2024
Luminare Health Benefits Inc., Utilization Management Program Description

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UM Program Description
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I. Overview

The Utilization Management (UM) Program description defines the structure of the UM program at Luminare Health Benefits (HB) Inc., which is a third-party administrator of medical and behavioral health benefits for self-funded and fully insured clients. The Healthcare Management (HCM) department offers a comprehensive package of medical management services.

Clients select the specific services they prefer and HCM provides the services from its HCM operational site. The HCM services are integrated with claims/benefits administration and provider networks as outlined in the client's agreement with Luminare Healthcare Management.

II. UM Program Purpose

The purpose of the UM program is to assist HCM in ensuring that eligible members receive appropriate care and services in an efficient manner and to enhance consistency in reviewing cases by providing a framework for clinical decision making.

III. Healthcare Management Division Mission Statement

Educate, Empower, Assist…
We support our members on their path to better health.

IV. UM Program Structure

The UM program is structured to promote access to care and services and to ensure quality cost–effective care and services for eligible members. The UM program attempts to minimize/eliminate over and/or under-utilization of medical, pharmaceutical, and behavioral health services by utilizing objective, evidenced-based guidelines, protocols, and criteria that support appropriate clinical decision-making. Quality management collaborates with UM in providing objective, systematic monitoring, and evaluation of the program.

The HCM Healthcare Management Medical Director provides clinical supervision, oversight and participates in the development, implementation, and evaluation of the UM program. The Quality Management (QM) committee chaired by the Medical Director reviews and approves the health care services utilization review plan and all associated policies and procedures. The HCM Department is led by the Chief Medical Officer.

UM activities are conducted in compliance with legal, regulatory, and accreditation standards along with plan specific language.
URAC UM 1-1 (b), M 1-2 (a)(b)

V. Program Objectives

The UM process assists members in accessing care and services available through their benefits plan. The UM program identifies and attempts to avoid unnecessary medical services from being rendered and ensures delivery of medically necessary and appropriate health care services including ambulatory care, inpatient care and care provided in alternative care settings. Additionally, UM helps to identify alternatives and other resources available to support appropriate medical practice patterns while improving quality of care and cost containment.

VI. Program Scope

The scope of the UM Program consists of clinical review activities that determine the coverage of services based on applicable medical necessity guidelines. It includes activities related to inpatient and ambulatory care and collaborates with other programs within HCM in care coordination, discharge planning and case management to meet the physical and behavioral healthcare needs of its members.

A. Definitions

Action Plan: Targeted interventions at key improvements or root causes.

Acute Care: Medical treatment and nursing care delivered on a 24-hour basis in an accredited facility defined as an acute care hospital.

Adverse Determination: A review decision that is inconsistent or contrary to the requested outcome (i.e. benefits for services have been denied, reduced, etc.).

Adverse Event: An occurrence that is inconsistent with or contrary to the expected outcomes of the Organizations' functions.

Ancillary Provider: An agency or organization that provides healthcare services often used as follow-up to acute care or as an alternative to acute inpatient care. These services include but are not limited to home healthcare, home infusion, durable medical equipment, hospice care, skilled nursing care and outpatient rehabilitation therapy services.

Anticipated Discharge Date: The date a concurrent review is expected if continued stay or care is necessary.

Appeal Process: A clinical review conducted by appropriate clinical peers, who were not involved in the peer clinical review, when the decision not to certify a requested admission, procedure, or services has been rendered and an appeal has been requested. *May also be referred to as a Third Level Review.*

Appropriateness: Determination or clinical justification that medically necessary services are provided in the least restrictive and lowest cost setting consistent with high quality.

Attending Physician: The physician with primary responsibility for the care provided to a patient in a hospital or other healthcare facility. *Note: for purposes of this manual, notification of attending physician denotes contact with the attending physician or his designee.*

Audit: Review of case files, measuring compliance with policies and procedures. *May also be referred to as Individual Performance Review.*

Barrier Analysis: Post-baseline interpretation of performance data that identifies root causes and key improvement and evaluates the effectiveness of improvements by comparing actual to expected results.

Benefits: The department that determines if payment for healthcare services is covered by the health benefit plan contract provisions. This function is distinct from the Healthcare Management function of HCM. *May also be referred to as Claims or Claims Administration Department.*

Business Day: Also known as *Working Day*. Any day the Luminare Healthcare Management Department is open for operation. This is Monday through Friday, excluding holidays or weather emergencies. When the information necessary to initiate a process is received after two (2) PM Eastern Time, the next full business day will be counted as the date received. The current Luminare HCM Operational Site business day hours of operation are:

Lancaster, PA – 8:00 AM – 7:00 PM Eastern Standard Time

Calendar Day: A day is counted as a calendar day if the information necessary to initiate a process is received prior to 2:00 PM Eastern time. When the information necessary to initiate a process is received after 2:00 PM Eastern time, the first calendar day will be the next day.

Case Management: A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates care options and services to meet a patient's health needs utilizing communication and available resources to promote cost-effective positive outcomes. *May also be referred to an Individual Case Management or Large Case Management.*

Certification: A determination that an admission, extension of stay or other proposed or current healthcare services has been reviewed by a HCM professional or physician advisor and based on the information provided, meets the clinical requirements for medical necessity and appropriateness, level of care or effectiveness in relation to

industry accepted criteria and patient health status under the auspices of the applicable health benefit plan. Certification is distinct from eligibility and benefit determinations.

Claims: The department that determines if payment for healthcare services is covered by the health benefit plan contract provisions. This function is distinct from the Healthcare Management function of Luminare Healthcare Benefits, Inc. *May also be referred to as Benefits or Claims Administration Department.*

Claims Administration Department: The department that determines if payment for healthcare services is covered by the health benefit plan contract provisions. This function is distinct from the Healthcare Management function of Luminare Healthcare Benefits, Inc. *May also be referred to as Claims or Benefits.*

Client: The customer purchasing services from the Healthcare Management Department. Examples of clients may include employer groups, individual employers, insurance companies, and state insurance risk pools.

Clinical Director: See Medical Director's job description.

Clinical Peer: A licensed Doctor of Medicine, osteopathy, chiropractic, or dentistry or a clinical psychologist employed by or under contract with Luminare who is trained in Utilization Management and provides direct and consultative intervention in cases under review when indicated by the given criteria and upon referral from HCM professional staff. *May also be referred to as a Second Level Reviewer or Physician Advisor.*

Clinical Peer Review: Clinical review conducted by appropriate health professionals when a request for an admission, procedure or service was not approved during initial clinical review. *May also be referred to as Peer Review, Physician Review or Second Level Review.*

Clinical Quality Indicator: Clinically oriented topic related to quality.

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

Clinical Review: Utilization Management conducted using industry accepted criteria by a HCM professional. *May also be referred to as First Level Review or Initial Clinical Review*

Comparable: Data about performance is contrasted to a historical baseline and ongoing progress as recorded at regular intervals.

Complaint: An expression of dissatisfaction by a consumer expressed verbally or in writing regarding an organization's products or services that is elevated to a complaint

resolution system. Complaints are sometimes referred to as grievances. This definition does not include appeals.

Concurrent Review: The term for Utilization Management processes conducted during a patient's hospital stay or course of treatment. This includes initial review requests received after the healthcare services have begun, and review requests to assess the extension of an already certified length of stay or course of treatment. *May also be referred to as Continued Stay Review.*

Consumer: An individual person who is the direct or indirect recipient of the services of the Organization. Depending on the context, consumers may be identified as a member, enrollee, patient, claimant, client, employee, etc.

Consumer Safety: The prevention of harm to *consumers.*

Continued Stay Review: The term for Utilization Management processes conducted during a patient's hospital stay or course of treatment. This includes initial review requests received after the healthcare services have begun, and review requests to assess the extension of an already certified length of stay or course of treatment. *May also be referred to as Concurrent Review*

Contractor: A business entity that performs a delegated function on behalf of Luminare

Covered Person or Member: Employees and their dependents that have elected to contract for, or participate in, a health benefit plan. *May also be referred to as Enrollees or Members.*

Criteria: An objective decision-support framework used to assess patient-specific morbidity and medical care requirement. The written on on-line screens, decision rules, medical protocols or guidelines used to determine medical necessity and appropriateness of a medical service under the auspices of the applicable health benefit plan.

Currently Certified Period: Period of certification from initial day of authorization to the last certified day.

Customer: An individual or group who is the direct or indirect recipient of services.

Data Integrity: The quality or condition of being accurate, complete, and valid, and not altered or destroyed in an unauthorized manner.

Delegation: The process by which Luminare Healthcare Management permits another entity to perform and assume responsibility for functions while retaining final authority and oversight.

Discharge Planning: The process that assesses a patient's needs in order to help arrange and coordinate the necessary services and resources to affect a medically appropriate and timely discharge or transfer from current services or level of care. The process may be initiated prior to admission, but if this is not feasible, should begin as early as possible in the hospital stay.

Discretionary Second Opinion: A health benefit requirement to obtain an opinion on medical necessity and appropriateness of a treatment plan by a healthcare provider independent of the one originally making the recommendation. The Healthcare Management Department may waive this if the clinical review matches the recommended treatment plan.

Employee: The person employed by the client that contracts for Luminare Healthcare Management services.

Employer Group: The customer purchasing services from the Healthcare Management Department. Examples of clients may include employer groups, individual employers, insurance companies, and state insurance risk pools.

Enrollee: Employees and their dependents that have elected to contract for, or participate in, a health benefit plan. *May also be referred to as Covered Persons or Members.*

ERISA: A group health plan that is required to comply with "The Employee Retirement Income Security Act of 1974".

ERISA Exempt: A group health plan that is not required to comply with "The Employee Retirement Income Security Act of 1974". *May also be referred to as Non-ERISA.*

Expedited Appeal: An appeal request for a third level review of a non-certification decision for care that is urgent or involves imminent or ongoing services. A physician advisor who was not involved in the original non-certification decision conducts the appeal review.

Expectations (Quality Criteria Indicator): Written objective and measurable standards of performance to be met.

Extended Care Facility: An appropriately licensed institution, or a distinct part thereof, that provides inpatient confinement with twenty-four (24) hour skilled nursing/physical restoration services. *May also referred to as Skilled Nursing Facility.*

External Customer: Anyone who is <u>not</u> employed by or directly contracted by Luminare to provide a delegated service to the Luminare members. <u>Examples</u> include members, subscribers, HR, representatives, providers, and clients. This category includes those defined by URAC as <u>consumers</u>.

First Level Internal Appeal: The formal, internal HCM review of an adverse determination. (i.e. benefits for services have been denied, reduced, etc.) To initiate the process the requesting party must either request the appeal in writing or verbally and if additional supporting information is to be considered provide that to the Healthcare Management Department within the stated timeframe. *May also be referred to as a Grievance.*

First Level Review: The term for Utilization Management processes conducted when first reviewing a requested service and occurring while the patient is still receiving the service. *May also be referred to as Initial Clinical Review.*

Grievance: The formal, internal HCM review of an adverse determination. (i.e. benefits for services have been denied, reduced, etc.) To initiate the process the requesting party must either request the appeal in writing or verbally and if additional supporting information is to be considered provide that to the Healthcare Management Department within the stated timeframe. *May also be referred to as a Grievance.*

Healthcare Management: The Luminare Health Benefits, Inc. Department that provides Utilization Management, Case Management, Medical Claims Review and Quality Management Services to clients based on specific contract requirements. For purposes of Healthcare Management Policies designation of HCM Staff would indicate applicability to the specific staff performing the functions addressed in the policy document.

Health Benefit Plan: Any public or private organization's written plan that insures or pays for specific healthcare expenses on behalf of enrollees or covered persons.

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions regarding their health.

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

Home Health Care: *Outpatient Healthcare Services* provided by a licensed home health agency to a patient in his/her place of residence. Services may include private duty nursing, skilled nursing visits, home health aide visits, physical therapy, occupational therapy, speech-language pathology, medical social services, hospice, and IV infusion therapy.

Independent Review: A process, independent of all affected parties, to determine if a health care service is medically necessary and medically appropriate or experimental/investigational. Independent review typically (but not always) occurs after

all appeal mechanisms available within the health benefits plan have been exhausted. Independent review can be voluntary or mandated by law. *Also known as external review.*

Individual Case Management: A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates care options and services to meet a patient's health needs utilizing communication and available resources to promote cost-effective positive outcomes. *May also be referred to as Case Management or Large Case Management*

Individual Performance Review: The appraisal or review and evaluation of an individual's skills, work, productivity, and needs. This process is designed to identify areas where the individual excels as well as areas that may need improvement or correction. *May also be referred to as an audit.*

Initial Clinical Review: The term for Utilization Management processes conducted when first reviewing a requested service and occurring while the patient is still receiving the service.

Inpatient: The term for Utilization Management processes conducted for review services to be performed as part of an admission to a facility or hospital.

Internal Customer: A Luminare employee, or an employee of a company that is directly contracted by Luminare to provide a delegated service to Luminare members.

Large Case Management: A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates care options and services to meet a patient's health needs utilizing communication and available resources to promote cost-effective positive outcomes. *May also be referred to as Individual Case Management or Case Management*

Last Covered Day: The last date that the care is certified as medically necessary and appropriate. Either discharge to an alternate level of care or an update on clinical status is required to extend the certification.

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.

Mandatory Second Opinion: A health benefit plan requirement to obtain an opinion on medical necessity and appropriateness of a treatment plan by a healthcare provider independent of the one originally making a recommendation. The Healthcare Management Department may not waive this requirement.

Member: Employees and their dependents that have elected to contract for, or participate in, a health benefit plan. *May also be referred to as Covered Persons or Enrollees.*

Minimum Necessary: In the context of Healthcare Management processes, this means limiting the collection of Protected Health Information to only that clinical information necessary to appropriately accomplish the specific services requested.

Multiple Employer Welfare Arrangement: An arrangement that allows a group of employers to collectively offer health insurance coverage to their employees. *Formerly known as a multiple employer trust.*

Non-Certification: A determination that an admission, extension of stay, or other healthcare service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Non-Clinical Administrative Staff: Staff who do not meet the definition of a health professional (including intake personnel).

Non-Clinical Staff: Employees or contracted consultants of a healthcare organization who 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. (Formerly seen as *Paraprofessionals*)

Non-Scripted Clinical Review: Clinical review that does not meet the definition of scripted. Requires a HCM professional staff member's review.

Outpatient Healthcare Services: Healthcare services rendered outside of an inpatient setting. Such service settings may include clinics, rehabilitation centers, mental health/substance abuse programs, ambulatory care facilities, infusion centers, doctor's offices, surgical centers, patient homes, or any other clinically appropriate settings for the provision of healthcare services not provided as a component of an inpatient course of treatment.

Panel Appeal: An appeal request for a review of a non-certification decision that was upheld at the time of third level HCM review. The second level internal HCM appeal review is conducted by a panel of three physician advisors independent of the physicians involved in the preceding non-certification decisions. *May also be referred to as a Second Level Internal Appeal or Second Level Grievance*.

Partial Hospitalization: In the context of healthcare services for psychiatric/mental health/substance abuse, sessions of active treatment with a minimum of six (6) hours per day, five (5) days per week in a facility licensed/certified by the state in which treatment is received to provide one or more of the following: psychiatric services, treatment of mental health disorders, chemical dependency treatment.

Patient: The enrollee, consumer, or covered person who requests certification or for whom a request for certification has been filed. The term patient may include an agent or representative authorized to act on the patient's behalf.

Patient Specific: Any information that could be utilized to identify an exact patient.

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. *May also be referred to as Clinical Peer Review, Physician Review or 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 for a peer-to-peer discussion. *Formerly referred to as Reconsideration*.

Physician Advisor: A licensed Doctor of Medicine, osteopathy, chiropractic, or dentistry or a clinical psychologist employed by or under contract with Luminare who is trained in Utilization Management and provides direct and consultative intervention in cases under review when indicated by the given criteria and upon referral from HCM professional staff. *May also be referred to as a Second Level Reviewer or Clinical Peer.*

Plain Language: Communication that uses short words and sentences, common terms instead of (medical) jargon, and focuses on the essential information recipients need to understand.

Plan Document: The documentation of the health benefit plan requirements. May also be known as a Summary Plan Document (SPD), Insurance Policy or a Certificate of Coverage.

Preauthorization: The process of requesting medical necessity review for a proposed treatment or services as required by the applicable health benefit plan.

Predetermination: The process of reviewing a request to determine if a proposed treatment of service would be a covered expense by the applicable heath benefit plan.

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 actions (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 dialog; (5) asking clinical follow-up questions; and (6) issuing non-certification.

Primary Physician: A 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 a non-certification determination ("lack of medical necessity" is not sufficient).

Prospective Review: Utilization Management conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient procedures and services). *May also be referred to as a First Level Review, Pre-Certification Review or Initial Clinical Review.*

Protected Health Information (PHI): Encompasses all individually identifiable health information (IIHI) maintained by a covered entity, regardless of form.

Personally Identifiable Information (PII): Information that can be used on its own or with other information to identify, contact, or locate a single person, or to identify an individual in context.

Provider: A licensed healthcare facility, physician or other healthcare individual or organization that delivers and/or provides healthcare services.

Quality Improvement Project: An initiative to measure and improve the service provided. May be department or organization wide.

Quality Criteria Indicator: Written objective and measurable standards of performance to be met. *May also be referred to as Expectations.*

Quality Program: A structured program which monitors and evaluates the quality and effectiveness of the Luminare policies, procedures and practices and provides appropriate intervention, as needed, to support compliance with these standards. A systematic data-driven effort to measure and improve customer/client and healthcare services.

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

Retrospective: The term for Utilization Management processes conducted where the healthcare service has been completed before the review request is received.

Review Date: The date a HCM policy & procedure is reviewed by members of the applicable policy & procedure committee.

Revision Date: The HCM policy & procedure revision/change has been reviewed and approved by members of the applicable policy & procedure committee.

Second Level Grievance: An appeal request for a review of a non-certification decision that was upheld at the time of third level HCM review. The second level internal HCM appeal review is conducted by a panel of three physician advisors independent of the physicians involved in the preceding non-certification decisions. *May also be referred to as a Panel Appeal, or Second Level Internal Appeal.*

Second Level Internal Appeal: An appeal request for a review of a non-certification decision that was upheld at the time of third level HCM review. The second level internal HCM appeal review is conducted by a panel of three physician advisors independent of the physicians involved in the preceding non-certification decisions. *May also be referred to as a Panel Appeal, or Second Level Grievance.*

Second Level Review: Clinical review conducted by appropriate health professionals when a request for an admission, procedure or service was not approved during initial clinical review. May also be referred to as Clinical Peer Review, Physician Review or Peer Clinical Review

Second Level Reviewer: A licensed Doctor of Medicine, osteopathy, chiropractic, or dentistry or a clinical psychologist employed by or under contract with Luminare who is trained in Utilization Management and provides direct and consultative intervention in cases under review when indicated by the given criteria and upon referral from HCM professional staff. *May also be referred to as a Physician Advisor or Clinical Peer.*

Second Opinion: A requirement of some health benefit plans to obtain an opinion about the medical necessity of selected proposed services (usually surgical) by a practitioner other than the one originally making the treatment recommendation.

Service Indicators: A measurement of performance related to customer service compared to a pre-determined standard.

Single Employer Health Plan: A group health plan consisting of only one employer.

Situs: The state or jurisdiction where the corporate office of the group health plan is physically located.

Skilled Nursing Facility: An appropriately licensed institution, or a distinct part thereof, that provides inpatient confinement with twenty-four (24) hour skilled nursing/physical restoration services. May also referred to as *Extended Care Facility*.

Standard Appeal: An appeal request for a third level review of a non-certification decision for healthcare services that is not expedited. A physician advisor who was not involved in the original non-certification decision conducts the appeal review.

Statistically Valid: Based on acceptable statistical principles and techniques.

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

Third Level Review: A clinical review conducted by appropriate clinical peers, who were not involved in the peer clinical review, when the decision not to certify a requested admission, procedure, or services has been rendered and an appeal has been requested. *May also be referred to as an Appeal Process.*

Urgent Care Request: Any certification request identified as Urgent, including a Utilization Management determination request in which:

- The request is determined to be an urgent request by a health care professional with knowledge of the covered person's medical condition;
- The application of the non-urgent care determination timeframes could seriously jeopardize the life or health of the patient or effect the patient's ability to regain maximum function;
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot adequately be managed without the care or treatment under review;
- For Outpatient services where the request is part of a transition of care (e.g., leaving a hospital or other facility to go home);
- A request for services made while the member is in the process of receiving the care, associated with inpatient care.

Utilization Management/Clinical Review: Evaluation of the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the provisions of the applicable health benefit plan; sometimes referred to a "utilization review."

Variance: A deviation, discrepancy, or variable from the norm, standard or process that may or may not result in a negative impact (adverse event) on the consumer.

Working Day: Also known as Working Day. Any day the Luminare Healthcare Management Department is open for operation. This is Monday through Friday, excluding holidays or weather emergencies. When the information necessary to initiate a process is received after two (2) PM Eastern Time, the next full business day will be counted as the date received. The current Luminare HCM Operational Site business day hours of operation are:

Lancaster, PA – 8:00 AM – 8:00 PM Eastern Standard Time

Written Agreement: A document that specifies the terms of the relationship between Luminare Healthcare Management and a client, customer, or contractor. This includes electronic documents.

Written Notification: Correspondence transmitted by mail, facsimile, or electronic medium.

Acronyms

AA: Administrative Assistant

CM: Case Management

CMMC: HCM Claims Medical Management Coordinator

DOL: Department of Labor

EDI: Electronic Data Interchange

EMID: External Member Identifier

EPO: Exclusive Provider Organization

HCM: Healthcare Management

HCMA: Healthcare Management Assistant

HIPAA: Health Insurance Portability and Accountability Act

IIHI: Individually Identifiable Health Information

IC: Intake Coordinator

ICM: Individual Case Management

IPR: Individual Performance Review

IRO: Independent Review Organization

LCM: Large Case Management

MEWA: Multiple Employer Welfare Arrangement

NCM: Nurse Care Manager (Utilization Management)

NPI: National Provider Identifier

PCP: Primary Care Physician

PHI: Protected Health Information

PII: Personally Identifiable Information

PLCM: Potential Large Case Management Alert

PPO: Preferred Provider Organization

PRA: Private Review Agent

QM: Quality Management

QIP: Quality Improvement Project

RNCM: Registered Nurse Care Manager (Case Management, Physician Review, Quality Management, or Utilization Management)

LH: Luminare

UM: Utilization Management

UMA: Utilization Management Assistant

UMC: Utilization Management Coordinator

UMID: Unique Member Identifier

URO: Utilization Review Organization

B. Utilization Management Reporting

Utilization goals are established by identifying benchmarks approved by the Quality Management Oversight committee. Analysis of the information is conducted, and the results are evaluated for potential or actual trends and under or over utilization. Interventions to improve utilization are reported to the Quality Management Committee for recommendations.

C. UM Program Staffing

Non-clinical Staff

Non-clinical staff process incoming calls, verify member eligibility, provide benefit contact information, and collect demographic information to assist in preparing requests for clinical review. The non-clinical staff do an initial screening evaluation to determine how to proceed with requests. Non-clinical staff do not conduct utilization review or evaluation/interpretation of clinical information during initial screening process. The non-clinical staff prepare requests for clinical review. Non-clinical personnel refer all requests that require clinical review to the appropriate clinical staff.
URAC UM 4-1 (a)(b), UM 5-1 (a)(b), UM 5-2 (a)(b)(c)

Clinical Staff

The Utilization Management Coordinators and Physician Review Nurses are licensed registered nurses (RN's) with active licenses having appropriate clinical experience. The Utilization Review and Physician Review Nurses utilize their medical knowledge and expertise to review requests for admissions, procedures, and services, as well as determine appropriate levels of care. The nurses approve requests that meet applicable clinical review criteria, medical policy, and established Medical Director Review Guidelines. Additionally, appropriate length of stay is determined by the clinical staff utilizing established clinical criteria. The Utilization review nurses do not issue adverse determinations. In situations where medical necessity determinations cannot be approved the Utilization Review and Physician Review RN's prepare

submission of the clinical request for Physician Review. HCM utilizes contracted, URAC certified IRO entities.
URAC UM 1-1 (a)

D. Clinical Review Criteria

Utilization Management Coordinators utilize MCG care guidelines, NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines), Clinical Policy Bulletins Guidelines, Trilogy and Medical Policy & Guidelines to determine the following: Medical necessity of the requested care; Appropriateness of the location and level of care; Appropriateness of the length of stay; and Assignment of the next anticipated review point. The American Society of Addiction Medicine® (ASAM) criteria is used for substance use services according to state requirements.

Requests that do not meet MCG care guidelines, NCCN guidelines, HCM Medical Policy, ASAM guidelines and/or potential contract exclusions are referred to IRO physician reviewers for determination.
URAC UM 1-1 (a)

1. MCG Care Guidelines

MCG care guidelines are nationally recognized clinical criteria utilized to screen and evaluate medical necessity and appropriateness of services. MCG care guidelines provide unbiased evidenced based standards that afford patient-centered care decisions. The guidelines are explicitly written and created by practicing clinicians and based on current clinical practices, principles, and processes. MCG care guidelines are evidence-based and developed from unbiased review of professional literature and data. The guidelines help direct the most efficient use of care resources which in turn, improve clinical and financial outcomes.
URAC UM 2-1 (a)(b)

The application of the MCG care guidelines by Utilization Management Coordinators and/or Physician Reviewers facilitates collection of the pertinent information required to authorize the requested medical/surgical procedure, treatment and/or admission, and to determine length of stay (LOS) and/or frequency and duration of services requested, as well as the appropriateness of the setting. MCG care guidelines are evaluated annually or earlier if new data regarding indications or technologies become available.
URAC UM 2-1 (c)

The following MCG Criteria Guidelines are utilized:

- Acute Adult and Pediatric Criteria
- Inpatient and Surgical Care
- General Recovery Care
- Recovery Facility Care
- Home Care
- Chronic Care
- Behavioral Health Criteria

2. Medical Director Policies

Review personnel use current written HealthCare Management Medical Director Policies to assist with benefits determination regarding specific medical procedures, medical devices and specified surgical procedures in addition to support or in place of MCG criteria. These guidelines are reviewed and approved by the Healthcare Management Medical director.
URAC UM 2-1 (a)(b)(c)

E. Utilization Management Process

Utilization management personnel are available to members and providers from 8:00am to 8:00pm Monday through Friday, eastern standard time (EST). Confidential voicemail is available after hours and during legal observed holidays when the departments is closed. UM personnel will address any voicemail within 1 business day. All service requests will be reviewed and processed based on timeframes and defined by urgency, legal and regulatory requirements.

Service requests, Inpatient admissions, outpatient services (based on specific plan requirements), request for care in alternative settings, behavioral health requests and transplants are reviewed through the utilization review process and appropriately licensed personnel. Non-clinical staff may complete requests that meet automated or defined Medical Director established requirements having no clinical decision-making task.

Utilization Management Nurses and Physician Review nurses utilize applicable care guidelines/criteria and internal Medical Director Guidelines to determine medical necessity of services, appropriate service location, appropriate level of care, service location and length of stay, as well as the interval for the next anticipated review timeline. Review turn-around-times and determination notification timeframes are dictated by review type (prospective, concurrent, or retrospective) and request urgency (urgent and non-urgent) *See definition section of program overview above*. Review determination and notification timeframes are also specified by plan product type and state and regulatory established timeframes.

Clinical staff review submitted documentation submitted from a reliable source: Physician documentation, medical office notes, facility reports, diagnostic and testing results, behavioral health documentation and medical records. This information is generally received with the request. In cases where there is insufficient information to proceed with the request, the clinical staff will request additional information to support the medical necessity review. When clinical information is provided within the allotted timeframe, a determination will be provided in the applicable timeframe. Again, Review determination and notification timeframes are also specified by plan product type and state and regulatory established timeframes.

Utilization Review staff do not issue non-authorization (denials/adverse determinations) based on the clinical review. Requests that do not meet applicable review criteria or are potential plan exclusions are referred to a URAC accredited independent review

organization for physician review. The HMC UM staff communicate with the IRO in order to provide appropriate request determination turnaround timeframes that allow the provider to perform peer review function as needed.

Physician Review Nurses and Utilization Management Nurses may communicate all non-certification decisions. Notification of non-certifications are communicated in writing to the member or individual acting on behalf of the member (medical care providers and facilities offering the care to the member). Members have the right to an appeal for any adverse determinations, as detailed by the member's benefit plan. Adverse determinations are solely determined by a physician or other health care provider with appropriate credentials to determine medical necessity, the appropriateness of care and/or if the care is determined to be experimental or investigational in nature.
URAC UM 1-1 (a), UM 6-2 (a)(b), UM 11-1 (a)(b), UM 12-1 (a)(b)(c)(d), UM 12-2 (a)(b)(c), UM 12-3 (a)(b), UM 12-4 (a)(b)(c)(d), UM 12-5 (a)(b)(c)

1. **Electronic Review and Automated Web Platform Requests**

   HCM provides access to its review staff Monday through Friday 8:00am to 7:00pm Monday through Friday and provides a mechanism for receiving and/or redirecting after hours calls or electronic data exchange. Providers may leave information in after business hours voicemail or may elect to utilize an automated web platform (portal submission) to submit authorization request. This automated system is available for notification of referrals, admissions, and services twenty-four (24) hours a day, seven (7) days a week.

   The purpose of electronic review and automated web platform submission requests is to provide access during both business and non-business hours.
   URAC UM 1-1 (a)(b)

2. **Care Collaboration/Discharge Planning**

   HCM nurses and staff assess discharge needs, including alternative levels of care for all cases where certification review is performed. This is done to facilitate continuity of care and to assist in determining the frequency of certification review. The reviewers will assess all available information for potential discharge opportunities at each stage of the certification review by utilizing MCG care criteria tool.

   In cases where discharge planning recommended by the attending physician or ordering provider is questionable for medical necessity or cases where the level of care does not meet designated review criteria, the review request will be sent to Physician Review.
   URAC UM 1-1 (a)

   Appeals

   For insurers and health plans utilizing precertification medical necessity reviews by the Healthcare Management Division (HCM), HCM provides an initial 1st

level appeal process when non-certification of medical necessity through physician review determinations.

The Utilization Review Nurse and/or Physician Review Nurse will provide the member (or their authorized representative), the treating/ordering physician or the service provider the opportunity to submit written comments, documents or records and any additional information relating to the case.

When mandated by state regulation and/or a client electing precertification medical necessity review by the Healthcare Management Division, a second level appeal process may be used when a non-certification of medical necessity has been upheld at the first level of appeal. Plan specifics apply for the second level appeal.

HCM utilizes URAC accredited Independent Review Organizations (IROs) as a subcontracted vendor to perform physician review, appeals and peer review. Each IRO is an independent entity maintaining their own URAC certifications and employ health care professionals who are clinical peers having unrestricted licenses, practicing in a state or territory of the United States. The reviewer has the same profession or scope of licensure as the requesting provider and who hold a current license.

Timeframes for appeals and communication of the outcomes are based on mandated notifications and timeframes. Appeals are determined and based on requested urgency of care as well as individual plan language or specifications.
URAC UM 1-1 (a), UM 14-1 (a)(b)(c), UM 14-2 (a)(b)(c), UM 14-3 (a)(b)(c), UM 16-1 (a)(b)(c), UM 16-2 (a)(b)(c)(d)

3. Consumer Complaints

The Healthcare Management (HCM) Division monitors complaints concerning customer service related to the Utilization Management (UM) in order to provide customer satisfaction and in order to identify areas of improvement in HCM processes. HCM monitors complaints from external customers or consumers including clients, members, providers, facilities, and anyone else acting on behalf of the member.

Every HCM staff member attempts complaint resolution with the complainant within the parameters of their job description. HCM employees will document and attempt to resolve the complaint.

Consumer complaints falling outside of UM medical necessity determinations and UM appeals processes will be referred to Quality Management and will follow applicable quality program processes.
URAC UM 1-1 (a)

F. Conflict of Interest

HCM has an established policy and procedure regarding Conflict of Interest. Conflict of

Interest is defined as any relationship or affiliation on the part of the staff or reviewers that could compromise the independent or objectivity of the HCM process. HCM has an established mechanism to ensure decisions are not influenced by any conflict of interest. HCM staff members receive training on conflict of interest upon hire and annually thereafter.

G. Delegation of Review

HCM elects to have reviews that do not meet MCG care criteria, plan coverage exclusions and internal review guidelines, as well as appeals and reconsiderations of adverse determinations reviewed by an external Independent Review Organization (IRO). For all delegated UM activities, the external IRO must comply with the program standards, federal and state laws, regulatory and accrediting agencies.

Externally reviewed care service and care reviews are subject to internal quality review conducted by the HCM Medical Director or his/her designee.
URAC UM 1-1 (a)

VII. Confidentiality

HCM has established policies and procedures to ensure the confidentiality of patient Information. All employees have a responsibility to keep member information confidential in accordance with applicable federal and state laws. Confidentiality is outlined in the Healthcare Management Division Policy Manual. All staff also participate in Health Insurance Portability and Accountability Act (HIPAA) training. Employees receive training upon hire and must also sign a Confidentiality statement during orientation and annually thereafter.

VIII. The Role of Quality Management (QM) in the UM Program

The Healthcare Management (HCM) maintains a Quality Management (QM) program. The QM program evaluates and ensures the quality of services provided to both internal and external consumers. The QM program involves all team members, the Healthcare Management Division and all other divisions when applicable.

The quality program assists in maintaining industry accreditation standards of regulatory entities, promotes consumer satisfaction and provides staff and employees with resources to support a quality UM program. Oversight of the quality program is provided by the Quality Management Committee. Additionally, the QM Committee provides an annual review of the UM program.

The Quality Management Committee is overseen by a senior level management member and meets at least quarterly with the Medical Director and requires at least fifty percent of the committee members in attendance. The committee members are HCM employees and therefore subject to the mandatory confidentiality agreement, corporate compliance, and conflict of interest attestation requirements. Other HCM staff may be invited to attend at the discretion of the QM committee.

The QM committee provides oversight to the quality program, is accountable for mandatory reporting, reviews and approves all quality improvement projects, evaluates the effectiveness of the quality program, and provides guidance to the staff on quality management priorities and

projects.
URAC UM 1-1 (a)(c)(e)

IX. Training, Education, and Performance

HCM provides initial orientation to new hires prior to assuming any position as well as facilitates educational opportunities for development of professional competence. UM personnel are educated in current policies, procedures, and role functions.

HCM encourages professional development through specialty certification (e.g. MCG certification) in order to assist the staff with expertise in their area of operation.

All staff receive an annual job performance evaluation and quarterly check-ins with their supervisors. The quarterly meetings between staff and their supervisors provide an opportunity to evaluate goal progression and explore key areas of accountability. Additionally, Quality Management perform audits for staff whose job include use of criteria or use of guidelines. Quality Management staff will also verify licensure and certification status of all professional staff as required by their job description.
URAC UM 1-1 (a)

X. Annual Evaluation

The Medical Director leads the development and evaluation of the HCM UM program. The success of the HCM UM program is reviewed annually in the Quality Management Oversight Committee. The program is approved by the committee, chaired by the Medical Director and the Chief Medical Officer.
URAC UM 1-1 (c)(d)(e)

Policy Revision and Review History		
Date	**By**	**Summary**
5/16/23	QM Specialist, MSpriet BSN, RN	2023-01: Updated Item D, adding ASAM Criteria & Item D1, adding MCG Criteria Guidelines in current practice
5/19/23	HCM QM Committee	2023-02: Approval and implementation of 2023-01 updates
10/13/23	QM Specialist, MMSpriet BSN, RN	2023-03: Update to reflect organizational name change from Trustmark Health Benefits, Inc., to Luminare Health Benefits, Inc.
10/31/23	HCM QM Committee	2023-04: Approval and implementation of 2023-03.
4/4/24	QM Specialist, MMSpriet BSN, RN & JFirestone MSN, RN	2024-01: Updated the year and URAC Tagging 8.0
4/4/24	HCM QM Committee: Executive Approval	2024-02: Approval and implementation of 2024-01.