Utilization Management and Quality Program 2025

Nevada Health Solutions

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Executive Summary

The mission of Nevada Health Solutions ("NHS") is to ensure consistent delivery of the highest quality healthcare and optimum patient outcomes. This is accomplished through the establishment of an integrated multidisciplinary team of healthcare professionals coordinating clinical and administrative services.

NHS' Utilization Management and Quality Program ("Program") is multi-dimensional and operates todirect and monitor the use and quality of health care services provided to its patients. The program includes pre-services, concurrent and retrospective review, and evaluation of the utilization of services provided to patients.

The Program is structured to assure that medical decisions are made by qualified health professionals using written criteria based on sound clinical evidence. The model is patient centric and empowers the patients with knowledge that allows them to become more active participants in health care decisions.

The philosophy, purpose, scope, structure, and tools of theProgram are outlined in the Program Description. The following summary highlights some of the primary functions of the Program that serve to ensure a patient's easy access to the most appropriate and efficient quality care to promote improved health outcomes.

Nevada Health Solutions Utilization Management and Quality Program

INTRODUCTION

TheProgram is designed to optimally manage healthcare resources to maximize the cost effectiveness and quality of the care provided to patients. It is designed to promote fair, safe, and consistent utilization management decision-making. The Program is under the clinical supervision of a Medical Director, a Nevada licensed physician andSenior Director of Medical Management, a Nevada licensed registered nurse, both providing support to develop and implement theProgram. The Program is updated as necessary and evaluated and approved annually by the Utilization/Quality Management Committee.

The following summary highlights some of the primary functions of theProgram that serves to ensure patients' easy access to the most appropriate andefficient quality care to promote improved health outcomes.

PURPOSE

The purpose of theProgram is to provide a comprehensive, integrated process that ensures patients in all age groups from newborn to geriatrics receive timely, safe, and appropriate medical care in the most efficient and cost-efficient manner. The Program provides a comprehensive process of review of inpatient and outpatient medical services for self-funded and commercial plans as contracted. This process assures the delivery of medically necessary, optimally achievable, quality patient care through appropriate utilization resources in a cost effective and timely manner. The focus of the Program is to ensure efficiency and continuity by identifying, evaluating, monitoring, and correcting elements that affect the overall effectiveness of the utilization management process. The Program's activities are developed and implemented in compliance with state and federal regulations.

Moreover, in order to continually assess and improve the quality of care available to patients, the Program includes quality evaluation with the Utilization/Quality Management Committee to facilitate the achievement of its goals and objectives.

GOALS

The goals of theProgram are to:

A. Provide a system that ensures medical services are delivered at an appropriate level of care in a timely, effective, and efficient manner. Medical services for both inpatients and outpatients include all medically appropriate services.

B. Provide patients with equitable access to care across their network.

C. Ensure that qualified health professionals using appropriate clinical information and evidence-based criteria sets make appropriate utilization management decisions

D. Continually monitor, evaluate, and optimize health care resource utilization by

applying utilization management policies and procedures to review medical care and services.

E. Educate contracted providers on the policies and procedures of theProgram and ensure compliance with policies, procedures, goals, and objectives.

F. Comply with all applicable federal and state laws, regulation and accreditation requirements including the State of Nevada Department of Insurance and the Department of Labor

G. Establish processes to collect and periodically monitor data, implement interventions, and measure results of the interventions for effective strategies to achieve appropriate utilization.

H. Monitor utilization of practice patterns of contracted providers and identify variations.

I. Conduct medical review of all potential denials of services, excluding denials due to non-eligibility and benefits.

J. Provide all medically necessary care within the contracted network of providers whenever possible.

K. Continually improve utilization criteria bases on outcome data and review of the medical literature.

L. Maintain responsibility for delegation utilization management activities by ensuring appropriate oversight of delegated entities.

SCOPE

The Program is designed to monitor, evaluate, and manage the qualityand cost of healthcare services delivered to patients. This Program provides for fair and consistent evaluation of medical necessity and care through use of nationally accepted and internally developed clinical practice guidelines.

Utilization management activities are developed, implemented, and conducted by the Medical Management Department under the direction of the Senior Director of Medical Management and the Medical Director. The utilization management staff performs specific activities, and all are qualified, experienced, licensed nurses and other health care professionals. Specific functions performed include:

A. Prospective, concurrent, and retrospective utilization review for medical necessity,appropriateness of hospital admission, level of care and continued inpatient confinement daily. This review is performed cooperatively with the personnel at the facility, attending physician(s) and any associated health care personnel that can provide information that will substantiate medical necessity and level of care.

B. Discharge planning in coordination with discharge planning personnel or appropriate case management personnel at the facility providing care for the member.

C. Review inpatient and outpatient utilization data to determine appropriateness of member and provider utilization patterns.

D. Review certifications requests including, but not limited to, skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic, and treatment procedures such as Physical, Occupational and SpeechTherapy and ensuring requests are within clients benefit plan.

UTILIZATION MANAGEMENT REVIEW PROCESSES

The following describes the utilization management review processes, including general overview, prospective, concurrent, and retrospective review.

GENERAL OVERVIEW

ACCESS TO REVIEW STAFF

Nevada Health Solutions (NHS) provides access to its review staff by a toll-free number 855-392-0778 or 855-487-0353 or telephone number 702-216-1653. To meet the needs of our clients, NHS will be available between the hours of 9 am to 5:00 pm of each normal business day in our client's time zone. NHS hours of operation does notinclude weekends and holidays and therefore, all UR requests will be processed on the next business day.

REVIEW SERVICE COMMUNICATION AND TIME FRAMES

Hours to Receive Communication

Nevada Health Solutions receives communications from providers and patients during the business day and after business hours. Mechanisms for receipt of communications include telephone, facsimile, email, and provider web portal.

Response to Communication

Nevada Health Solutions responds to communications within one business day.

Outgoing Communication

Nevada Health Solutions conducts its outgoing communications related to utilization management during providers' reasonable and normal business hours, unless otherwise mutually agreed.

REVIEW SERVICE DISCLOSURE

Required Self-Identification

Members of the utilization review staff, when answering the telephone, identify themselves by first name, job title and the name of Nevada Health Solutions.

Information Regarding Utilization Management and Procedures

Upon request, members of the utilization review staff verbally inform patients, facility personnel, attending physicians, other ordering providers and other health professionals of Nevada Health Solutions' utilization management requirements and procedures.

ON-SITE REVIEW REQUIREMENTS

Reviewer Identification

Members of the utilization management staff conducting an onsite review will carry a picture ID with his/her first name, last initial and the name of Nevada Health Solutions.

Scheduling Review

If required, members of the utilization management staff conducting on an onsite review will schedule such onsite reviews at least one business day in advance, unless otherwise agreed and documented.

Facility Procedures

Members of the utilization management staff conducting an onsite review will follow reasonable hospital or facility procedures, including checking in with designated hospital or facility personnel if required.

INITIAL SCREENING

When a request for certification is received by Nevada Health Solutions, an intake coordinator conducts an initial screen of the request. That screening includes the collection and transfer into the database used by Nevada Health Solutions to process such requests.

Pre-Review Screening Staff Oversight

Intake Coordinators have ready access to licensed health professionals while performing initial screening. Such access includes any of the following modalities: in person, telephone, email and/or via the clinical decision support tool being used to support the utilization management function.

Pre-Review Screening Non-Certification

Nevada Health Solutions does not issue non-certifications based on initial screening.

INITIAL CLINICAL REVIEW

Initial Clinical Reviewer Qualifications

Nurse Reviewers are appropriate health professionals and possess an active professional State of Nevada license and other states as required.

Initial Clinical Reviewer Resources

Nurse Reviewers have access to a licensed Doctor of Medicine or Doctor of Osteopathic Medicine.

Non certification

Nevada Health Solutions does **not** issue non-certification based on initial clinical reviews.

PEER CLINICAL REVIEW AND INITIAL UTILIZATION MANAGEMENT DECISION

Peer Clinical Review Cases

Nevada Health Solutions conducts peer clinical reviews for all cases where a certification is not issued through initial clinical review or initial screening.

Peer Clinical Reviewer Qualifications

Peer clinical reviewers are a Doctor of Medicine or Doctor of Osteopathic Medicine holding a valid and unrestricted license in the state of Territory of the US. Moreover, the Peer Clinical Reviewer is located in a state of territory of the US when conducting review and when appropriate in the same licensure category as the ordering provider. The Peer Clinical Reviewers are qualified, as determined by the medical director to render a clinical opinion about the medical condition, procedures, and treatment under review.

UTILIZATION MANAGEMENT REVIEW PROCESS

Prospective Review Process (Pre-service – Urgent and Non-Urgent)

The prospective review process ensures that no service is rendered to a patient prior to determining both the medical necessity of the service as well as the coverage limits of the patient's benefit plan.

All Prospective reviews include:

- Prior Authorization
- Step Therapy i.e., Physical Therapy prior to surgery
- Preadmission review
- Pretreatment review
- Utilization Care Management

Safety Issues

During the Prospective Review Process, clinical staff will also analyze information provided for potential safety or medical errors. Clinical reviewers will screen information for the following potential safety issues (but not limited to):

- Adverse drug interactions
- Contraindicated or inappropriate treatment
- Conservative treatment not addressed or ruled out

If a safety issue is identified, the clinical reviewer will forward the case and information to the Medical Director and the Senior Director of Medical Management. After researching the potential safety issue, they will determine further action(s) needed to be taken or refer the case/information to the appropriate entity or authority for further action.

Prior Authorization

Decision Timeframes

Utilization decisions are made as soon as possible for cases involving urgent care, but no later than 72 hours of the receipt of request. Non-urgent cases are determined within fifteen (15) calendar days of the receipt of the request, except for those members living in the State of Kentucky (see addendum A)

Oral notification of the decision is given to the requesting provider and patient (only if denied) by the next business day that the decision is made. Electronic, verbal, or written notification of the determination of denial with appeal rights is given within one (1) business day.

Inpatient Services

Nevada Health Solutions requires pre-authorization of all admissions (pre-services and urgent). Failure to authorize admission may result in payment denial. Nevada Health Solutions should receive notification of an emergency admission within 24 hours of the admission date. Nevada Health Solutions considers a request made while a member is in the process of receiving care to be an urgent concurrent request if medical care requested meets the definition of urgent, even if Nevada Health Solutions did not previously approve the earlier care. Therefore, these admissions will have an oral decision from Nevada Health Solutions within seventy-two hours (72) hours of the request. In cases where the request for health care services comes from a practitioner, Nevada Health Solutions sends the request for additional information to the practitioner. If the request is denied, Nevada Health Solutions orally communicates the denial to the facility, patient, and provider within 24 hours of the request followed by a letter with appeal rights to the patient, facility and provider within one (1) business day of the oral notification. Patients are not notified of denial if they have no financial responsibility per their plan.

Outpatient Services

1. All outpatient procedures (i.e., surgery, DME, home health, non-routine radiological test) require pre-authorization from Nevada Health Solutions. Urgent requests follow the procedure as outlined above.
2. Decisions for non-emergent or non-urgent procedures are rendered within fifteen (15) calendar days of the request.

Emergency Room Visits

Patients may seek emergency care as needed at participating and non-participating facilities.

Concurrent Review Process

The concurrent review process ensures that the ongoing care provided to a patient is reviewed on a periodic basis to ensure the continued need for acute care and that the care is in conformance with the patient's plan benefits. Concurrent Reviews include inpatient admissions, home health, infusion therapy and outpatient rehab such as Nevada Community Enrichment Program.

Objectives

The objectives of the concurrent review process include the following:

1. To ensure the length of treatment is medically necessary and appropriate based on medical record documentation
2. To ensure urgent and emergent treatment for medical necessity is in accordance with program criteria
3. To identify services provided by non-contracted providers to determine medical necessity and appropriateness of services
4. To ensure follow-up services and/or continuing care needs are met and are in compliance with plan policies regarding covered benefits.

Procedures

Nevada Health Solutions staff orally notifies the provider, patient and facility of approval or denial status within seventy-two (72) hours receiving clinical information. Communication of a non-certification decision is given on the day prior to the start of a non-certified day (unless specific certified days were agreed upon with the physician and/or patient). Patients, facilities, and practitioners assume continued approval in the absence of notification. If days are denied, non-certification letters are sent to the physician, patient only if patient has financial responsibility and the hospital within one (1) calendar day of the oral notification to deny services.

The Medical Management Utilization Department will be responsible for the following activities in the concurrent review process:

1. Obtaining medical updates for purposes of reviewing patients for continued care and providing updates to the Medical Director
2. Coordinating with the hospital utilization review and discharge planning staff to arrange for follow-up and transition to the outpatient setting.
3. Notification to hospital case management/utilization review personnel of total number of extended days, next anticipated review, total days certified and date of admission during our normal business hours.

Retrospective Review Process

The retrospective review process is employed in cases where clinical information could not be obtained during the patient's hospitalization or emergency department visit. Clinical information is not reviewed for retrospective denials for urgent pre-service requests after UM hours. If the post service review is denied, non-certification letters are sent to the physician, patient, and the hospital's Utilization Management Department within thirty (30) calendar days of the request.

Objectives

1. To determine medical necessity, compliance with the health plan's benefits and appropriateness of services rendered by the providers
2. To identify and address Program compliance issues
3. To identify possible quality issues and refer them to the Medical Director/and or the Sr. Director of Medical Management
4. To report changes and outliers in participating provider practice patterns to the Medical Director and Utilization/Quality Management Committee
5. To provide a mechanism for education of providers/patients, feedback to providers and corrective action

Procedures

The Medical Management Utilization Department is responsible for the following activities in the retrospective review process and making determinations based solely on the medical information available to the practitioner/provider at the time the medical care is provided:

1. Reviewing request against established guidelines in order to determine medical necessity, benefit compliance and appropriateness of services provided.

PATIENT SAFETY ISSUES IDENTIFIED DURING REVIEW PROCESS

Utilization Management staff may identify actual and/or potential quality issues during utilization review activities, including prospective review. These issues are referred to the Senior Director and Director of Medical Management as well as the Medical Director to address quality issues for further investigation, follow-up, and resolutions.

GUIDELINES & CRITERIA FOR DETERMINATIONS

Nevada Health Solutions utilizes nationally recognized guidelines in making medical necessity and experimental/investigational determinations, and in monitoring the quality of care provided to the patients.

MEDICAL NECESSITY DEFINITION

Medically necessary health care services mean health care services that a provider would render to a patient for purposes and preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in terms of type, frequency, extent, duration, and place of service

MEDICAL NECESSITY CRITERIA

The Program is conducted under the administrative and clinical direction of the Senior Director of Medical Management, the Medical Director and, External Clinical Review Criteria include the current version of MCG (formerly known Milliman Care Guidelines). Resources used for medical literature review include UpToDate.com, National Institutes of Health (nih.gov), National Comprehensive Cancer Network (nccn.gov) and their reference lists.In addition, Internal Clinical Review Criteria are developed when the Medical Director determines existing clinical review criteria are inadequate. When needed, the Medical Director consults with physicians with current knowledge relevant to the subject involved with the criteria to be developed.

It is Nevada Health Solutions policy that all medical appropriateness/necessity criteria are developed, reviewed, and approved by the Medical Director, prior to implementation. Moreover, as part of the review of the Program, all criteria are reviewed and updated as needed, but no less than annually, and are documented in the Utilization/Quality Management Committee minutes. Providers are advised annually that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are also available upon request and on Nevada Health Solutions' website. The individualneeds of the patient and the resources available within the local delivery system are considered when applying Utilization Management criteria.

Inpatient Certification

The Program uses the current version of the Milliman Care Guidelines ® clinical decision support tools for treating specific patient conditions with appropriate levels of care to gain optimal progression toward discharge or transition. Developed by clinical experts at MCG (formerly Milliman Care GuidelinesLLC), Hearst Health Network, the Care Guidelines provide a focused summary of the current best evidence, reflecting the actual practices of care providers throughoutthe United States, as well as the latest medical literature. The guidelines are reviewedand updated by MCG annually. They are designed to be used along with health care professionals' clinical judgment.

Outpatient/Other Certification

Where it exists, the current version of MCG is used to determine medical necessity for outpatient services. When absent from MCG criteria sets, internal criteria for certification are based on current evidence-based medical literature.

When absent from MCG criteria sets, other criteria and/or internal criteria for certification are based on current evidence-based medical literature.

At least annually, the criteria are reviewed by the Medical Director. The criteria are used by the Utilization Management staff during the prior authorization process. The internally developed criteria are available upon request and on Nevada Health Solutions' website.

Diagnostic Imaging

The current version of the MCG Criteria is used as the basis for authorization of the following elective, outpatient imaging studies including but not limited to Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET Scan), Diskography or Computed Tomography Angiogram (CTA)

Durable Medical Equipment

Where it is applicable, the current version of the MCG and/or NHS medical policy is used to determine medical necessity for Durable Medical Equipment. At least annually, the criteria are reviewed by the Senior Director of Medical Management, and Medical Director.

Transplant

It is Nevada Health Solutions' policy that all requests for organ transplants be reviewed byits Medical Director and Utilization/Case Manager so that patients can be directed to the most appropriate transplant facility for evaluation based on benefits.

Once the patient has been approved, the patient is enrolled in the United Network for Organ Sharing (UNOS).

All patients that are approved for transplant are followed closely by Utilization Management staff and the Medical Director. The purpose is to ensure ongoing medical necessity for transplant.

New Technology Assessment

Nevada Health Solutions investigates all requests for new technology or a new application of existing technology using the HAYES Medical Technology Director ® and the California Technology Assessment Forum (CTAF) as guidelines to determine whether the new technology is investigational in nature. If further information is needed Nevada Health Solutions utilizes additional sources, includingMedicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices.

If the new technology or new application of an existing technology is addressed in the above documents, the information is taken into consideration by the Medical Director at the time of benefit determination. If the new technology or new application of an established technology is not addressed in the above documents, the Medical Director may confer with an appropriate specialist consultant for additional information. The decision is based on safety, efficacy, cost, and availability of information in published literature regarding controlled clinical trials. If a decision cannot be made, a committee of specialists may be convened to review the new medical technology and make a recommendation to the Medical Director.

Currently NHS does not utilize Artificial Intelligence (AI) or Medical Learning (ML) but would use FDA regulator obligations for AI and ML software as well as National Standards before implementing.

CONSISTENCY OF APPLICATION OF UTILIZATION DECISION CRITERIA

Nevada Health Solutions evaluates consistency of application of decision criteria through:

I. The Medical Director in cooperation with the Utilization/Quality ManagementCommittee oversees the coordination of training and education programs thatprovide the utilization management staff and physician reviewers with the required knowledge and skills needed to manage utilization related issues.

II. Administrative staff will provide education sessions for staff to promote continual professional growth concerned with utilization management.

III. Periodic audits are performed to review determinations against criteria for medical necessity; moreover, there are supervisor's periodic review of determinations and weekly UM rounds attended by UM staff members and Medical Director to evaluate determinations and problem cases.

IV. Appropriate action plans are developed as necessary.

V. The Medical Director and Utilization/Quality Management Committee annually perform review of Utilization Management Physician Leader (Consultants and [Independent Review Organization] IRO) determinations.

VI. Provider education regarding appropriate utilization is initiated as needed. Education will be coordinated with the appropriate physician leader(s) and Medical Director.

VII. Results of the provider education are assessed at appropriate intervals.

INTERRATER RELIABILITY

Nevada Health Solutions reviews and assesses the consistency of personnel involved in making utilization review determinations using Utilization Management criteria, no less than annually. This process includes physicians and non-physicians' determinations. Cases are reviewed at identified intervals as part of a group educational process; these include but are not limited to at least weekly UM rounds to evaluate determinations and problem cases. When inconsistencies or areas of improvement are identified, processes and/or interventions are developed or revised, and implemented after staff education is provided. Monitoring of these improvements occurs during weekly rounds.

The goals of interrater reliability include, but are not limited to:

- Minimizing variation in the application of clinical guidelines
- Evaluating staff's ability to identify potentially avoidable utilization
- Evaluating staff's ability to identify quality of care issues
- Targeting specific areas most in need of improvement
- Targeting staff needing additional training

The Senior Director of Medical Management and the Director of Medical Management Department conduct audit of daily work of the Utilization Management staff. When there are issues or concerns, a process improvement plan will be determined based on the findings. Areas of improvement, which are identified as part of the audit is then discussed with individuals and/or at departmental staff meetings and appropriate changes are made within the department's processes.

DECISION/NOTIFICATION TIMELINES

UTILIZATION MANAGEMENT DECISION /NOTIFICATION TIME FRAMES

Nevada Health Solutions follows applicable state and federal regulations on decision and notification timeframes for all utilization management determinations. Where regulatory and accreditation bodies differ, Nevada Health Solutions will use the strictest/shortest timeframe to assure compliance with all requirements. The following is a summary of Nevada Health Solutions' decision and notification timeframes:

	Decision TAT	Practitioner Notification of Approval	Written Practitioner/Patient Notification of Denial
Non-Urgent * Pre-Service	15 Calendar Days of Receipt of Request	Within 15 Calendar Days of the Request	Within 15 Calendar Days of the Request
Urgent /Expedited *Pre-Service	72 Hours of Receipt of Request	Within 72 hours of the Request	Within 72 Hours of the Request
Urgent Concurrent Review	72 Hours of Receipt of Request	Within 72 Hours of Request	Within 72 hours of the Request
Post-Service (Retro review) Decision	30 Calendar Days of Receipt	Within 30 Calendar Days of the Request	Within 30 Calendar Days of the Request

TIME FRAMES FOR INITIAL DETERMINATIONS

Nevada Health Solutions issues determination within the following time frames for each of the three general categories of utilization management reviews, prospective, retrospective, and concurrent. ***See addendum A for exceptions in the State of Kentucky and addendum A.1 for exceptions in the State of Maryland**

PROSPECTIVE REVIEW TIME FRAMES

Case involving Urgent Care

As soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of request for a utilization management determination.

Non-Urgent

Within two (2) days after receipt of the information necessary to make a determination, but no later than fifteen (15) calendar days of the receipt of a request for a utilization management determination. This period may be extended one time by Nevada Health Solutions for up to fifteen (15) calendar days, provided that Nevada Health Solutions determines that an extension is necessary because of matters beyond the control of Nevada Health Solutions and notifies the patient prior to the expiration of the initial fifteen (15) calendar day period of the circumstances requiring the extension and the date when Nevada Health Solutions expects to make the decision. If a patient fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the patient must be given at least forty-five (45) calendar days from receipt of notice to respond to Nevada Health Solution' request for more information.

CONCURRENT REVIEW TIME FRAMES

Reductions or Terminations of a Previously Approved Course of Treatment

Nevada Health Solutions issues the determination early enough to allow the patient to request a review and receive a decision before the reduction or termination occurs.

Request to Extend a Current Course of Treatment

NHS will provide a determination within 72 hours unless stated otherwise by individual state. (see addendums)

RETROSPECTIVE REVIEW TIME FRAMES

Review takes place within thirty (30) calendar days of the receipt of request for a utilization management determination. This period may be extended one time by Nevada Health Solutionsfor up to fifteen (15) calendar days if Nevada Health Solutions determines that an extension is necessary because of matters beyond the control of Nevada Health Solutions. In such a circumstance, Nevada Health Solutions will notify the patient prior to the expiration of the initial thirty (30) calendar day period of the circumstances requiring the extension and the date when Nevada Health Solutions expects to make the decision. If the patient fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information and the patient must be given at least forty-five (45) calendar days from receipt of notice to respond to the plan request for more

information.

INFORMATION UPON WHICH UTILIZATION MANAGEMENT IS CONDUCTED

SCOPE OF REVIEW INFORMATION

Nevada Health Solutions, when conducting routine prospective, concurrent, or retrospective reviews:

- Accepts information from any reasonably reliable source (except via mail) that treatment, length will assist in the certification process
- Collects only the information necessary to certify the admission, procedure or of stay or frequency or duration of services
- Does not routinely require hospital, physician, and other providers to numericallycode diagnoses or procedures to be considered for certification but may request such codes if available.
- Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency, or duration of services.
- Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know to avoid duplicate requests for information from patients or providers.
- Does not accept Vendor forms for reviews without accompanying clinical documentation by the ordering/treating provider
- Requires medical record entries by the ordering/treating provider to be legible, complete, dated, timed (if applicable) and authenticated in written or electronic form by the person responsible for providing or evaluating the services provided. Where it is clear that an individual document extends to multiple pages and that the entire document is then authenticated, then a signature on a single page would suffice for other pages as well.
- For Out of Area hospitalizations, physician's progress notes are required to make medical necessity determinations.

PROSPECTIVE AND CURRENT REVIEW DETERMINATIONS

For prospective review and current review, Nevada Health Solutions bases review determinations solely on the medical information obtained by Nevada Health Solutions at the time the medical care was provided.

RETROSPECTIVE REVIEW DETERMINATIONS

For respective review, Nevada Health Solutions bases review determinations solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

LACK OF INFORMATION

If the initial clinical reviewer determines from a review of the file that the information submitted with the request for certification is insufficient information upon which to base a determination, he/she contacts the member, attending physician, ordering provider or facility rendering service no later than five (5) business days after receipt of the request requesting the information, specifying the time frame within which the information must be received before Nevada Health Solutions issues an administrative denial non-certification based on lack of information. The time frame specified in that communication must be appropriate to the clinical circumstances of the review (that is, whether the review is prospective, concurrent, retrospective, urgent or non-urgent).

If the provider receiving such a notice provides no further information, the initial clinical reviewer confers with a peer clinical reviewer and, unless the peer clinical reviewer believes that the file has enough information upon which to make an evaluation of medical necessity, the initial clinical reviewer provides the provider written notification that the request for certification has been denied for lack of information.

If the provider, on the other hand, responds by providing more information or by communicating that there is no more information available, Nevada Health Solutions treats the case as though there was sufficient information upon which to base a certification decision under the procedures outlined in this program description.

For those residents of the **State of Maryland see Addendum A.**1.

NOTICE OF INITIAL DETERMINATIONS

CERTIFICATION DECISION NOTICE AND TRACKING

Either an initial clinical reviewer or peer clinical reviewer may issue a certification. When a person authorized to issue a certification does so, he/she or a person that he/she so designates will contact the attending physician or other ordering provider and facility rendering service by telephone, facsimile, electronic or web-based tools to advise him/her/it of the certification decision. Where the provider is obligated by the contract to notify the patient of the decision, he/she/it will be reminded of that obligation in this call. If the provider is not obligated to notify the patient, the person providing notification will also notify the patient. The notification of certification will include the case number of the request for certification. Upon request from the provider or patient, the person issuing the notification also will issue a written notification to the requesting party.

CONTINUED CERTIFICATION DECISION REQUIREMENT

If the notification described above is for continued home health care or services or inpatient care, the notification 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.

NOTICE OF NON-CERTIFICATION

If an initial clinical reviewer is unable to issue a certification decision, he/she will refer the case to an available peer clinical reviewer. Only a peer clinical reviewer may issue a non-certification decision. The definition of "reason for the non-certification" is included in the written notice of non-certification. The peer clinical reviewer also documents in the case file documentation the clinical rationale upon which his/her non-certification decision was based. The written notice of non-certification is sent to the patient and either the attending physician, the ordering provider or facility rendering service. Before the written notice of non-certification is sent, the initial clinical reviewer reviews the letter to make sure that the principle reason in the notice is sufficiently specific to the patient's circumstances and condition meets the definition of "principle reason" under URAC accreditation standards and applicable state and federal laws and regulations.

The written notice of non-certification includes:

- The specific principal reason for non-certification
- A statement that the clinical rationale is used in making the non-certification decision is provided in writing upon request.
- Instructions for initiating an appeal of the non-certification.
- Instructions for requesting a clinical rationale for the non-certification.

CLINICAL RATIONALE FOR NON-CERTIFICATION REQUIREMENTS

Request from the patient, attending physician, ordering provider, or facility-rendering services for the clinical rationale upon which a non-certification was based is referred to the initial clinical reviewer or peer clinical reviewer involved with the case, who then sends to the requesting party the clinical rationale as documented according to the above.

REVERSAL OF CERTIFICATION DETERMINATIONS

Nevada Health Solutions does not reverse a certification determination unless it receives new information that is relevant to the certification and that was not available at the time of the original certification. If new information does become available that had been in the possession of Nevada Health Solutions at the time of the certification decision and would have prevented the person who made the certification decision from doing so, that information is conveyed along with the full case file to an available peer clinical reviewerwho then handles the review under the procedures outlined above. **For those residents of the state of Maryland see Addendum A.1.**

FREQUENCY OF CONTINUED REVIEWS

Initial clinical reviewers conduct continued reviews for the extension for an additional determination with a frequency that is based solely on the severity and complexity of the patient's condition, or on necessary treatment and discharge planning activity. Initial clinical reviewers do not routinely conduct such reviews on a daily basis. This policy applies to both inpatient and outpatient settings.

DENIAL PROCESS

The process of review, utilizing established criteria, involves the initial review by appropriate clinical reviewers. The Medical Director or medical consultants review services not meeting criteria. All denials and alternate level of care decisions are made at the physician level. The denial process consists of the following:

1. The initial review assesses medical necessity against established medical necessity criteria and the patient's benefit package and limitation.
2. If criteria are met, the services are approved.
3. If the service(s) does not meet criteria or if the criterion specifically requires physician authorization, the reviewer submits the case for review.
4. All denial decisions are followed with written notification to the requesting practitioner and patient, if the patient is financially liable.
5. Denial decisions include the rationale for the denial and information on the appeal process in writing.

ADVERSE DETERMINATIONS

The adverse determination letter includes the following information:

1. The specific reason(s) for the denial in easy understandable language
2. A reference to the benefit provision, guideline, protocol, or other similar criterion onwhich the denial was based.
3. Notification that the patient or practitioner can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.
4. Explanation of the appeal process including the right to member representation, the right to submit written comments, documents, or other information relevant to the appeal and time frames for deciding appeals.
5. If the denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeals process.
6. That a Medical Director is available to discuss the denial determination with the practitioner

PEER-TO-PEER RECONSIDERATION OF ADVERSE DETERMINATION

AVAILABILITY

Peer clinical reviewers are available to discuss review determinations with attending physicians or other ordering providers.

POST-DECISION CONVERSATION

When Nevada Health Solutions makes a determination to issue a non-certification and no peer-to-peer conversation has occurred in connection with that case, Nevada Health Solutions provides, within one business day of a request by the attending physician or ordering provider, the opportunity to discuss the non-certification with either the clinical

peer reviewer making the initial determination or with a different clinical peer, if the original clinical peer reviewer cannot be available within one business day. If a peer-to-peer conversation or review of additional information does not result in a certification, Nevada Health Solutions informs the provider and patient of the right to initiate an appeal and the procedure to do so.

PROVIDER/PATIENT APPEALS PROCESS

APPEALS CONSIDERATIONS

Non-Certification Appeals Process

Nevada Health Solutions' procedures for filing an appeal from a non-certification, outlined here, are made available in writing upon request by any patient, provider or facility rendering service.

A patient, attending physician, ordering provider, or facility rendering service, having received a denial of certification non-certification may appeal that decision by notifying Nevada Health Solutions through the means indicated in the written notice of denial of certification. Nevada Health Solutions must receive such notice within 180 days of the date of the denial of certification. If the appeal must be expedited because it is a case involving urgent care, the need for expeditious review must be clearly articulated in the notice of appeal. Upon receipt of the notice of appeal, Nevada Health Solutions routes the notice to the appeals coordinator/appeals nurse.

Information upon Which Appeal Decision is based

The patient, provider, or facility rendering service may submit, with its notice of appeal, written comments, documents, records, and other information relating to the case. All such information is included in the case file and provided to the appeal peer reviewer to whom the case is assigned. That reviewer takes all this information, along with all information submitted or considered in the initial consideration of the case, into account during his/her consideration of the case.

If the appeal peer reviewer overturns the initial denial, Nevada Health Solutions implements that decision.

Appeal Record Documentation

Each appeal case file contains, at a minimum, the following information:

1. The name of the patient, provider, and/or facility rendering service
2. Copies of all correspondence from the patient, provider, or facility rendering service and Nevada Health Solutions regarding the appeal
3. Dates of appeal reviews, documentation of actions taken, and final resolutions
4. Minutes or transcripts of appeal proceedings (if any)
5. Name and credentials of the appeal clinical reviewer considering the appeal.

Determination of Whether Appeal is Standard or Expedited

The initial clinical reviewer, upon receiving the notice of appeal, determines whether the appeal is to be treated as a standard appeal or an expedited appeal. If the notice of appeal asks for an expedited appeal and the initial clinical reviewer cannot conclude from the notice that the case is one involving urgent care, he/she immediately forwards the case to a peer clinical reviewer to make the determination of whether the appeal involves urgent care such that the appeal needs to be expedited.

Appeal Peer Reviewer Qualifications

Once it has been determined, under the procedure outlined about, whether the appeal is standard or expedited, the initial clinical reviewer forwards the case, with instructions about time constraints, to a qualified appeal peer reviewer from Nevada Health Solutions' list of available appeal peer reviewers. If the list of available appeal peer reviewers does not contain a reviewer, who meets the qualifications outlined in this section, the appeal coordinator/appeals nurse handling the case contacts any outside entities with whom Nevada Health Solutions has contracted who can provide qualifiedappeal peer reviewers for the appeal.

The appeal is considered by an appeal peer reviewer who:

1. Hold an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States.
2. Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting an appeal consideration.
3. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate.
4. Are neither the individual who made the original non certification, nor the subordinate of such an individual; and
5. Are board-certified (if applicable) by:
    i. A specialty board approved by the American Board of Medical Specialties (Doctor of Medicine); or
    ii. The Advisory Board of Osteopathic Specialists from the major areas of clinical services (Doctor of Osteopathic Medicine)
    iii. The American Dental Association (ADA) specialty boards or the American Board of General Dentistry (ABGD)
    iv. The American Board of Podiatric Surgery (ABPS) or the American Board of Podiatric Medicine (ABPM)

Appeal Reviewer Attestation

Upon receipt of a consumer file for appellate review, the appeal reviewer executes an attestation that he/she:

1. Has a scope of licensure or certification that typically manages the medical

condition, procedure, treatment, or issue under review; and
2. Current, relevant experience and/or knowledge to render a determination for the case under review.
3. Has no previous knowledge or involvement in the case under review and has been given the opportunity and process to recuse themselves.

The initial clinical reviewer managing the case includes the attestation in the consumer's file.

APPEAL TIME FRAMES

Expedited Appeals Process Time Frame

For an expedited appeal, once the appeal peer reviewer renders a decision, he/she forwards that decision, along with the principle reason and clinical rationale underlying that decision, to an initial clinical reviewer for generation of a verbal notification of the determination to the requesting party within 72 hours of the request followed by a written confirmation of the notification of the appeal decision within three days of the verbal notification, is to be sent to the patient and attending physician or ordering provider or facility rendering service.

Standard Appeals Process Time Frame

For a standard appeal, once the appeal peer reviewer renders a decision, he/she forwards that decision, along with the principal reason and clinical rationale underlying that decision, to the appeals coordinator/appeals nurse for generation of a written notification of the appeal decision within 30 calendar days of the initiation of the appeal process, to be sent to the patient and attending physician or ordering provider or facility rendering service.

EXCEPTION WHERE PATIENT HAS NO FINANCIAL RESPONSIBILITY

Where the patient bears no financial responsibility, notice to the patient is not required.

WRITTEN NOTICE OF UPHELD NON-CERTIFICATION

The written notice of an upheld non-certification includes:

1. The principal reasons for the determination to uphold the non-certification.
2. A statement that Nevada Health Solutions provides, in writing, the clinical rationale underlying the appeal decision upon request.
3. Information about additional appeal mechanisms, which is available to the appealing party under payer contract or regulation.

MAINTENANCE OF APPEAL RECORDS AND DOCUMENTATION

Nevada Health Solutions maintains complete records on each appeal rendered. These records include the following information, but not limited to:

- Name of the Patient
- Name of the Provider and/or Facility providing the services
- Name and credentials of the clinical peer that meets the qualifications specific to the case reviewed as well as the attestation of credentials and knowledge.

- Dates of appeals reviews, documentation of action taken, final resolution and any minutes or transcripts of appeal proceedings (if applicable)

Nevada Health Solutions will store and maintain the records electronically where upon copies can be generated in a timely and reliable format.

ORGANIZATION STRUCTURE

The following are the key staff that is directly accountable for Utilization Management decisions, systems, and procedures:

President

- Serves as President of Nevada Health Solutions Governing Board
- Responsible for strategic direction and overall oversight of NHS

Medical Director

Responsible for providing day-to-day guidance and direction of UM activities. Specific functions include:

- Assists with developing and coordinating policies and procedures
- Available for consultation on a daily basis with the Senior Director of Medical Management, Director of Medical Management and UM Team Managers regarding UM and Care Coordination issues primarily for situations that may not meet medical necessity criteria.
- Guide and assist in the development and revision of clinical criteria, clinical practice guidelines, new technology assessments, and performance standards for Utilization and Quality Management review adaption and approval.
- Develop and implemen utilization management strategies

Senior Director, Medical Management

The Senior Director of Medical Management is responsible for overall coordination, implementation, and monitoring of activities to yield quality driven, compliant, efficient, and cost-effective results. In addition, the Senior Director of Medical Management is responsible for the strategic direction, management, and oversight of the operations of the Medical Management Department. The person with this accountability is a licensed registered nurse with extensive utilization management experience. Specificresponsibilities include:

- Serves as Vice President of Nevada Health Solutions Governing Board
- Serves as an advanced clinical resource to staff with responsibilities concerning Utilization Guidance decisions.
- Serves as committee chair of Utilization/Quality Management Committee
- Assures that the Program fulfills its purpose and goals and complies with the regulatory agencies and accreditation bodies.
- Implements policies and procedures concerning utilization guidance processes andsystems, including the processes for authorization, current review, discharge planning, transitional care services and referral management.
- Ensures the use of Nevada Health Solutions identified utilization guidance criteria fordecision making. Recommends to the Committee policies and procedures to

guide the utilization guidance process

- Ensures referral of all authorization requests that cannot be approved based on medicalnecessity to the Medical Director for review
- Ensures referral of cases with potent quality of care concerns to the Medical Directorfor review
- Ensures the appropriate documentation of utilization guidance decisions
- Participates in the utilization guidance decisions
- Provides adequate qualified staff coverage for utilization guidance processes
- Delegates to other staff with responsibilities concerning utilization guidance decisions as needed to meet goals.

Director, Medical Management

Responsible for the day-to-day implementation of the Nevada Health Solutions Program Specific responsibilities include:

- Implementing theProgram according to the annual work plan
- Collecting/Reporting UM activity to the Senior Director of Medical Management
- Coordinating departmental UM activity
- Collaborating with providers and facilities
- Conducting monitoring activities
- Presenting work plan status reports and updates to the UM/QM Committee
- Monitoring compliance with standards
- Making recommendations for interventions to improve utilization management issues
- Coordinating implementation of interventions
- Developing UM policies and procedures for UM/QM Committee for approval
- Developing, or coordinating development of, documentation of UM/QM activities

Outpatient Clinical Services Manager and Inpatient Clinical Services Manager

Responsible for the implementation, management, and evaluation of an effective and systematic Program, provides day- to-day guidance to UM staff and manages all aspects of utilization review activities. Working with the Medical Director, the Senior Director of Medical Management and the Director of Medical Management, Utilization/Quality Management Committee, the managementteam promotes efficient resource utilization throughout the organization, providing leadership, teambuilding and direction needed to ensure attainment of UM targets. Duties include:

- Responsible for clinical staff, including staffing, training, and resource contact
- Prepares monthly reports and assists in the presentation of the information to committee for oversight
- Weekly rounds to collaborate with staff
- Ensure consistent criteria application through coordination and analysis of inter-rater reliability testing
- Assists providers in managing care for patients in an acute level of care as well as discharge planning in a manner that result in improved outcomes. (Inpatient Clinical Services Manager)
- Monitor compliance with standards

- Make recommendations for interventions to improve utilization management issues
- Working with the Director of Medical Management in coordinating implementation of interventions
- Assist the Director of Medical Management in developing UM policies and procedures

Transitional Care Coordinators

Care Transition Coordinators acts as liaison for selected patients who are being transitioned from one care setting to another. They visit patients in the hospital and then regularly communicating with patients after discharge. Coordinators encourage and assist the patient in following the attending physician's care plan and educates the patient regarding their medical condition with the goal of improving health outcomes and preventing another transition (readmission to the hospital).

Utilization Management Nursing Staff

The Utilization Management Staff are registered nurses and licensed practical nurses. Their accountability objective is to coordinate medical and prior authorization requests to perform preadmission, concurrent and retrospective review for inpatient admissions and outpatient services and to ensure the delivery of high quality, cost effective medical are to all patients.

Non-Clinical Staff Representatives

Support staff includes clerical and administrative staff utilized for data entry and other support function. These individuals under no circumstances perform any activities related to the utilization management process other than:

- Performance of review of services request for completeness of information
- Collection and transfer of non-clinical data. Such data may include demographic information, employer name, insurance information, date of surgery, physician name, facility name etc.
- Acquisition of structured clinical data using explicit scripts or algorithms
- Activities that do not require evaluation or interpretation of clinical information

Physician Consultants

Physician Consultants are available for the review of individual cases and provide medical review consultation. The Medical Director and/or other clinical staff may use any of the consultants representing the major specialties. All external consultants are board certified by one of the American Boards of Medical Specialties (ABMS).

Qualifications of Decision Makers

All requests require a determination of medical necessity and/or whether a service is experimental or investigational are reviewed by a licensed clinical associate for medical appropriateness utilizing MCG, NCCN or other standardized evidence-based medicine sources.

The registered nurse or licensed practical nurse has the authority to approve all situations that meet the medical review criteria. Potential denials or questionable cases that cannot be approved

by the registered nurses or licensed practical nurse are referred to a Nevada Health Solutions' Medical Director for review. An appropriately licensed Medical Director is responsible for making all denial determinations based on medical necessity and experimental/investigational decisions.

Board-certified specialty physicians (appropriately licensed for Nevada) are utilized when appropriate as needed to make medically appropriate determinations for their respective specialty areas. The Nevada Health Solutions Medical Director and/or nursing staff make all utilization management decisions based on appropriateness of care and service and are not financially incentivized to approve or deny care in any way.

CONFIDENTIALITY

Nevada Health Solutions preserves the confidentiality of the individual medical records and information in accordance with Federal (including Health Insurance Portability and Accountability Act) and State statutes. Nevada Health Solutions does not disclose or publish individual medical records, personal information or other confidential information without the patient's written consent or specific legal authority. If there is an urgent/emergent situation, the only mechanism of release may be an initial verbal authorization (witnessed by at least one additional Medical Management staff member in addition to the UM nurse) from a patient to allow conversation with another party regarding UM issues or medical care/services. Medical Management staff follows legal standards concerning whom they may speak with about the patient to discuss issues if the patient is rendered unable to provide verbal and /or written authorization. In cases of guardianship and/or Power of Attorney, the nurse attempts to have a copy of the documents faxed to Nevada Health Solutions for file documentation prior to discussion regarding the patient.

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

The Medical Director and/or Senior Director of Medical Management will identify and follow-up any confidentiality issues/breaches reporting them to the HIPAA Privacy Officer who monitors and compiles the report in compliance with the confidentiality policy and procedures.

CONFLICT OF INTEREST

Nevada Health Solutions associates are required to adhere to the Nevada Health Solutions policies and procedures for conflict of interest. The Code of Business Conduct policy defines and outlines the staff member's responsibilities for complying.

DELEGATION OVERSIGHT

Nevada Health Solutions delegates utilization management activities to other organizations that meet the organizations' standards and regulatory requirements. Nevada Health Solutions retains accountabilities for all delegated activities and has a thorough process in place to systematically monitor a Delegate's ability to perform delegated functions including clinical quality

improvement. The functions to be delegated are evaluated pre-contractually and at least annually thereafter. If a Delegate fails to perform any aspect of a delegated function, A Corrective Action Plan (CAP) is implemented. If a CAP is initiated, the Delegate must identify specific actions intended to improve performance standards and obtain Nevada Health Solutions approval of the plan. If the Delegate fails to improve performance within the agreed upon time frames, Nevada Health Solutions has the ability to modify or rescind delegation.

OVERVIEW OF DELEGATION OVERSIGHT RESPONSIBILITIES:

- Pre-assessment of the Delegate's capacity to perform delegated activities prior to delegation
- Ongoing monitoring and evaluation of performance through quarterly or regular reports or as specified in corrective action plans
- Annual approval of the Delegates required annual documentation utilizing the program description, work plan, evaluation, and policies and procedures
- At least annual performance evaluation of the Delegate's ability to perform delegated activities according to defined requirements which can occur on-site or by desktop
- Although we may delegate the authority to perform services and/or functions, Nevada Health Solutions retains responsibility and accountability for activities, including the right to rescind delegation
- Documentation of the responsibilities or requirements of each Delegate are included in the delegation agreement

CONTRACTUAL DOCUMENTS ARE IN PLACE TO SPECIFY

- The scope of the activities delegated.
- The Delegate's accountability for those activities and the type and frequency of reports that must be submitted to Nevada Health Solutions.
- The process by which the Delegate's performance is evaluated.

UTILIZATION/QUALITY MANAGEMENT COMMITTEE

The Utilization/Quality Management ("UM/QM") Committee ("Committee") is responsible for the oversight and direction of all UM/QM functions including the timely development and implementation of an effective UM/QM program. The purpose of theCommittee is to continually monitor, evaluate and optimize health care resource utilization and disseminate statistical information on bed-days, provider authorization trends and ancillary services. The Committee also educates committee members in the health care delivery system and shares information and expectations for improvement. The Committee meets at a maximum on a monthly basis, at a minimum quarterly, or frequently if circumstances require or to accomplish Program objectives and deadlines.

The Committee serves as a peer review body for problem identification, action, resolutions and confirmation of corrective measures and referral/authorization review of request for services.

This is accomplished through review of physician referral/requesting patterns and concurrent and retrospective review of inpatient utilization.

FUNCTION/RESPONSIBILITY

A. Administrative information is presented to the committee members and discussed
B. Approve all Utilization Management policies and procedures, both new and revised
C. Review all Utilization Management policies and procedures on an annual basis
D. Identifies under or over utilization issues
E. Monitor clinical decision-making processes
F. Review Utilization Management statistics
G. Facilitates physician education regarding new technologies and medical guidelines and Utilization Management Policies and Procedures
H. Performs retrospective review of utilization data.
I. Analyzes Utilization Management data trending reports and makes decision for corrective actions for any Utilization Management deficiencies that have been identified in the outcomes.
J. Communicates with staff the Quality Management's priorities and projects.

STRUCTURE/MEMBERSHIP

A. Senior Director of Medical Management, Chair
B. Medical Director
C. Director of Medical Management
D. Other members of the Medical Management Department: administrative, nursing, and ancillary services
E. Other Physician/Pharmacist Leaders who convene as needed at the request of the Medical Director. They are selected ad hoc and include a representative sample of board-certified specialty care physicians. It is the responsibility of the Medical Director to include a Physician Leader in the decision-making process as appropriate.
F. receives approval of Committee minutes.
G. Reports to the President on utilization issues

MEETINGS AND PARTICIPATION

A. The members of the Committee are chosen by the Chair and approved by the President annually with the possibility of reappointment for a two (2) year term. The choice is based on significant membership, knowledge, and understanding of the Utilization Management Process.
B. Active participation on the Committee includes consistent meeting attendance and involvement in discussion of agenda items, establishing practice guidelines, selecting monitoring indicators, analyzing bed-day reports, and assisting in problem utilizationresolutions as requested by the Committee.

C. Physicians are compensated for attending meetings and reviewing referrals only. No incentives are provided directly or indirectly to providers regarding review decisions.

VOTING RIGHTS

A. Each member has one equal vote.
medical issues, appropriateness of care, clinical standards, or quality of care.
B. All approved action is by a majority vote
C. If the Committee is unable to constitute a quorum for voting purposes because of conflict of interest, alternative member(s)will be selected as needed at the discretion of the Chair, or the topic will be rescheduled.
D. When necessary, voting may occur electronically.

CONFLICT OF INTEREST

A Committee member with a conflict of interest, which might impair objectivity in any review or decision process, is not permitted to participate in any deliberation involving such issues or cast a vote on any related issues.

QUORUM

For voting purposes, a quorum represents a simple majority (50% +1) of voting members or at least six (6) members (whichever is less).

STATEMENT OF CONFIDENTIALITY

Each Committee member is required to sign a statement of confidentiality. Any guest physicians or other guests must sign a statement of confidentiality.

HEALTH PLAN REPRESENTATIVES

Health Plan representatives may obtain permission to attend Committee meetings only by scheduling in advance of the scheduled meeting date and with the approval of the Committee Chair.

MINUTES

Minutes of all Committee meetings are recorded contemporaneously and maintained by the minute taker. Minutes are dated and signed by the Committee Chair to ensure that they represent official findings of the Committee. Minutes reflect Committee decisions, recommendations, action plan implementation with time frames and responsible person(s), evaluation, and follow-up. Peer review issues are de-identified for provider and patient confidentiality. Health Plan representatives may review the Committee minutes on request.

ANNUAL PROGRAM EVALUATION

Annually, the Medical Director and Senior Director of Medical Management or their Designees present an evaluation of the Program to theCommittee for its review and approval.
The annual evaluation analyzes the Program's effectiveness and the impact of the Program on patients and providers. The evaluation identifies Program strengths and limitations, improvement opportunities and unfinished business, in addition to assessing demographics and effectiveness of the Program's initiatives. The evaluation has indicators for over and underutilization, timeliness of decision making, access tocare issues, and clinical criteria utilization.

The Program evaluates and monitors the effectiveness and efficiency inachieving Nevada Health Solutions' UM/QM objectives and goals by continuously utilizing evidence-based monitoring and measurement of clinical and service performance indicators, quality of care and quality of service issues, patient complaints and timeliness of services delivered to patients. Identification of causal effects, design and implementation of improvement opportunities and re-measurement of initiatives ensures a continuous cycle of evidence-based monitoring of care and delivery systems.

The annual evaluation identifies problems and/or concerns that may limit a patient's equitable access to health care and provides recommendations for improvement. The Program is reviewed and updated annually.

PERFORMANCE MONITORING AND REPORTING

NHS will monitor and report quarterly the following:

Quality Specific Metric Evaluation

- Conducting and integrating quality improvement and continuous quality improvement activities.
- Reviewing findings, conclusions, and recommendations of all Quality Management Improvement activities and studies (QIPs)
- Delegation oversight of Independent Review Organization (IRO) (verbal)
- Inter-rater Reliability
- Redirection
- Complaints
- Client, patient, and physician satisfaction surveys

Utilization Program Compliance Evaluation

- Key Indicator Reports as required by URAC
- Approvals and Denials
- Appeals and IRO
- Inpatient Activity - Average Length of Stay – Bed Days per 1,000
- Readmissions
- Over/Under Utilization (if any)
-

NHS addresses the maintenance of records it tracks, as required by URAC Guidelines, including but not limited to, the volume of reviews broken down by nurse, telephone call abandonment rate, percentage of answered calls, average speed to answer and certain other answering phone statistics which allow NHS to determine whether it has sufficient staff to return calls in a timely manner and adjust as needed. NHS is also able to track the volume of phone calls received on its two phone numbers (local and toll free).

(Year) Utilization Program Compliance Evaluation						
***Indicator (Required by URAC)**	**Performance Goal**	**Q1 1/1 to 3/31**	**Q2 4/1 to 6/30**	**Q3 7/1 to 9/30**	**Q4 10/1 to 12/31**	**Comments**
Timeliness of decisions & notifications ▪ **Inpatient**	95%					
Timeliness of decisions & notifications ▪ **Outpatient**	95%					
Appeal determinations & notifications ▪ **Inpatient**	95%					
Appeal determinations & notifications ▪ **Outpatient**	95%					
Lack of Information ▪ **Inpatient**	95%					
Lack of Information ▪ **Outpatient**	95%					
Adverse Decision Audit	90%					
Provider Satisfaction Survey	90%					
Member Satisfaction Survey	90%					
Consumer Satisfaction Log	90%					

Utilization Program Compliance Evaluation – Page 2

(Year) Utilization Program Compliance Evaluation						
***Indicator (Required by URAC)**	**Performance Goal**	**Q1 1/1 to 3/31**	**Q2 4/1 to 6/30**	**Q3 7/1 to 9/30**	**Q4 10/1 to 12/31**	**Comments**
*Customer Service (Telephone Statistics) % Of Abandoned Calls Goal < 5%	<5%					
*Customer Service (Telephone Statistics) % Of Answered Calls Goal >95%	95%					
*Customer Service (Telephone Statistics) Average Speed to Answer ASA – Goal < 2 mins.	< 2 min					
Additional Reporting						
Approvals & Denials						
IRO Appeals Upheld						
IRO Appeals Overturned						
Readmissions						
Over/Under Utilization (if any)						

ADDENDUM A

This Addendum ("Addendum") to the Utilization Management Program ("Program"), which only appliesto utilization review services provided for covered lives located in **Kentucky**, is effective January 1, 2020("Effective Date") and states as follows:

1. For any contract Nevada Health Solutions enters into after the Effective Date of this Addendum for the provision of utilization review services to Kentucky covered lives, only licensed physicians, who are of the same or similar specialty and subspecialty, when possible, as the ordering provider, shall (i) make a utilization review decision to deny, reduce, limit or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational and (ii) supervise qualified personnel conducting case reviews.

2. Expect for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, utilization review decisions will be made inaccordance with the following timeframes. There is not an option for an extension of these timeframes.

a) For "urgent health care services" notify the covered person, authorized person, or providerof the decision within twenty-four (24) hours after obtaining all necessary information. This includes All requests for hospitalization and outpatient surgery.

b) For "non-urgent health care services", make the decision and notify the covered person, authorized person, or provider of the decision within five (5) days of obtaining all necessary information.

c) Necessary information is defined as: (i) the results of any face-to-face clinical evaluation, (ii) any information determined by the Kentucky Department of Insurance to be necessary to making a utilizationreview determination.

d) The notice may be provided in an electronic format, including e-mail or facsimile, if the coveredperson, authorized person, or provider has agreed in advance in writing to receive the notices electronically.

e) If Nevada Health Solutions fails to make a determination and provide written notice within theapplicable timeframe, the service requested is deemed authorized.

ADDENDUM A.1

This Addendum to the Utilization Management Program ("Program"), which only applies to utilization review services provided for covered lives located in **Maryland**, is effective January 1, 2025, and states as follows:

1.) In the Peer Clinical Reviewer Qualifications section of the Program, a new sentence has been added to the end of the section as follows:

"All adverse decisions for medical/surgical services for Maryland covered lives must be made by a licensed physician, or a panel with at least one physician on the panel, who is:
a. Board certified or eligible in the same specialty as the treatment under review; and
b. Knowledgeable about the requested health care service or treatment through actual clinical experience.

If Nevada Health Solutions' medical director does not have the requisite experience in the specialty, Nevada Health Solutions will utilize a Maryland certified IRO to handle the request."

2.) In the PEER-TO-PEER RECONSIDERATION OF ADVERSE DETERMINATION section of the Program, a new paragraph shall be added to the POST-DECISION CONVERSATION section as follows:

"If an initial determination is made by Nevada Health Solutions or its Maryland certified IRO not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, Nevada Health Solutions will provide the health care provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the health care provider seeking the reconsideration. If the physician is unable to immediately speak with the health care provider seeking the reconsideration, the physician shall provide the health care provider with the following contact information for the health care provider to use to contact the physician:
(i) a direct telephone number that is not the general customer call number; or
(ii) a monitored e–mail address that is dedicated to communication related to utilization review."

3.) In the TIME FRAMES FOR INITIAL DETERMINATIONS section of the Program, "and addendum A.1 for exceptions in the State of Maryland" shall be added. Below are the exceptions for the State of Maryland.

Nevada Health Solutions shall adhere to the following timelines for Maryland covered lives:
(i) Nevada Health Solutions will make all **initial determinations** on whether to authorize or certify a nonemergency course of treatment or health care service, including pharmaceutical services not submitted electronically, for a patient **within 2 working days** after receipt of the information necessary to make the determination;

(ii) Nevada Health Solutions will make all determinations on whether to authorize or certify an **extended stay** in a health care facility or additional health care services **within 1 working day** after receipt of the information necessary to make the determination;

(iii) Nevada Health Solutions will make all determinations to authorize or certify a request for **additional visits or days of care** submitted as part of an existing course of treatment or treatment plan **within 1 working day** after receipt of the information necessary to make the determination; and
Nevada Health Solutions will promptly notify the health care provider of the determination.
After receipt of the initial request for health care services and confirming through a complete review of information already submitted by the health care provider, if Nevada Health Solutions determines that it

does not have sufficient information to make a determination, Nevada Health Solutions will promptly, but not later than **3 calendar days** after receipt of the initial request, inform the health care provider that additional information must be provided by specifying:

(i) the information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and

(ii) the criteria and standards to support the need for additional information.

(iv) Nevada Health Solutions will make initial determinations on whether to authorize or certify an **emergency course of treatment or health care service** for a member **within 24 hours** after the initial request after receipt of the information necessary to make the determination.

If Nevada Health Solutions determines that additional information is needed after confirming through a complete review of the information already submitted by the health care provider, Nevada Health Solutions will: 1. promptly request the specific information needed, including any lab or diagnostic test or other medical information; and 2. promptly, but not later than **2 hours** after receipt of the information, notify the health care provider of an authorization or certification determination when made by Nevada Health Solutions.

Nevada Health Solutions will initiate an expedited procedure for an emergency case if the patient or the patient's representative requests or if the health care provider attests that the services are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the member or the member's ability to regain maximum functions.

If Nevada Health Solutions fails to make a determination within the above time limits, the request will be deemed approved.

ADDENDUM B

DEFINITION OF TERMS

Appeals: A written or verbal request by a consumer, ordering provider or prescriber to contest an organizational determination (e.g., services have been denied, reduced, etc.).

Appeals Consideration: Clinical review conducted by appropriate clinical peers, who were not involved in peer clinical review, when a decision not to certify a requested admission, procedure, or service has been appealed. This is sometimes referred to as "third level review."

Attending Physician: The Doctor of Medicine or Doctor of Osteopathic Medicine with primary responsibility for the care provider to a patient in a hospital or other health care facility

Attending Provider: The physician or other health care practitioner with primary responsibility for the care provided to a patient in a hospital or other health care facility

Authorization: A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan. Also referred to as certification

Authorization: A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan. Also referred to as certification

Board-certified: A certification – approved by the American Board of Medical Specialties, the American Osteopathic Association, or another organization as accepted by URAC – that a physician has expertise in a particular specialty or field.

Case: A specific request for medical or clinical services referred to an organization for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not.

Case Involving Urgent Care: Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or b) in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

Certification: A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan. Also referred to as authorization

Client: A business or individual that purchases services from Nevada Health Solutions.

Clinical Decision Support Tools: Protocols, guidelines, or algorithms that assist in the clinical decision-making process.

Clinical Peer: A physician or other health professional that holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review.

Clinical Practice Guidelines: Systematically developed statements to assist decision-making about appropriate health care for specific clinical circumstances.

Clinical Rationale: A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient's condition or treatment plan and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review Criteria: The written screens, decision rules, medical protocols, or guidelines used by Nevada Health Solutions as an element in the evaluation of medical necessity and appropriateness of requested admissions, treatments, procedures, and services under the auspices of the applicable health benefit plan.

Clinical Staff: Employees or contracted consultants of the health care organization who are clinically qualified to perform clinical triage and provide health information services.

Concurrent Review: Utilization management conducted during a patient's home health care or other course of treatment or (including outpatient procedures and services). Sometimes called "continued stay review".

Consumer: An individual person who is the direct or indirect recipient of the services of Nevada Health Solutions. Depending on the context, consumers may be identified by different names, such as "member," enrollee," "beneficiary," "patient," "injured worker," "claimant," etc. A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and Nevada Health Solutions. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

Criteria: A broadly applicable set of standards, guidelines, or protocols used by Nevada Health Solutions to guide the clinical processes. Criteria should be: (1) Written; (2) Based on professional practice; (3) Evidence-based; (4) Applied consistently; and (5) Reviewed, at a minimum, annually.

Evidence-based: Recommendations based on valid scientific outcomes research, preferably research that has been published in peer reviewed scientific journals.

Expedited Appeal: An appeal of a non-certification of a case involving urgent care

External review: A review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State or Federal external review process.

Facility: An institution that provides health care services.

Facility Rendering Service: The institution or organization in or by which the requested admission, procedure, or service is provided. Such facilities may include but are not limited to hospitals; outpatient surgical facilities; individual practitioner offices; rehabilitation centers; residential treatment centers; skilled nursing facilities; laboratories; imaging centers; and other organizational providers of direct services to patients.

Health Professional: An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.

Initial Clinical Review: Clinical review conducted by appropriate licensed or certified health professionals Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification. This is sometimes referred to as "first level review." In Nevada Health Solutions, Initial Clinical Reviews are conducted by Nurse Reviewers.

License: A license or permit (or equivalent) to practice medicine or a health profession that is 1) issued by any state or jurisdiction in the United States; and 2) required for the performance of job functions.

Medical Director: A Doctor of Medicine or Doctor of Osteopathic Medicine who is duly licensed to practice medicine and who is an employee of, or party to a contract with, an organization, and who has responsibility for clinical oversight of Nevada Health Solutions' utilization management, credentialing, quality management, and other clinical functions.

Non-Certification: A determination by an organization that an admission, extension of stay, equipment, or other home health care, or pharmacy service has been reviewed and, based on the information provided does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the applicable health benefit plan. If the request for certification is not fully approved, the determination shall be considered to be a non-certification.

Non-Clinical Administrative Staff: Staff who do not meet the definition of health professional (including intake personnel). In Nevada Health Solutions, this function is filled by persons with the job title of Intake Coordinator.

Non-Clinical Staff: Employees or contracted consultants of a health care organization that do not perform clinical assessments or provide callers with clinical advice. They may be responsible for obtaining demographic information, providing benefit information, and re- directing callers.

Ordering Provider: The physician or other provider who specifically prescribes the health care service being reviewed.

Oversight: Monitoring and evaluation of the integrity of relevant program processes and decisions affecting consumers.

Patient: The covered consumer for whom a request for certification may or may not have been filed.

Peer Clinical Review: Clinical review conducted by appropriate health professionals when a request for an admission, procedure, or service was not approved during initial clinical review. This is sometimes referred to as a "second level review."

Peer-to-Peer Conversation: A request by telephone for additional review of a utilization management determination not to certify, performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

Pre-Review Screening: Automated or semi-automated screening of requests for certification that may include: (1) collection of structured clinical data (including diagnosis, diagnosis codes, procedures, procedure codes); (2) asking scripted clinical questions; (3) accepting responses to scripted clinical questions; and (4) taking specific action (certification and assignment of length of stay explicitly linked to each of the possible responses). It excludes: (1) applying clinical judgment or interpretation; (2) accepting unstructured clinical information; (3) deviating from script; (4) engaging in unscripted clinical dialogue; (5) asking clinical follow-up questions; and (6) issuing non-certifications.

Primary Physician: The physician who is primarily responsible for the medical treatment and services of a consumer.

Principal Reason(s): A clinical or non-clinical statement describing the general reason(s) for the non-certification determination ("lack of medical necessity" is not sufficient to meet this

requirement).

Prospective Review: Utilization management conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient procedures and services). This is sometimes called "pre-certification review" or "prior certification."

Provider: A licensed health care facility, program, agency, or health professional that delivers health care services. This includes home health agencies, durable medical equipment companies, infusion therapy companies, prosthetics, etc.

Rationale: The reason(s) or justification(s) – commonly based on criteria – for a specific action or recommendation.

Reconsideration: Additional information submitted in writing for a non-certified case decision to support approval

Referring Entity: Nevada Health Solutions or an individual that refers a case to an organization - Referring entities may include insurance regulators, health benefits plans, consumers, discharge planners, and attending providers.

Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the patient.

Review of Service Request: Review of information submitted to Nevada Health Solutions for health care services that do not need medical necessity certification nor result in a non-certification decision.

Reviewer(s): The individual (or individuals) selected by Nevada Health Solutions to consider a case. This includes nurse reviewers, peer clinical reviewers, and appeal clinical reviewers.

Staff: Nevada Health Solutions' employees, including full-time employees, part-time employees, and consultants.

Standard Appeal: An appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals of expedited appeals.

Structured Clinical Data: Clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation.

Utilization Management ("UM"): Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities. UM encompasses prospective, concurrent, and retrospective review in which clinical criteria are applied to a request.

Policy History/Revision Information

Date	Action Description
03/12/2020	Page 7: Added Prospective Reviews included list and under Decision Time Framesadded (see addendum A). Page 36: Addendum A line 2 added “There is not an option for an extension of thesetimeframes”; a) added “This includes all requests for hospitalization and outpatient surgery”.
11/12/2020	Page 4: Under Scope, Item D added “and ensuring requests are within client benefit plan”;Under Access Hours added NHS Hours of Operation Page 10 – Under Medical Necessity Definition added “and place of service; Under MedicalNecessity Criteria – Removed Hayes California Technology Assessment Form (CTAF) Page 22: Under Appeal Reviewer Attestation added line 3 Page 24: Under Medical Director removed “Assuring that the UM program fulfills its purpose and goals and complies with regulatory agencies and accreditation bodies and serving as committee chair of Utilization Management and Quality Management Committees; Under Sr. Dir. Med Mgmt. added “Serves as an advanced clinical resource tostaff with responsibilities concerning Utilization Guidance decisions”; “serves as committee chair of Utilization Mgmt. Committee and Quality Management Committee” Page 25: Added “Assuring that UM Program fulfills its purpose and goals and complies with regulatory agencies and accreditation bodies” Page 27: Under Confidentiality changed Compliance Privacy Quality ImprovementManager to HIPAA Privacy Officer Page 29: Under Structure Membership Items A & B changed from Medical Director to Sr.Director Med. Mgmt. Page 30: Under Voting Rights Item A changed from 12 to 1; added Item D “When necessary, voting may occur electronically. Page 33 & 34: Added Quality Improvement Dashboard Report Page 35: under Summary changed Medical Director to Sr. Director of Med. Mgmt.' added"The Quality Management Committee meets at least quarterly and maintains approved records of all committee meetings. Page 36: Added Addendum A; Under item #2 added "There is not an option for anextension of these timeframes; Under item #3 added "This includes all requests forhospitalization and outpatient surgery." Page 41: Added "Reconsideration" definition Page 42: Removed year from front page and added Policy History/Revision Information
12/10/2020	2021 UM/QM Program approved
09/16/2021	Page 4 – Access to Staff - under hours of operation – changed “open” to “available”.
12/10/2021	2022 UM/QM Program approved
01/27/2023	2023 UM/QM Program has been revised to include the recommended changes from URAC.
03/28/2023	Pg. 9; Procedures changed to “If days are denied, noncertification letters are sent to the facility and physician within one calendar day but a letter is only sent to the patient if the patient has financial responsibility. Pg. 35 added “Communicates with staff the Quality Management’s priorities and projects”
08/23/2023	Page 19; non-urgent added: two (2) days after receipt of the information necessary to make a determination; Page 21; Lack of Information added: no later than five (5) business days after receipt of the request. Page 38; under Utilization Program Compliance Evaluation/Additional information: removed column Inpatient Activity
01/26/2024	2024 UM/QM Program approved by UM/QM Committee
02/20/2024	Page 39; Under telephone statistics; Average Speed to answer; removed “due to the pandemic, the performance goal was increased due to staff reductions.”
05/21/2024	Page 28: Removed the title/position: VP Clinical Affairs
12/11/2024	Added Addendum A.1 for the state of Maryland
1/31/2025	2025 UM/QM Program approved by UM/QM Committee