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Utilization Review and Quality Improvement Plan

Physicians Health Plan of Northern Indiana, Inc.

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PHP

UTILIZATION REVIEW AND QUALITY IMPROVEMENT PLAN

I. AUTHORITY

The Quality Improvement Committee ("QIC") has been established as a standing committee of Physicians Health Plan of Northern Indiana, Inc. and its affiliate entities (hereafter known as "PHP") in accordance with the Bylaws of PHP. The Board of Directors has delegated oversight authority to the Quality Improvement Committee (QIC,) which has the responsibility of administering the Utilization Review and Quality Improvement Plan, a component of PHP's quality management program, as required by applicable law, and periodically reporting utilization review and quality management activities to the Board of Directors. The Board of Directors further designates the Medical Director with the authority and responsibility for the overall operation of the Utilization Review and Quality Management programs. P-QM 3.a and e, P-QM 4.a and b.

II. PURPOSE P-QM 1

PHP maintains a utilization review and quality management program that promotes objective and systematic measurement, monitoring and evaluation of services, work processes and implements quality improvement activities based upon the outcomes. The primary purpose of the Utilization Review and Quality Improvement Plan is to establish procedures based on professionally recognized standards to assess and monitor the Health Services delivered to Covered Persons, including mechanisms to implement corrective action, when necessary, and to assess the availability, accessibility, utilization, continuity and satisfaction of care and services.

III. SCOPE P-QM 3.b

To fulfill this purpose, the program is comprehensive, ongoing and includes effective mechanism to identify, continuously monitor, evaluate and resolve issues that impact accessibility, complaints, satisfaction, quality, safety, utilization and continuity of clinical care and services delivered to Covered Persons in all lines of our business by Providers in both inpatient and outpatient settings, with a focus on enhancing the delivery of quality care in a cost-effective manner. The Scope of the quality improvement process includes a wide range of activities including process and outcomes of clinical care, behavioral health, ancillary services, pharmacy services, vendor and delegated services, member services, satisfaction, patient safety, and efficient use of resources. The program shall address the needs of internal and external “customers,” including PHP’s internal departments, clients and members. The program shall include monitoring of clinical and non-clinical services.

IV. OBJECTIVES P-QM 3.b

A. To assess effective and efficient utilization of medical facilities and services.

B. To maintain a quality management program that promotes objective and systematic measurement, monitoring and evaluation of services, work processes, and implements quality improvement activities based upon the outcomes. P-QM 1

C. To analyze data collected for appropriate utilization of health care resources and quality services.

D. To identify opportunities to improve the outcomes of medical and behavioral health care utilization and services available to members.

E. To develop, implement and monitor action plans to improve medical and behavioral health care as well as services.

F. To establish, recommend, implement, and evaluate medical policies addressing protocols and criteria.

G. To develop, recommend, implement and evaluate alternative inpatient and outpatient services to enhance the quality and cost-effectiveness of care.

H. To monitor the consistency and application of medical policies and determinations; and to resolve identified issues through continuing education programs, changes in PHP procedures, or changes in medical practices that improve the quality and cost-effectiveness of health care.

I. To recommend corrective actions and monitor the results of corrective actions where deficiencies with an individual, department or organization's performance have been identified to assure that quality of care and/or service has been improved.

J. To monitor the process and resolution of complaints and grievances.

K. To participate in the Professional Review Oversight process.

L. To adhere to the policy governing the protection and confidentiality of clinical and patient protected health information.

V. COMMITTEE STRUCTURE P-QM 3.b

The Quality Improvement Committee (QIC) includes these members:

A. Chief Operating Officer, who serves as Chairperson of the Committee
B. Medical Review Accreditation Nurse (Co-chair)
C. Medical Director P-QM 3.e
D. Director of Operations
E. Director of Medical Management
F. Compliance Officer
G. Director of Analytics
H. Director of Network & Provider Management
I. AVP of Ancillary Services
J. Controller
K. Director of Claims & Customer Service
L. Participating Physician Provider P-QM 4.e

The QIC will meet at least quarterly or more frequently as deemed necessary by the Committee. P-QM 4.c

The QIC shall be assisted in its responsibilities pertaining to clinical issues associated with quality and utilization review by subcommittees whose structure shall include a cross representation of PHP participating physician providers and PHP support personnel. There shall be one standing subcommittees; however, ad hoc subcommittees may be appointed as needed or identified by the QIC.

A. <u>Standing Subcommittees:</u>

The Standing Subcommittees shall meet at least quarterly or more frequently as deemed necessary by the subcommittee chairman or the QIC. The subcommittees shall keep minutes of its meetings, which shall be signed by the chairman and submitted to the QIC. The standing subcommittees shall have

those authorities and responsibilities as described in this UR/QI Plan, Peer Review Plan or as delegated to them by the QIC or PHP's Board of Directors. The Standing Subcommittee Structure shall be as follows:

1. Medical Advisory Subcommittee. The Medical Advisory Subcommittee, which shall also act as the Peer Review Committee, is composed of the following voting members:

    a. The Medical Director, who services as Chairman;
    b. The Participating Physician Provider, who serves on the QIC;
    c. A maximum of seven (7) selected participating providers representing a mix of specialists and primary care physicians;
    d. Non-voting ex-officio members of the Subcommittee include:
        i. Chief Operating Officer
        ii. Director of Operations
        iii. Medical Management Director
        iv. Medical Review Accreditation Nurse
        v. Other persons who may attend at the invitation of the Committee Chairman

    The Subcommittee will meet at least quarterly or more frequently as deemed necessary by the Chairman.

B. Ad hoc Committees

1. Ad hoc Committees are temporary committees established by the QIC or PHP's Board of Directors to address a specific issue. When an Ad hoc Committee is appointed, the recommendation establishing the committee shall include:

    a. The issue, project, or task to be addressed, investigated, developed or designed, or objectives to be achieved;
    b. The authority and responsibilities of the Committee;
    c. Designation of a Chairman of the Ad hoc Committee;
    d. Designation of who is to serve on the Ad hoc Committee. This may be in the form of specialty designation or employment designation instead of specific name, i.e., two internists or a UR staff nurse. The Chair or Co-Chair of the QIC or Medical Director would then be responsible for making arrangements with an individual to serve on the Ad hoc Committee
    e. Establishment or approval of a timeframe to accomplish the work assigned to the Ad hoc Committee

2. Ad hoc Committees have limited duration.
    a. Committee members and chairpersons can be removed by the QIC or Board of Directors without prior notice and without cause.
    b. The entire committee may be dissolved or decommissioned at any time with or without prior notice or cause.
    c. Once an assigned issue, project, or task has been completed, the committee automatically dissolves unless the QIC or Board of Directors assigns additional projects.

A. Responsibilities of the QIC include, but are not limited to:

1. Monitors and analyzes reports, progress, action plans, follow up and achievement toward goals of QI activities from committees, subcommittees, departments, services, teams and Delegated Vendors. P-QM 3.g, P-QM4.h

2. Reviews, provides guidance, prioritizes, and approves Quality Improvement Projects (QIPS). P-QM 4.f, P-QM4.g

3. Provides analysis and evaluation of the results of quality improvement, utilization review, case management, and disease management activities (including but not limited to member and provider satisfaction survey results, member complaint and service issues, member and provider communication, member access, network adequacy and individual and/or aggregate utilization data and problem cases identified while performing utilization review.

4. Requires performance reporting, including reporting on performance measures or key process indicators from any source including delegated entities. P-QM 3.g, P-QM4.h

5. Recommends institution of needed action as a result of reviews of reports or data analysis. P-QM 4.h

6. Ensures that follow up to needed action occurs as appropriate. P-QM 4.h

7. Obtains input and recommendations from the Medical Advisory Subcommittee on clinical related policies, procedures, and criteria, including commercial criteria which may be implemented for utilization review purposes. P-QM 4.e

8. Obtains input and recommendations from the Medical Advisory Subcommittee to address reports of individual and/or aggregate utilization data and problem cases identified while performing utilization review or quality improvement.

9. Appoint subcommittees, Ad hoc committees, work groups, or teams to address specific issues, tasks or projects, reporting back to the QIC.

10. Monitors compliance with URAC Accreditation Standards, recommending action as needed.

11. Evaluates the effectiveness of the Utilization Review and Quality Improvement (UR/QI) Plan and Program at least annually. P-QM 3.c, P-QM 4.i

12. Reports the findings of the annual evaluation, along with recommendation for updates and changes to the Plan and Program to the Board of Directors for approval annually. P-QM 4.i

13. With the assistance of the Medical Advisory Subcommittee, carries out the Peer Review Plan, as described in that Plan.

B. Responsibilities of the Medical Advisory Subcommittee include, but are not limited to: P-QM 4.e

1. Provides input and recommendations on clinical related policies, procedures and criteria, including commercial criteria which may be implemented for utilization review purposes.

2. Provides input and recommendations addressing reports of individual and/or aggregate utilization data and problem cases identified while performing utilization review or quality improvement.

3. Provides assessment, evaluation and recommendations on clinical issues related to quality

4. Improvement and utilization review.

5. Participates in the annual assessment and evaluation for effectiveness of the UR/QI Plan and Program.

6. Evaluate and provide recommendations pertaining to assessment of achievement and setting goals for member access and network adequacy.

7. Acts as the Peer Review Committee as described in the Peer Review Plan.

8. Reviews and provides input pertaining to the annual evaluation of mental health parity.

VII. MINUTES AND REPORTS P-QM 4.d

Complete and accurate minutes will be prepared and maintained for each meeting. Minutes will reflect the name of the committee, subcommittee, or Ad hoc Committee; the date and duration of the meeting; the members and guests present and absent; and their names, titles specialty and professional credentials. The minutes will reflect the major decisions and recommendations, status of activities in progress and the implementation status of recommendations, when appropriate. Applicable reports and substantiating data will be appended for reporting purposes. The MAC meetings will consist of two sections; i.e., a business meeting portion, and a peer review/quality portion. (The meeting minutes will refer to individual practitioners or patients by number only, except when specific reference is necessary to meet the goals of the utilization review actions.) Due to the length of time between meetings, the committee or subcommittee chairperson or, in his absence or unavailability, one or more members appointed by the committee or subcommittee are delegated to approve, sign and forward the minutes to the QIC, or for the QIC, forward to the Board of Directors. The minutes will also be submitted to the originating committee or subcommittee at their next meeting. The originating committee or subcommittee, upon motion, duly seconded and approved, can approve the minutes as written or amend the minutes. Minutes which are amended will be taken back to the QIC Committee or Board of Directors, unless the amendment is a typographical error, editorial change, format change or meeting attendance correction, which does not change the actions, recommendations, or intent of the Committee as originally documented.

All reports will be screened by the Quality Department to assure they are clear and understandable. The QIC is responsible for reviewing each report for comment and recommendation to assure appropriate utilization and/or quality of care or service.

The QIC and its subcommittees, with the assistance of an administrative assistant, will maintain copies of all minutes, reports, worksheets, and other data in a manner that will assure their confidentiality, the confidentiality of individual practitioners and members, and restrict access only to QIC members, and specific individuals as designated by PHP's Chief Executive Officer.

The Utilization Review and Quality Improvement activities shall be reported quarterly to the Board of Directors via QIC minutes and reports. (Reports can include not only written word reports, but also graphs, statistics and trending reports.) The evaluation of the effectiveness of the Utilization Review and Quality Improvement Plan and Program with recommended updates and changes shall be submitted to the Board of Directors for their approval annually. P-QM 3.c

VIII. STATEMENT OF CONFIDENTIALITY AND NON-DISCRIMINATION

PHP has the right to request and receive any and all information and records relating to the attendance, examination, diagnosis, or treatment rendered to a Covered Person which is necessary to implement PHP's utilization review and quality improvement operation. Personal health information obtained during the process of utilization review or quality improvement is considered confidential and is protected to the extent required by state and federal law.

Individual medical records shall be maintained in a secure area with access limited to Medical and Quality Management and other authorized personnel. PHP may forward this information to appropriate parties outside of PHP for utilization review, quality assurance, discharge planning, and catastrophic case management review when such assistance is necessary to allow PHP to fulfill its functions. Health information will be shared only with those individuals or entities authorized to receive such information and shall be done in accordance with requirements of state and federal privacy laws.

A review of sensitive material will be conducted during the peer review portion of the QIC or its subcommittees' meetings or referred to the Professional Review Oversight Committee, as appropriate. Each QIC and its subcommittees' members sign an agreement aimed at protecting the confidentiality of medical records and protected health information. Each employee of PHP also is required to sign a Confidentiality Agreement, agreeing that medical information is confidential, shall only be used or disclosed in compliance with PHP's policies and state or federal privacy laws, and is the sole and exclusive property of PHP.

Information gained in the process of utilization review or quality improvement shall be retained for at least three years if the information relates to a case for which an adverse decision was made or if the information relates to a case which appears may be reopened.

The procedures and minutes of the QIC and its subcommittees will be open to review by state and federal regulating agencies and accrediting organizations. The minutes of the peer review portion of QIC and its subcommittees' meetings are protected as provided for under Indiana and Federal peer review statutes.

Decisions shall not be based on a provider's race, religion, sex, color, disability, ethnic origin, national origin, age, marital status, veteran status, sexual preference, sexual orientation, gender identity, specialty patient type, or any unlawful basis or prejudice not specifically mentioned herein. Each year, every member of the QIC and its subcommittees will sign an affirmative statement attesting to non-discrimination when making UR/QIC determinations.

IX. STAFFING FOR UTILIZATION REVIEW/CASE AND QUALITY MANAGEMENT

The Medical Management and Quality Department has sufficient resources to meet the UR/QI Plan objectives, carry out the scope of activities to be conducted, and complete annual and ongoing activities. Human Resources include persons staffing the following positions: P-QM 2

*Medical Director** - a physician with a current unrestricted license in the State of Indiana who is responsible for reviewing the medical necessity or appropriateness of admissions, services and procedures, in accordance with criteria established by the Medical Director in cooperation with the QIC. A designated physician(s) may occupy the position of Medical Director in the Medical Director's absence. This physician must be a Participating Provider who:

- Holds an active, unrestricted license to practice medicine in the State of Indiana
- Is a doctor of medicine or osteopathic medicine
- Determined qualified by the medical director to conduct peer clinical review rendering clinical opinions about medical conditions, procedures and treatment

*Newly hired or contracted Medical Directors who are not licensed in the State of Indiana upon the date of hire must hold an active, unrestricted license in the United States, apply for Indiana licensure within six months of their date of hire and

obtain the same in due course. In accordance with the Indiana Department of Insurance regulations they may carry out utilization review activities with an unrestricted license in the United States until their application is acted upon.

Behavioral Health Advisor - a physician with a current unrestricted license in the State of Indiana who is responsible for reviewing the medical necessity and appropriateness of behavioral health admissions and outpatient services, in accordance with criteria established by the Medical Director in cooperation with the QIC. This physician must be a Participating Provider who:

- Holds an active, unrestricted license to practice medicine in the State of Indiana;
- Is a doctor of medicine or osteopathic medicine specializing in Psychiatry; and
- Determined qualified by the medical director to conduct peer clinical review rendering clinical opinions about medical conditions, procedures and treatment

Medical Management Team Lead - a registered nurse with a current unrestricted license in the State of Indiana who oversees all aspects of the Medical Management Department, with the level of knowledge equivalent to that ordinarily acquired through completion of a Nursing Degree, with extensive professional work experience.

Nursing Personnel - a staff of registered nurses and/or licensed practical nurses with current unrestricted licenses in the State of Indiana who monitor medical appropriateness of all hospital admissions and coordinate all aspects of utilization review and case management utilizing alternate methods of care as appropriate, with extensive hospital experience and a background in utilization review and/or case management.

Medical Review Service Personnel – staff, who conduct post-service utilization review and have experience in hospital, physician office or managed care services, and are certified by the American Academy of Procedural Coders (AAPC).

Medical Review Accreditation Nurse – an individual with experience in Quality Management tools and techniques, who aids in developing, executing, and analyzing quality management mechanisms to identify problems, assess processes, and/or initiate improvements in member and provider satisfaction, access, availability, quality safety, utilization and continuity of clinical care and services.

IT Department – PHP provides human resources from other departments to assist in functions of the UR/QI Program, including manpower, software, and hardware supported by the IT Department.

X. ORIENTATION AND TRAINING OF THE MEDICAL MANAGEMENT DEPARTMENT

PHP provides a structured orientation program for each member of the Medical Management Department, orienting the individuals on the history of the company and providing an introduction to the major aspects of the Company's operation.

Medical Management Department personnel are provided with written job descriptions and with various policy and procedure manuals containing instructions and information needed to perform their daily duties. Each member of the Medical Management Department is provided training on the Utilization Review and Quality Improvement Plan (including guidelines and review criteria), the Benefit Contracts sold through PHP, and use of the computer systems. Medical Management staff also participate in ongoing training on the proper handling and use of confidential information. This training includes updates on changes in applicable state and federal privacy and records laws. The substance of the departmental orientation is outlined on the Orientation Form specific to each Job Description.

Medical Management staff also participate in various training seminars available to medical management professionals, as designated by PHP, and may participate from time to time in visitation or conferences with other health care and medical management professionals.

XI. ACCESS TO MEDICAL MANAGEMENT DEPARTMENT

Medical Management staff may be contacted during PHP's regular business hours of Monday through Friday, 8:00 a.m. until 5:00 p.m. EST. and 7:00 a.m. to 4:00 p.m. CST., at (260) 432-6690, or at PHP's toll-free number of 1-800-982-6257 or for the hearing impaired (TDD) (260) 459-2600.

PHP maintains an automated telephone system that has instructions for callers, in order that they may be directed to the proper party for assistance. PHP conducts ongoing telephone audits, to ensure that the system is working properly. All callers to the PHP phone system are informed that their call may be monitored or recorded and reviewed for training purposes.

Incoming calls received outside normal business hours are intercepted by PHP's automated telephone system, which provides instructions to allow the caller to leave a confidential recorded message. The telephone system records the date and time of the call. Medical Management staff will make a reasonable attempt to respond to the caller within one (1) working day after the date on which the call was received and, in any event, will respond within two (2) working days. When contacting a provider's office, members of the Medical Management Department will identify themselves by name, company name and utilization review license number.

Covered Persons and providers can access general information regarding PHP at our website www.phpni.com.

XII. CONFLICT OF INTEREST

No person may participate in the review and evaluation of any case in which he/she has been personally or professionally involved. QIC members and other PHP employees shall have the continuing, affirmative duty to report any personal ownership, interest, or other relationship that might affect their ability to exercise impartial, ethical, and business judgments in the area of their responsibilities.

XIII. PLAN EVALUATION P-QM 3.c, P-QM 4.i

At least annually, the Utilization Review and Quality Improvement Plan and Program shall be reviewed, evaluated for effectiveness and revised (if necessary) by the QIC with input and assistance from the Board of Directors, other committees, management and staff to assure that it meets the needs of PHP Providers and Covered Persons. Input from participating providers is obtained through membership on the QIC and other committees. Approvals of revisions and changes will be made by the QIC Committee, PHP Administration and the Board of Directors. The Indiana Department of Insurance will be notified of any material change within 30 days after such change.

The Medical Director will be responsible for annually preparing a reappraisal report using as source documentation:

- Committee minutes;
- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service;
- Individual and aggregate utilization and quality data including trending of measures to assess

performance in the quality and safety of clinical care and quality of service;
- Memos, correspondence, etc., relating to the Utilization Review and Quality Improvement Plan and Program;
- Department, Service, QIP Team, Delegated Vendor Reports and Annual Assessments of the Utilization Review and Quality Management Plan and Program;
- Analysis of the results of QI/UR initiatives;
- An assessment of adequacy of resources for the program;
- Previous Annual Reappraisal Reports;
- Other valid data reports and tools pertinent to the evaluation for effectiveness of the program;

XIV. UTILIZATION REVIEW PROTOCOLS AND ACTIVITIES

In order to assure the delivery of high quality care in the most cost-effective manner and assure effective and efficient utilization of participating services and facilities, the following protocols and activities will be implemented:

A. Pre-Admission Certification

B. Concurrent Review

C. Certification of Non-Participating Provider Services

D. Primary Care Provider Utilization*

E. Behavioral Health/Chemical Dependency

F. Case Management

G. Disease Management

H. Post-Payment Utilization Review*

I. Criteria and Procedures

J. Denial Procedure and Notification

K. Appeal Procedure

In addition to the above protocols and activities, review may focus on those diagnoses, problems, procedures, and/or practitioners with identified and/or suspected utilization problems. Review procedures for specific Covered Persons may also be implemented, when indicated and approved by the QIC.

A. PRE-ADMISSION CERTIFICATION

The purpose of this element of PHP's Utilization Review and Quality Improvement Plan is to limit inpatient services to those that are believed to be necessary and effective. It will be accomplished by pre-certifying services such as:

- All scheduled hospital admissions;
- All scheduled admissions to alternate care facilities; e.g., Rehab;

* Utilized when performing in-house utilization review.

- All skilled nursing facility admissions;
- Emergency admissions (within 48 hours of admission);
- Selected outpatient procedures as determined by the QIC.

PHP's utilization review activities will focus on determining whether admissions and lengths of stay are necessary and appropriate according to generally accepted standards of medical practice, required for the care of the Covered Person.

1. METHODOLOGY: This activity will be accomplished in the following manner:

   a. The Participating Provider or designee will be required to notify PHP's Medical Management not less than two (2) business days in advance of hospitalizing Covered Persons for all non-emergency admissions.

   b. This required prior approval may be obtained by calling or faxing the Medical Management Department. The Medical Management Department will make all reasonable efforts to notify the provider promptly if additional information is necessary to evaluate the proposed admission.

   c. All proposed admissions will be medically assessed concerning such things as:

      - Diagnosis
      - Appropriateness of level of care in relation to the treatment plan, patient acuity and other related factors, i.e., planned admission to Intensive Care Unit;
      - Appropriateness of procedure or the prescribed plan of treatment;
      - Anticipated length of stay;
      - Timeliness of admission (e.g., when is surgery scheduled?); and
      - Eligibility of certain procedures for coverage (e.g., cosmetic procedures, oral surgery, etc.)

   d. The Medical Management personnel shall notify the Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative) and the Participating Provider and ancillary provider, if any, of the utilization review determination within two business days after receiving a request for a determination that includes all information necessary to complete the determination.

   e. If consistent with screening criteria, the admission will be approved and the Covered Person, Participating Provider and ancillary provider will be notified in writing of the approval.

   f. If the admission is not consistent with screening criteria, the Participating Provider may accept a different level of care consistent with the criteria or request review of the case by PHP's Medical Management Department. The purpose of the review will be to:

      - Determine if there is additional information that would justify a proposed course of treatment care;
      - Further explain PHP's benefit contract and the comprehensive coverage available; and
      - Encourage the most appropriate utilization of Health Services.

   g. Certification of benefits may, during the course of treatment, be extended beyond those initially approved if medically justified and approved in advance by PHP's Medical Management Department.

   h. All Participating Provider hospitals will be required to contact PHP to confirm benefits and eligibility for each Covered Person admitted. This serves as assurance that the Plan is aware of all hospitalizations and will identify Providers not in compliance with the pre-admission certification program.

i. The Participating Provider or designees will be required to notify PHP's Medical Management Department within forty-eight (48) hours of all emergency admissions so that these admissions can be assessed and length of stay assigned in the same manner described above. If after review of admission criteria, the admission is determined to not be medically necessary, payment for provider or facility services may not be made by PHP.

2. AREAS OF CONCERN: Specific areas likely to be denied include:

a. Admissions for purely diagnostic evaluation.

b. Non-emergent weekend admissions. Only those admissions where a definite course of treatment supports the need for the weekend admission will be approved.

c. Preoperative admissions which do not meet the medical necessity for early preoperative admission.

B. CONCURRENT REVIEW

This activity is designed to encourage, as medically necessary, the timely discharge of hospitalized Covered Persons, and to permit a concurrent assessment of the appropriateness of diagnostic tests and treatment performed in conjunction with inpatient stays. Further, concurrent review should provide for proactive assessment for discharge planning and home health care arrangements.

1. METHODOLOGY: This activity will be accomplished in the following manner:

a. PHP will maintain a list of all Covered Persons hospitalized on any given day, indexed by hospital. This list will be based on information obtained during the admission certification process as well as benefit determination calls from hospitals. Medical Management will monitor this list on an ongoing basis.

b. PHP must be informed of all qualifying events, i.e., unexpected admission to a more acute level of care.

c. It is anticipated that all Covered Persons will receive discharge planning and arrangements made by the hospital in collaboration with the attending physician and Medical Management on or by the date of discharge.

d. If the Participating Provider believes the Covered Person requires additional days because of supportable medical facts, the Participating Provider must confer with PHP's Medical Management Department to request an extension. Medical Management will notify the Participating Provider promptly if information necessary to the determination has not been received and will continue to solicit information prior to the expiration of the approved length of stay.

e. On a regular basis, Medical Management will review the subsequent progress of each patient receiving an extension and seek necessary assistance from the Medical Director and/or the Behavioral Health Advisor for Behavioral Health cases if there is uncertainty about the continuing need for a patient remaining in the hospital.

f. No Covered Person will be denied benefits beyond his/her anticipated stay solely because of his/her provider's failure to obtain the required extension. However, a Covered Person will be notified promptly by Medical Management when a hospital stay has continued beyond the approved length of stay. This notification will serve as notice that PHP may not be responsible for benefits following the issuance of the written notification to the Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative).

g. The Utilization Review and Quality Improvement Plan will include a system to monitor the appropriateness of length of stays and the scope of services performed in conjunction with inpatient stays. These may include diagnostic, therapeutic, or rehabilitative services, prescription medications, use of specialized equipment, etc.

C. AUTHORIZATION OF NON-PARTICIPATING PROVIDER SERVICES

The purpose of this activity is to reduce to a minimum, care provided by providers who are not contractually obligated to comply with PHP policies, which have been implemented to optimize quality of care in a cost-effective manner.

1. METHODOLOGY: The activity will be implemented in the following manner:

a. Participating Providers who request to refer a Covered Person to a non-Participating Provider will be required to submit in writing the following information to the Medical Management Department on a referral request form:

- The medical service to be provided and the period of time during which it will be provided;
- The medical justification for the service; and
- The reason that the referral cannot be made to a Participating Provider or facility.

b. Such referrals will be reviewed and must be approved in advance by PHP's Medical Director. In the event a Covered person receives emergency Health Services from a non-participating provider, the Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative) must notify PHP within forty-eight (48) hours of the initiation of such services, or as soon as was reasonably possible thereafter. Continuation of care thereafter shall require coordination by a Participating Provider and the prior approval of PHP's Medical Director.

c. Authorization will cover a designated level of service for a specified period of time. In no instance will an unrestricted, open-ended referral be authorized.

d. Non-emergency referrals to non-participating providers will not be authorized unless the Covered Person's medical needs require specialized or unique services not available through a Participating Provider or facility.

D. PRIMARY CARE PROVIDER UTILIZATION*

Each Covered Person is encouraged to utilize a primary care provider who is responsible for the management and continuity of the member's health care, in order to limit duplication of evaluation and treatment and discourage self-referral of Covered Persons to multiple providers for the same medical problem.

The primary care provider will assume, insofar as possible, the responsibility for the management and continuity of the Covered Person's health and medical care. The primary health records will be maintained by the primary care provider regardless of whether the care is provided by the primary care provider, a specialty provider, or other provider to whom the Covered Person has been referred.

Access to specialists is an important feature of PHP's program. When the primary care provider refers a Covered Person to a specialist, it is the specialist's responsibility to report back in writing to the Covered Person's primary care provider in keeping with good medical practice.

* Utilized when performing in-house utilization review.

The effectiveness of this program in controlling utilization will be monitored by analyzing medical management data and claim information.

E. BEHAVIORAL HEALTH/CHEMICAL DEPENDENCY

In order to coordinate and monitor the care of Covered Persons requiring behavioral health/chemical dependency treatment and control utilization, PHP requires that all hospitalizations for behavioral health or chemical dependency services be authorized by the Medical Management Department.

1. INPATIENT BEHAVIORAL HEALTH/CHEMICAL DEPENDENCY: All inpatient admissions for behavioral health/chemical dependency problems will require precertification at the time of admission in order for coverage to be provided unless during hours when PHP's office is closed when medical reasons cannot wait until the office is open.

2. OUTPATIENT BEHAVIORAL HEALTH/CHEMICAL DEPENDENCY: All intensive outpatient and partial day behavioral health/chemical dependency services will require precertification in order for coverage to be provided.

3. METHODOLOGY: Pre-certification will be accomplished in the following manner:

   a. The Participating Providers or designee will be required to notify the Medical Management Department when treating Covered Persons for behavioral health/ chemical dependency problems.

   b. All Participating Providers, hospitals, and other local treatment facilities dealing with behavioral health/chemical dependency patients, will be notified in writing that PHP benefits will only be payable when approval has been given by PHP.

   c. All requests to approve benefits for behavioral health/chemical dependency treatment will be medically assessed concerning such things as:

      - Appropriateness of level of care in relation to the treatment plan, patient acuity, and other related factors;
      - The frequency and scope of procedures or therapy to be performed; and
      - The anticipated length of stay for inpatient treatment.

   d. PHP's Medical Management Department, in conjunction with PHP's Medical Director or Behavioral Health Advisor will make a determination as to whether and to what extent benefits will be provided.

      - Benefits may be limited to care rendered in a certain setting (e.g., non-hospital based treatment programs), for a specified period of time.
      - "Exception" procedures may be established for emergency cases.
      - Benefits may be extended beyond an initially approved period of time, if medically justified and approved in advance by the PHP Medical Director or Behavioral Health Advisor.
      - The Participating Provider will receive a written confirmation of the benefit determination.

   e. Policies for optimal care will be developed and published as part of the Utilization Review and Quality Improvement Plan.

   f. To assure that all services provided are medically necessary and to control utilization, practice patterns of referring primary care Providers and Participating psychiatric Providers to whom Covered Persons are referred may be monitored by the Medical Management Department and by the QIC based upon such criteria as cost per patient and frequency of visits per patient.

F. CASE MANAGEMENT

Case Management is a program that has been implemented to identify cost-effective medical alternatives which provide appropriate care. A Case Manager will work with the provider and the Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative) to determine the most cost-effective method of appropriate care. Once alternatives are identified, they will be presented to the Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative), other authorized individuals, and provider for consideration. The Participating Provider, Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative) will make the final decision.

Case Management has Five Core Components:

1. INTAKE AND SCREENING: Potential Covered Persons are identified initially through referral. Preliminary screening determines whether Covered Persons are eligible for case management services.

2. ASSESSMENT AND REASSESSMENT: Information is gathered about a Covered Person's needs — medical, functional, social, environmental, financial, and any information about the network of support that is already in place. Evaluations are scheduled to continue the reassessment process.

3. CARE PLANNING: A care plan is developed, specifying services to be delivered, their frequency, their duration, and their goals. This plan is designed in cooperation with the Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative), care givers, specialist, providers, and others involved with the Covered Person's care. Services suggested are to support and enhance medical treatment plans.

4. SERVICE ARRANGEMENT AND COORDINATION: Services needed to fulfill the care plan are arranged and coordinated with the Participating Provider and service providers.

5. MANAGEMENT: Review and management is provided as services are delivered and the care plan is modified as warranted by the Covered Person's condition.

Case Management differs from acute discharge planning in that it focuses on Covered Persons with severe illness or injuries requiring intensive long term management which focus on integrating and mobilizing resources to meet the Covered Person's needs.

G. DISEASE MANAGEMENT

Disease Management programs are implemented to focus on a specific disease process, or a targeted segment of Covered Persons and are established in order to reduce, maintain or prevent complications and avoidable outcomes of the disease process.

The objective of Disease Management is to maintain an optimal level of health and well-being through the promotion of a collaborative multidisciplinary team approach.

Disease Management is a process that identifies chronic, at-risk populations across the continuum of care and evaluates the Covered Person's health status for the purpose of establishing a program or plan of care. Disease Management attempts to proactively engage the resources and community services available so that the patient can maintain optimal function without high cost interventions.

The Participating Provider and Medical Management personnel will be responsible for coordinating activities of the Disease Management program. Medical Management personnel will coordinate services and recommend cost-effective alternatives.

H. POST-PAYMENT UTILIZATION REVIEW*

As part of its objective to control health care costs, PHP will conduct post-payment utilization reviews of Provider practice patterns. As part of this review, the individual Provider's average cost per patient is compared to the average cost per patient of other Providers in his/her specialty. Individual Provider profiles will be developed and periodically distributed to Participating Providers.

I. CRITERIA AND PROCEDURES

Utilization review decisions are based upon written screening criteria and review procedures. The criteria and procedures will be revised from time to time by PHP in response to utilization conditions impacting on the quality and cost of care. Such criteria and review procedures shall be available for review and inspection by the Commissioner of Insurance of the State of Indiana or his/her designated representative; provided, however, that such information is considered confidential and privileged and not subject to the open records law or subpoena except to the extent necessary for the Commissioner to enforce IC 27-8-17 and 760 IAC 1-46-4.

PHP's medical policies are developed by the Medical Director, in accordance with input from appropriate health care Providers and/or standards or guidelines that may have been developed by other utilization review entities. Such criteria are approved by the QIC.

J. DENIAL PROCEDURE AND NOTIFICATION

A decision to deny a request for an admission, extension of stay, service or procedure for lack of medical necessity (including appropriateness) may only be made by PHP's Medical Director according to criteria (including a lack of information necessary to reach a decision) previously established by the Medical Director in cooperation with PHP's QIC.

Medical Management personnel shall notify the Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative) and the Participating Provider and ancillary provider, if any, of the Medical Director's decision to deny a request within two (2) business days after receiving a request for a determination that includes all information necessary to complete the determination.

Such notice shall be made in the most expeditious manner appropriate to the circumstances; *i.e.*, by phone, e-mail, fax, etc., with written confirmation by regular mail to the Covered Person (or his/her parent or guardian, if a minor or incompetent, or designated representative), with copies to the Provider and ancillary provider, if any. The letter of confirmation shall explain the principal reason for the denial and the procedure to initiate the appeal.

In the event a request for an admission, extension of stay, service or procedure does not contain all information necessary to complete a determination of medical necessity (including appropriateness), Medical Management personnel shall make reasonable efforts to obtain such additional information as shall be deemed necessary by the Medical Director to reach a decision.

The Medical Management personnel shall verbally issue a notice of intent to deny certification under the following circumstances: (1) the medical information presented does not meet recognized criteria for medical necessity; (2) in the event of a request for pre-certification, sufficient information to determine medical necessity is not received within 10 business days of a request for such; (3) in the case of concurrent review, necessary medical information is not received after repeated efforts to obtain such information over a period of two business days.

The Medical Management personnel shall verbalize the intent to deny due to lack of medical necessity to the Covered Person (or his/her parent or guardian if a minor or incompetent or designated

* Utilized when performing in house utilization review.

representative), Participating Provider and ancillary provider as soon as possible but will not exceed two business days of receiving all pertinent facts of the case or upon declaring the inability to obtain such information.

If no new information is presented to the Medical Director that reverses the decision within two business days, Medical Management personnel shall issue a letter denying certification. The letter shall explain the denial, the principal reason for the denial, and the procedure to initiate an appeal.

K. APPEAL PROCEDURE - Utilized when PHP is acting as a utilization review agent.

On appeal, the decision of the Medical Director denying a request for an admission, extension of stay, service or a procedure, will be reviewed according to PHP's "Member Grievance and Appeal Procedure".

The provider may file an appeal on behalf of the member. PHP will contact the member to obtain written acknowledgement that the member does want reconsideration of the issue or adverse benefit determination to ensure the member's confidentiality is not breached.

The first level of due process is a grievance. Upon receipt of a grievance, PHP will acknowledge the grievance within 3 business days. PHP will conduct a thorough investigation of the facts of the grievance and render the decision. Our decision regarding the grievance will be made a soon as possible, but no later than:

a. 15 business days after receiving the grievance for pre-service denials
b. the earlier of 20 business days or 30 days after receiving the grievance for post- service denials

The second level of due process is the appeal. Upon receipt of appeal request, PHP will acknowledge the request for an appeal within three business days of our receipt of it. An Appeal Committee will resolve the appeal. The Committee will be comprised of qualified individuals who were not involved in the initial denial or the first level grievance. One or more of the individuals on the Committee will have knowledge of the health service at issue and be in the same licensed profession as the provider who proposed the denied service.

The Committee's decision regarding the appeal will be made as soon as possible and with regard to the clinical urgency of the Appeal, but no later than 15 calendar days after the appeal was filed. A written notification will be issued within five business days after the Appeal Committee's decision. If the situation meets the requirements of an Urgent Care Claims, we will follow due process mentioned above, with the following changes in the timeframe:

a. Acknowledgement 24 hours
b. Decision, 24 hours after requested information received or 24 hours after receipt of the initial request

The third and last step of the appeal process is external appeal. External Appeal may be requested if an Appeal or Urgent Care Claim decision upholds our original denial and the original denial involved medically necessary service, utilization review determinations or experimental or investigational nature of health service.

External Appeal requests must be written and received by PHP within 120 calendar days after notification of the Appeal decision or Urgent Care claim decision. The IRO must make a determination within 14 business days and must provide notification of its decision within 72 hours of making it. The review organization's determinations are binding on PHP.

XV. QUALITY IMPROVEMENT ACTIVITIES AND METHODOLOGY

The Quality Management Program at PHP is based on the principles of Deming, Juran and Shewhart for continuous quality improvement (CQI). PHP maintains a quality management program that promotes objective and systematic measurement, monitoring and evaluation of services, work processes, and implements quality improvement activities based upon the outcomes. CQI techniques and tools are utilized to improve the quality and safety of clinical care and service delivered to our members. At PHP quality is everyone's responsibility and an inter-departmental collaborative approach is used to monitor, identify, analyze, act measure results of action and moves toward or maintains improvement levels.

A. Quality Monitoring Activities:

PHP has established ongoing monitoring of specific quality indicators. These include Key Performance Indicators, routine, and focus monitors to measure key processes and outcomes of care and service. These indicators are to be directly related and relevant to the quality of services realized by PHP's population of members, clients and providers, encompass all lines of business, both medical and behavioral health and span a variety of delivery settings. These are based on important aspects of care and service for our members, clients and providers. This monitoring activity as described in this plan, its supportive policies and procedures, plans and reports may include but not be limited to:

- Access and Availability to Care and Services
- Provider Network Accessibility and Availability
- Member Satisfaction P-QM 5.a
- Client Satisfaction P-QM 5.a
- Complaints and Appeals P-QM 5.a
- Process and Service Outcome and Trends for Members P-QM 5.a
- Consumer Safety
- Data Integrity
- Service Quality Improvement
- Utilization and Case Management
- Provider Credentialing and Re-credentialing
- Clinical Policy and Criteria Review
- Delegated Functions

B. Quality Improvement Projects: P-QM 7

In striving to meet URAC Accreditation Standards, PHP shall establish quality improvement projects (QIPs) that address opportunities for error reduction or performance improvement related to the services covered by the accreditation, whereby:

- At any given time, PHP has implemented no less than three (3) quality improvement projects; P-QM 7.a
- All three (3) quality improvement projects must focus on clinical quality; and P-QM 7.b
- At least one (1) of the three (3) clinical quality improvement projects must address consumer safety for the population served. P-QM 7.c

PHP may establish more than three (3) QIPs and can pursue non-clinical QIPs; however, they usually will not contribute toward meeting URAC QIP Standards.

The design of the quality improvement projects should encompasses the principles of continuous quality improvement. They include:

- Goals are enumerated which set forth expected, measurable results P-QM 9.a
- A rationale must be presented as to why the study is important and how targeted results have been derived from guidelines, benchmarks, product-specific goals or historical controls
- The project is designed to improve performance through specific implemented strategies P-QM 9.b
- The methodology for the study should incorporate a quality improvement cycle and establish projected time frames and specific interventions for meeting goals for quality improvement P-QM 9.c
- Leading indicators are used to evaluate the level of performance improvement throughout the projected time frame for meeting quality improvement goals P-QM 9.d and e
- Quantifiable results are required for baseline and post-intervention periods and to measure the level of improvement above the baseline P-QM 9.e
- The study must provide for a barrier analysis and a conclusion related to goals and objectives, effectiveness of interventions, and decisions related to "next steps" or further improvements P-QM 9.f, g, and h

C. **Development of Standards, Criteria, Goals, Benchmarks and Thresholds**: P-QM 3.f, P-QM 8.b(i, ii, and iii)

Prior to evaluation of the quality of care and services, standards and benchmarks are established. They may be based on standards of practice of professional organizations, criteria developed within PHP or in cooperation with local hospitals or providers. Measurement of outcomes, success and/or improvement is based on goals, benchmarks or thresholds which are based on valid internal or external statistical comparisons. Similar to standards and criteria, these may be based on professional organizations, current clinical literature, or developed internally. Where benchmarks or thresholds do not exist, quantifiable baseline measurements are performed and benchmarks established.

D. **Improvement Process:** P-QM 3.f, P-QM 5.b, P-QM 8.a

Individuals carrying out the elements of the quality improvement process, shall select, collect analyze and ensure data integrity prior to integrating data that is used to manage key work processes. Results of evaluations of care and services shall be analyzed and compared to the standards, criteria, goals, benchmarks or thresholds which were set prior to the evaluation and can be compared to PHP's own performance, customer data or Comparative data. Negative variation, when a statistically valid sampling has occurred, will require an Action Plan to be submitted with the report to the Quality Improvement Committee.

E. **Action Plans**: P-QM 5.c

When a Quality Improvement Activity does not meet comparative standards, criteria, goals, benchmarks or a threshold has been exceeded, a formal Action Plan shall be implemented. The Action Plan is the written plan to improve or correct the identified problem or meet acceptable levels of performance measures.
Action Plans should show:

- analysis to root cause of the variation,
- valid action steps to address the root causes and
- expected time frame for initiation and completion of the action
- Assigns measurable objectives for each action, including the expected change, the person, group, or situation expected to change, and the time frame for correction of the change
- States the person(s) responsible for implementing the change

- Specifies when reassessment follow-up will take place

As the Plan-Do-Study-Act PDSA Cycle is a component of the Quality Improvement Process, portions of the variation remaining after initial action should continue to be addressed and updated in Action Plan reports to the Quality Improvement Committee. Part of the Committee's responsibility is to advise the individuals conducting the evaluations when the Action Plan is inconsistent with the action required to resolve the problem/variation, insufficient action has been taken, timing of action is inappropriate, aid in breaking down barriers to improvement or other issues which would prevent or delay the improvement. P-QM 5.e

F. **Maintaining Improvement:** P-QM 5.f

Once an acceptable level of performance has been met, the quality improvement activity will be periodically re-measured to determine that the improvement was sustained. Acceptable level of performance is usually determined to be a return to meeting or exceeding benchmarks, staying under thresholds or meeting standards, criteria or goals. Dependent upon the issue and volume, acceptable performance should be maintained for 3 – 6 months before stopping routine monitoring.

G. **Strategies for Interventions and Improvement** may be directed at PHP employees, providers, members, and/or a contracted vendor. Interventions may include: P-QM 5.d(i and ii)

- Training or education on processes
- Adoption and/or dissemination of clinical practice guidelines, policies or preventive care guidelines
- Feedback to providers and practitioners
- Direct mailings to targeted groups regarding wellness, preventive care and/or management of chronic conditions
- System changes
- Revised policies and/or procedures
- Feedback to internal staff

H. Use performance review findings along with comparative and competitive data (where available to project future performance and drive innovation P-QM 9.h

I. **Data Sources**:

A variety of internal and external data sources may be utilized in quality improvement monitoring, analysis and benchmarking. In part, they include:

- Claims
- Medical Records
- Surveys
- HEDIS Reports
- CAHPS Reports
- QualMetrix Complaint Logs
- InterQual Reports
- QNXT Data
- Phone and Track Logs
- Indiana Department of Insurance Data
- External Data Sources deemed valid and reliable (i.e., based on data from sources identified in PHP Medical Technologies Policy, published by an American Specialty Board, CMS, AHRQ, Leapfrog Group, etc.)

J. **Selection and Prioritization of Quality Improvement Projects:** P-QM 6

PHP shall implement criteria to guide in the selection and prioritization of quality improvement projects, resulting in activities designed to:

- Support the overall quality management strategy approved by clinical leadership; P-QM 6.a
- Generate a measurable impact, which includes attaining measureable performance levels; and P-QM 6.b
- Provide improvement on member health outcomes or internal work processes based on various factors including but not limited to: P-QM 6.c
    - Degree to which project will improve:
        - Medical Outcomes
        - Access to Care
        - Consumer Satisfaction
        - Provider Satisfaction
    - Degree to which project:
        - Improves a key process
        - Eliminates Waste
        - Reduces Redundancy
        - Facilitates the Continuum of Care
    - Degree to which project is supportive of:
        - PHP Mission
        - PHP Strategy
        - Increasing Market Share

Individuals may submit a completed QIP Form to the Quality Improvement Committee along with a PHP Quality Improvement Project Prioritization Form. They shall indicate the title of the project, submission date, and number of consumers affected by the project proposal. The QIC shall then review the submitted data and prioritize the project based on the form criteria and scoring guidelines. The QIC may return the QIP form to the initiating individual requesting additional information or clarification before final consideration.

XVI. PEER REVIEW

PHP conducts peer review as part of its quality improvement program in accordance with PHP's *Peer Review Procedure*. In addition, the QIC shall function as a peer review committee under the Indiana Peer Review Act, Indiana Code § 34-30-15 *et seq.* (the "Act") when engaged in an evaluation of patient care and/or the professional competence or conduct of its Providers. The QIC claims all Privileges and immunities afforded under the Act. All proceedings, communications and decisions by the QIC related to peer review activity shall be deemed confidential. Neither the personnel of the QIC nor any participant in the peer review activities conducted by the QIC shall disclose outside of the QIC the content of, communications to, records or decisions of the QIC regarding peer review activity, except as permitted by the Act and PHP. Any recommendation or request made by the QIC to take an Adverse Action against a Provider shall be referred to the Physician Review Oversight Committee in accordance with the *Peer Review Procedure*. For a copy of the *Peer Review Procedure*, please contact PHP's Medical Director.

XVII. DEFINITIONS

Unless otherwise specifically defined herein, capitalized terms used herein shall be defined as follows:

"*Adverse Action"* shall mean any action, or recommendation to take action, primarily based upon an evaluation of the competence or professional conduct of a Provider or Applicant, in rendering patient care,

which action results in, or could result in, a denial, refusal to renew, material restriction, suspension, revocation or termination of Privileges.

"*Applicant*" shall mean a licensed health care provider who has submitted an application to PHP seeking to become a Provider.

"*Benefit Contract*" shall mean the group or individual health plan issued and insured by PHP, or by a health benefits entity affiliated with PHP through ownership, contract, partnership or joint venture, or the group health plan which is a self-funded plan of a sponsoring employer administered by PHP and which provides the terms and conditions entitling a Covered Person to Health Services.

"*Covered Person*" shall mean an individual (1) enrolled for coverage under a Benefit Contract issued by PHP; (2) enrolled for coverage under a Benefit Contract issued by a health benefits entity affiliated with PHP through ownership, contract, partnership or joint venture; or (3) enrolled for coverage under a Benefit Contract administered by PHP.

"*Day(s)*" shall mean, with respect to time allowed for delivery or receipt of any notice, calendar days (*i.e.*, including Saturdays, Sundays, and legal holidays) unless the due date for such notice or receipt falls on a Saturday, Sunday or legal holiday, in which case, the due date shall be the first date immediately following which is not a Saturday, Sunday or legal holiday.

"*Health Services*" shall mean the health care services and supplies offered by Provider which are covered under the Covered Person's Benefit Contract.

"Participating Provider" shall mean an individual health care provider who is a party to a Provider Participation Agreement with PHP or who is identified as an eligible Provider under a Provider Group Participation Agreement with PHP, or an individual health care provider who is affiliated with a Participating Provider.

"*PHP*" shall mean Physicians Health Plan of Northern Indiana, Inc., an Indiana not-for-profit corporation, and its affiliated entities.

"*Privileges"* shall mean the right of a Participating Provider to provide Health Services to Covered Persons.

"*Provider(s)"* shall mean the following licensed health care providers: a physician, dentist, podiatrist, chiropractor, optometrist, psychologist, pharmacist, registered nurse, practical nurse, physical therapist, nurse practitioner, occupational therapist, physician assistant, respiratory therapist, midwife or clinical social worker -- in each instance who is under contract with PHP, or is affiliated with an individual or group practice under contract with PHP, to provide Health Services to Covered Persons.

Statistically valid: Based on accepted statistical principles and techniques.