failure itself constitutes an adverse organization determination and may be appealed.

Medicare Denial Notices
• The Notice of Denial of Medical Coverage -Integrated Denial Notice (NDMC-IDN) for outpatient services, benefit exhaustion and benefit exclusions will be utilized in compliance with Medicare regulatory requirements.
• The NDMC must include the following:
  - OMB Control Number is correctly stated in the bottom right corner of every page
  - Marketing approval number and CMS Approved date are correctly stated in the bottom left corner of every page
  - Form number and date are correctly stated in the bottom left corner of every page above the marketing approval number
  - Anthem legal disclaimer is correctly stated at the bottom of the first page: Anthem Blue Cross has contracted with <Provider Organization name> to provide these services. Anthem Blue Cross is the trade name of Blue Cross of California, an Independent licensee of the Blue Cross Association
  - Denied service is stated
  - Specific denial reason is stated using language that is readable and understandable
  - Body of the letter is in a 12-point font or greater
  - The form heading is in 14-point font
  - Informs the member of their right to a reconsideration
  - Describes both the standard and expedited reconsideration processes, including the right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeal process
  - Appeal information includes correct Health Plan name, address, fax, phone, and TTY/TDD numbers
  - The envelope must state “Important Plan Information”.

Medicare Criteria
• Medicare Criteria, if established, is the predominant criteria to be utilized by the delegated Provider Organization for Medicare UM determinations. There is evidence of following:
  - Criteria are objective and based on sound medical evidence
  - Resources and criteria are referenced
    - The order of criteria to be utilized by the delegated Provider Organization for Medicare UM determinations is as follows:
      - National Coverage Determinations (NCD)
      - Statute/CMS Coverage Manuals (e.g., Medicare Policy Benefit Manual, Medicare Managed Care Manual, Medicare Claims Processing Manual and Medicare Learning Network)
      - Local Coverage Determinations (LCD)
Medicare Approval Notices

- The approval notice must include the following:
  - Federal Contracting Statement “A health plan with a Medicare Contract”
  - Anthem legal disclaimer is correctly stated at the bottom of the first page: Anthem Blue Cross has contracted with <Provider Organization name> to provide these services. Anthem Blue Cross is the trade name of Blue Cross of California, an Independent licensee of the Blue Cross Association.
  - Marketing approval number and CMS Approval Date are correctly listed at the bottom of the first page
  - The body of the letter is in 12-point font or greater
  - The form heading is in a 14-point.
  - Authorized service, number of authorized units and valid authorization dates are stated.
  - Provider Organization telephone number and hours of operation are stated.
  - Provider Organization telephone number for the hearing impaired and hours of operation are stated.
  - The envelope must state “Important Plan Information”.

Web Links:
Anthem Blue Cross Medicare Advantage Templates
http://www.iceforhealth.org/library.asp?sf=&scid=2202#scid2202

ICE Utilization Management Medicare Timeliness Standards

ICE Medicare Advantage Pre-Service Denial Matrix

Attachments:
None

Reference Sources:
NCQA UM 2.A.1; 42 CFR § 422.100(b)(iii), 422.113(c)(2)(ii), 422.568(a-d),422.2272(b); Medicare Managed Care Manual, Chapter 3 § 50.6, Chapter 13, 50.2
Purpose:
To ensure that all Medicare Expedited Initial Organization Determination referrals are processed following the Medicare regulatory requirements. To ensure that all Medicare Expedited Initial Organization Determination referrals are processed, referred and reported per contracted health plan requirements.

Policy:
It is the policy of “X” Provider Organization to comply with Medicare and contracted health plan requirements when processing Medicare Expedited Initial Organization Determination referrals. “X” Provider Organization will notify pertinent staff of this policy.

Responsibility:
Utilization Management Department

Procedure:
- Anthem Senior Services will make the decision whether or not to expedite a request and will communicate that decision to the member via telephone to “X” Provider Organization via fax. After the decision to expedite has been reached, “X” Provider Organization will make the medical necessity determination within the applicable timeframe.
- If a physician supports and/or represents the member’s request for expedited initial review, it must be granted regardless of whether the request meets criteria.
- Physician request for “urgent” status is the same as a physician supported expedited request and does not require referral to Anthem Senior Services Department for determination of whether request meets expedited criteria.
- [“FOR PROVIDER ORGANIZATION: PLEASE INSERT THE PROCESS FOR WHEN MEMBER REQUESTS AN EIOD FROM ANTHEM’S SENIOR SERVICES DEPARTMENT”]

Medicare Expedited Initial Organization Determination Decision
- If a decision is made to deny expediting the request, “X” Provider Organization must process the request through their standard authorization procedure. The 14 calendar day period begins with the day the request was received determination.
- If a decision is made to expedite, “X” Provider Organization must make the determination whether adverse or favorable, as expeditiously as the member’s health condition requires, no later than 72 hours after receipt of the request.

Medicare Expedited Initial Organization Determination Notification
- Practitioner and member are given verbal, electronic or written notification of approval decisions within 72 hours after request.
- If only written notice of approval decision is given, it must be received by member and practitioner within 72 hours after request.
- Practitioner and member are sent written notification of denial decisions within 72 hours after request. The notice must be received within 72 hours of receipt of request.
● When verbal notice of denial decision is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the verbal notice.

● If the determination is adverse (e.g., service denial), “X” Provider Organization must issue an appropriate notice of denial of medical services to the member.
  ➢ If “X” Provider Organization fails to provide the member with timely notice of a determination, this failure itself constitutes an adverse organization determination and may be appealed.

**Medicare Expedited Initial Organization Determination Extension**

● The 72-hour deadline may be extended up to 14 calendar days only if member requests or “X” Provider Organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (e.g., the receipt of additional medical evidence from non-contracted practitioners may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted practitioners.

● Practitioner and member are given written notification of the decision to extend within 72 hours of receipt of request.

● Member will be notified in writing of the reasons for the delay and informed of the right to file an expedited grievance if he/she disagrees with “X” Provider Organization’s decision to grant an extension.

● Decision is made no later than upon expiration of the extension.

● Practitioner and member are given written, electronic or written notification of approval decisions no later than upon expiration of the extension.

● If only written notice of approval decision is given, it must be received by member and practitioner no later than upon expiration of the extension.

● Practitioner and member are sent written notification of denial decisions no later than upon expiration of the extension. The notice must be received no later than upon expiration of the extension (no longer than 14 calendar days after receipt of request).

● When verbal notice of denial decision is given, it must occur no later than upon expiration of extension and must be followed by written notice within notice within 3 calendar days of the verbal notice.

● “X” Provider Organization will track all expedited initial organization determination requests with the following elements:
  ➢ Member name/identification
  ➢ Date and time of receipt of the request
  ➢ Date and time of medical record requests
  ➢ Date and time all information received
  ➢ Extension filed, if applicable
  ➢ Date and time of decision
  ➢ Date and time of verbal notification
  ➢ Date and time of written notification

**Web Links:**
ICE Medicare Extension Standard and Expedited Review
http://www.iceforhealth.org/library.asp?sf=&scid=2202#scid2202

ICE Medicare Expedited Criteria Not Met
http://www.iceforhealth.org/library/documents/ICE%20ExpCRTNotMet%20Final%20201205.doc

**Attachments:**
Sample Expedited Initial Organization Determination Tracking Log

**Reference Sources:**
42 CFR § 422.568(f), 422.570(c)(2)(ii), 422.570(d)(1), 422.572(a)(b)(c)(e)
| Date/Time of Request | Sender | M = Member | P = PCP | S = SCP | HP = Health Plan | N = Other | Method | P = Phone | F = Fax | L = Letter | I = In Person | Health Plan | Member Name/I# | Service Requested | Date/Time Referred to Medicare Advantage | Date and Time of Medical Record Request | Date/Time Admission Received | Date-Time of Extension File (if applicable) | Date-Time of Verbal Notification for M, P, S, O | Date-Time Written Notification Mailed/Faxed |
|----------------------|--------|------------|--------|--------|------------------|----------|--------|-----------|--------|-----------|----------------|-------------|----------------|------------------|----------------------------------------|-------------------------------|--------------------------------------|----------------------------------------|---------------------------------------------|--------------------------------------|------------------------------------------|
|                      |        |            |        |        |                  |          |        |           |        |           |                |             |                |                  |                    |                                        |                                |                                       |                                        |                                             |                                       |                                         |
Purpose:
To ensure that all Medicare notices are issued per Medicare regulatory requirements and all contracted health plan requirements.

Policy:
It is the policy of “X” Provider Organization to comply with Medicare and contracted health plan requirements when issuing Medicare Non-Coverage of Concurrent Care/Termination of SNF and CORF Services letters to members. “X” Provider Organization will notify pertinent staff of this policy.

Responsibility:
Utilization Management Department

Procedure:
“X” Provider Organization is responsible for issuing all notices of Non-Coverage of Concurrent Care/Termination of SNF and CORF Services. A termination of service is the discharge of a member from covered providers/practitioners, or discontinuation of covered providers/practitioners services, when the member has been authorized by the Provider Organization to receive an ongoing course of treatment from the provider/practitioner.

- “X” Provider Organization will audit its UM department for compliance with timeliness of notification and appropriate use of Medicare letter templates and denial reason matrix, and compliance with all standards for processing Medicare UM member standard authorizations and denials.
- “X” Provider Organization will issue the “The Notice of Medicare Non-Coverage” (NOMNC) when a member is discharged from a Skilled Nursing Facility (SNF) or Comprehensive Outpatient Rehabilitation Facility (CORF) services or;
- A determination that such services are no longer medically necessary with the respect to the applicability of the fast-track appeals process to situations involving the exhaustion of benefits, termination of services based on the exhaustion of Medicare benefits (100 calendar days), per CMS directive, the Notice of Denial of Medical Coverage (NDMC) should be used to convey this information, rather than the NOMNC. The QIO (Quality Improvement Organization), does not normally conduct appeal reviews related to exhaustion of benefits, therefore, these appeals must be handled by Anthem Senior Services.

- “X” Provider Organization will ensure that their individual health plan NOMNC template contains the following:
  - Name, address and phone number of the entity making the determination must be at the top of the letter.
  - The date that coverage of services ends
  - The date that the member’s financial liability for continued services begins
  - How to contact the QIO
  - Description of the member’s right to a fast-track appeal with the QIO
  - The member’s right to receive detailed information on why coverage is ending
  - Information on the availability of other Anthem appeal procedures if the member fails to meet the deadline for a fast-track appeal
The NOMNC must include the following:

- OMB Control Number is correctly stated in the lower right corner of every page
- Marketing approval number and Medicare Approval Date are correctly stated in the bottom left corner of every page
- Form number and date are stated above the marketing approval number
- Member name
- Delivery date
- Appeal information includes correct Health Plan demographic information
- Font will be size 12, Times New Roman
- The envelope must state “Important Plan Information”.

“X” Provider Organization will ensure the issuance of the NOMNC that notifies the member of the termination of services or discharge, no later than 2 calendar days or 2 visits before the proposed end of services.

- If the member’s services are expected to be fewer than 2 calendar days or 2 visits in duration, member must be notified at the time of admission or upon initiation of services.
- In a non-institutional setting, the notice must be given no later than the next to last time services are furnished.

The member or the member’s representative must sign and date the notice upon delivery to indicate that he or she has received the notice and understands the purpose and contents of the notice.

Delivery of Notice to Representative - Representative - an individual member has authorized to act on his or her behalf and/or a person who has Durable Power of Attorney for Health Care of the member.

- Representatives of incompetent members may be notified by telephone if personal delivery is not immediately available. Telephone contact requirements include:
  - Telephone contact with the representative must convey the notice contents.
  - Conversation must be documented in the member’s record. The date of the conversation is the date of receipt of the notice.
  - Confirm telephone contact with written notification mailed the same day.

Written Notice to Representative

- If telephone contact is not possible, the notice must be sent via certified mail, return receipt requested.
  - The date that someone at the address signs is the date of receipt
  - If the member and/or their representative refuse to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the member and/or the representative refused to sign.
  - Post office returns with no indication of refusal date, the member’s liability begins on the second business day after mailing.

If the member disagrees with the termination of services/discharge, the member must contact the QIO, verbally or in writing, no later than noon of the day before the services are to end.

The QIO immediately notifies Anthem Senior Services and provider of the member’s request for a fast-track appeal.

Upon notification by the QIO that a member or representative has requested an appeal, the Provider Organization must issue the Detailed Explanation of Non-Coverage (DENC) to both the QIO and member no later than close of business of the day the QIO notifies the HP of the appeal.

The DENC must include the following:

- Name, address and phone number of the entity making the determination must be at the top of the notice.
- Member name
- Date notice was generated
- Member identification number
- Type of service being terminated (e.g., SNF, CORF)
- Facts used to make the decision
- Detailed explanation of why current services are no longer covered
- Specific Medicare coverage rules and policy used to make decision
- Statement of availability of Policy or Coverage Guidelines
  - "If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: <Provider Organization Phone Number>.")
- OMB Control Number is correctly stated in the lower right corner of every page
- Marketing approval number and Medicare Approval Date are correctly stated in the bottom left corner of every page
- Form number and date are stated above the marketing approval number
- The envelope must state, “Important Plan Information”.

- Anthem Senior Services will obtain records from provider, and send copy of the medical records to the QIO by close of business day of notification. Anthem Senior Services may request that the records be send directly to the QIO.
- The QIO must make a decision and notify the member and Anthem Senior Services by close of business the following day. On the next business day, Anthem Senior Services will notify "X" Provider Organization of the fast-track appeal request and the QIO’s determination.
- If the decision is overturned "X" Provider Organization must prepare and issue a new NOMNC notice when new discharge orders are written.

Web Link:
Anthem Blue Cross Medicare Advantage Templates
http://www.iceforhealth.org/library.asp?sf=&scid=2202#scid2202

Attachments:
QIO Process

Reference Sources:
42 CFR § 405.1202(f)(1), 422.624(a)(2), 422.624(b)(1)(2), 422.624(c)(1), 422.626.(d)(1), 422.626(d)(5), 422.626(e), 422.626(f), 422.2262, 422.2264; Medicare Managed Care Manual, Chapter 3 § 50.1, 50.2, Chapter 13 § 90.4, 90.5, 90.6, 90.7
Anthem QIO PROCESS

QIO notifies Anthem that member is appealing NOMNC

Anthem notifies facility (SNF, HHA, CORF) of appeal and provides Request for Records from QIO to Facility and Provider Organization

Facility provides records directly to QIO

Provider Organization or Facility issues DENC to member
(Who provides DENC to QIO and member depends on who issued the original NOMNC e.g. facility or PG)

QIO notifies Anthem and member of decision. Anthem notifies Facility and PMG.

If QIO overturns NOMNC, a new NOMNC will need to be issued by Facility/PMG when member is ready for discharge.
Purpose:
To ensure that all Medicare member appeals are processed, referred and reported per contracted health plan requirements.

Policy:
It is the policy of “X” Provider Organization to comply with Medicare and contracted health plan requirements when processing Medicare member appeals. “X” Provider Organization will notify pertinent staff of this policy.

Responsibility:
Utilization Management Department

Procedure:

**Expedited**
- Medicare expedited appeals will be directed to call the Anthem Senior Market, Grievance and Appeal Department.
  - For expedited verbal appeals, members will be directed to call the Anthem Senior Services Grievance and Appeal Department.
  - Expedited written appeals will be faxed immediately.
- For expedited appeals, medical records will be sent within 24 hours or sooner.

**Standard**
- All standard appeals will be referred to the Anthem Senior Services Grievance and Appeal Department.
- All standard appeals will be in writing.
- Standard written appeals will be faxed immediately.
- For standard appeals, medical records will be sent within 7 calendar days.
- All transplant appeals are referred and handled by the Health Plan.

Attachments:
None

Reference Sources:
None
Commercial and Medicare Informational Attachments
Flesch-Kincaid Reading Level Using MS Word

Set Up:
Open the “colored” icon in the left upper screen of Word.
Click on Word Option at the bottom of the screen.
Click on Proof and make sure that the “show readability statistics” is checked.

To Use Reading Level:
Highlight the portion of the document that you want to assess reading level.
Click on spell check. It may go through the process to check the document and at the end it will say “word has finished checking this document, do you want to continue with the rest of the document?” Click NO.
The Flesch-Kincaid Grade level will appear.

Anthem Blue Cross
Tips for writing denial rationale statements in plain language

<table>
<thead>
<tr>
<th></th>
<th>Simple words</th>
<th>Use common, familiar, everyday language.</th>
<th>Avoid words with 3 or more syllables</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Short sentences and paragraphs</td>
<td>Are easier to read, understand and remember. Keep sentences to one thought; and paragraphs to one topic.</td>
<td>Use 10-15 words per sentence Use 3-5 sentences per paragraph Avoid conjunctions (i.e., and, or)</td>
</tr>
<tr>
<td>3</td>
<td>Active voice</td>
<td>Active (vs. passive) voice statements clearly show who does what to whom.</td>
<td>“We based this decision...” vs. “This decision is based...”</td>
</tr>
<tr>
<td>4</td>
<td>Avoid jargon, acronyms and abbreviations</td>
<td>If you must use jargon, define the term in plain language.</td>
<td>Place technical or medical terms in parenthesis after plain language explanation.</td>
</tr>
</tbody>
</table>
Flesch-Kincaid Grade Level (readability statistics)

\[
0.39 \left( \frac{\text{Total words}}{\text{Total sentences}} \right) + 11.8 \left( \frac{\text{Total syllables}}{\text{Total words}} \right) - 15.59
\]
Before checking the FK reading level:

- Remove clinical or technical terms only when explained in plain language or when they appear in a policy name or other reference.
- Remove regulatory or accrediting terms such as "medically necessary” or "investigational”.
- Leave in periods at end of sentences.

After checking the FK reading level:

- Replace all words that were removed prior to checking reading level.
- Review final denial rationale statement to ensure all required elements are stated in a clear and concise manner.

*** The illustrations above show that the multiplier for syllables over words is larger than words over sentences. Therefore, the key to improving readability is shorter words and shorter sentences.