Paramount Care, Inc.
Paramount Care of Michigan, Inc.
Paramount Insurance Company
Ohio Benefit Administrators

UTILIZATION MANAGEMENT

PROGRAM DESCRIPTION

2024

2024 Utilization Management Program Description

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UTILIZATION MANAGEMENT PROGRAM OVERVIEW

Paramount's Utilization Management Program is designed to enhance the members' experience of care, ensuring the delivery of high-quality, cost-efficient care, in alignment with the Institute for Healthcare Improvement (IHI) Quadruple Aim.

The UM program is comprised of policies, procedures and workflows focusing on the prompt review of member and provider requests for services and/or items which require determination based on member eligibility, benefit and medical policy coverage and review of medical necessity.

The program is under the administrative and clinical direction of the Chief Medical Officer of Health Services and the Quality Oversight Committee. The Associate Clinical Director of Behavioral Health (doctoral level clinical psychologist) has substantial involvement in the implementation of the behavioral health care aspects of the program. The UM leadership team is responsible for an annual review of the program description, including policies and procedures, and ensuring revisions are made to reflect any regulatory and/or process changes. The Quality Oversight Committee then evaluates and approves the Utilization Management Program.

GOALS AND OBJECTIVES

Utilization Management is performed to ensure an effective and efficient medical and behavioral health care delivery system. It is designed to evaluate the cost and quality of medical services provided by participating physicians, facilities, and other ancillary providers. The goal of utilization management is to ensure appropriate utilization, which includes evaluation of both potential over and underutilization.

The purpose of the utilization management program is to achieve the following objectives for all members:

- To ensure effective and efficient utilization of facilities and services through an ongoing monitoring and educational program. The program is designed to identify patterns of utilization, such as overutilization, underutilization.
- To ensure fair and consistent application of review criteria for Utilization Management decision-making. To focus resources on a timely resolution of identified problems.
- To assist in the promotion and maintenance of optimally attainable quality of care.
- To educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.
- To ensure transition of care is addressed as members move through the healthcare continuum.

Paramount works cooperatively with its participating providers to ensure appropriate management of all aspects of the members' health care.

The desired goals of the Utilization Management program are:

- Treatment of the member in the least restrictive setting and manner.
- Promote member and provider satisfaction.
- Support for the Primary Care Provider (PCP).
- Utilization of participating providers.
- Promote optimal use of available benefits.
- Reduction of inappropriate/preventable hospital admissions/readmissions and emergency room utilization for ambulatory-sensitive reasons.

DEPARTMENTAL ORGANIZATION

Utilization management staffing is comprised of a multi-disciplinary team, collaborating to deliver a comprehensive, integrated approach with roles and responsibilities of team members delineated to prevent duplication of activities. These professionals include registered nurses, licensed practical nurses, mental health/chemical dependency professionals (nurses and licensed social workers), social worker assistant, and support staff. Staffing is organized by service performed to maximize efficiency and cross training of staff.

Analysis is done to monitor work queues, distribution of assignments, and internal audits to ensure top of licensure work, adherence with documentation and alignment with regulatory standards. Adjustments can be made to work queues in real time to improve response times and productivity.

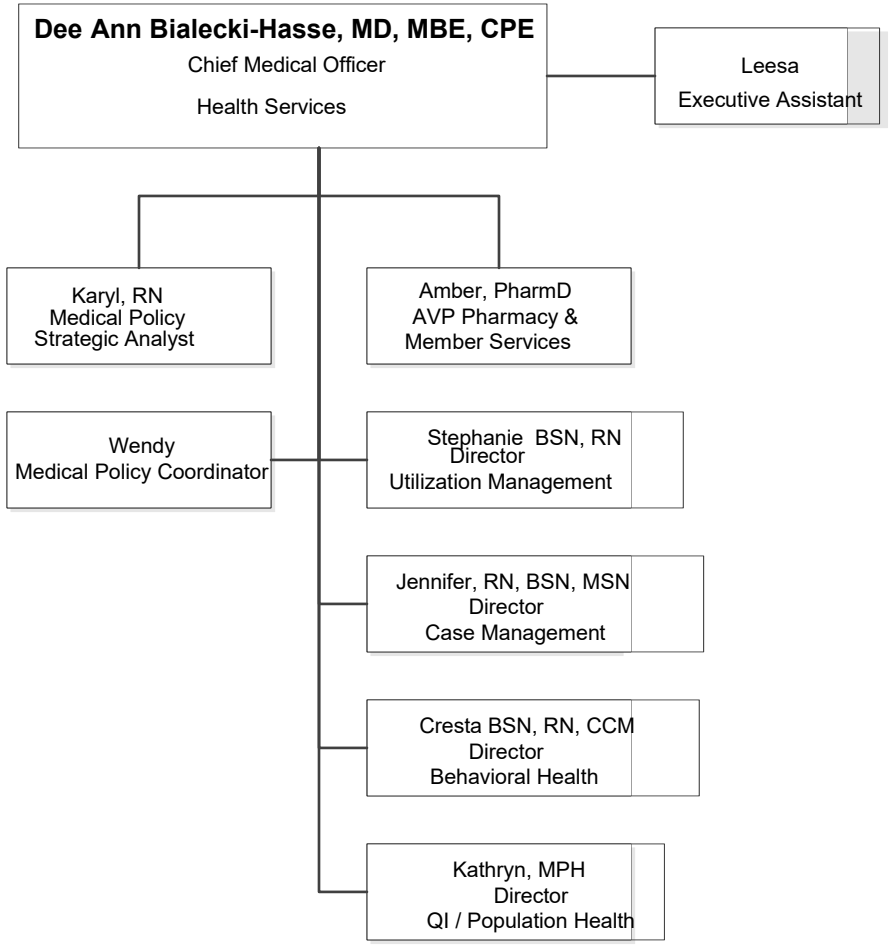
The department consists of the Chief Medical Officer, Director of Utilization, Director of Behavioral Health, Behavioral Health UM/CM Manager, UM Clinical Manager, Quality Assurance Associate, RN Appeals Coordinators, UM Coordinators, UM Project Coordinator, UM Team Leads, Utilization/Assistant Coordinators, UM Staff Development Educator, as well as Utilization Management Department Support Coordinators.

The Pharmacy Team collaborates within the structure of the care management department. This team has an AVP of Pharmacy, Pharmacists, Pharmacy Team Leader, Pharmacy Administrative Coordinator, Clinical Pharmacy Coordinators, and Pharmacy Utilization Nurse Coordinators.

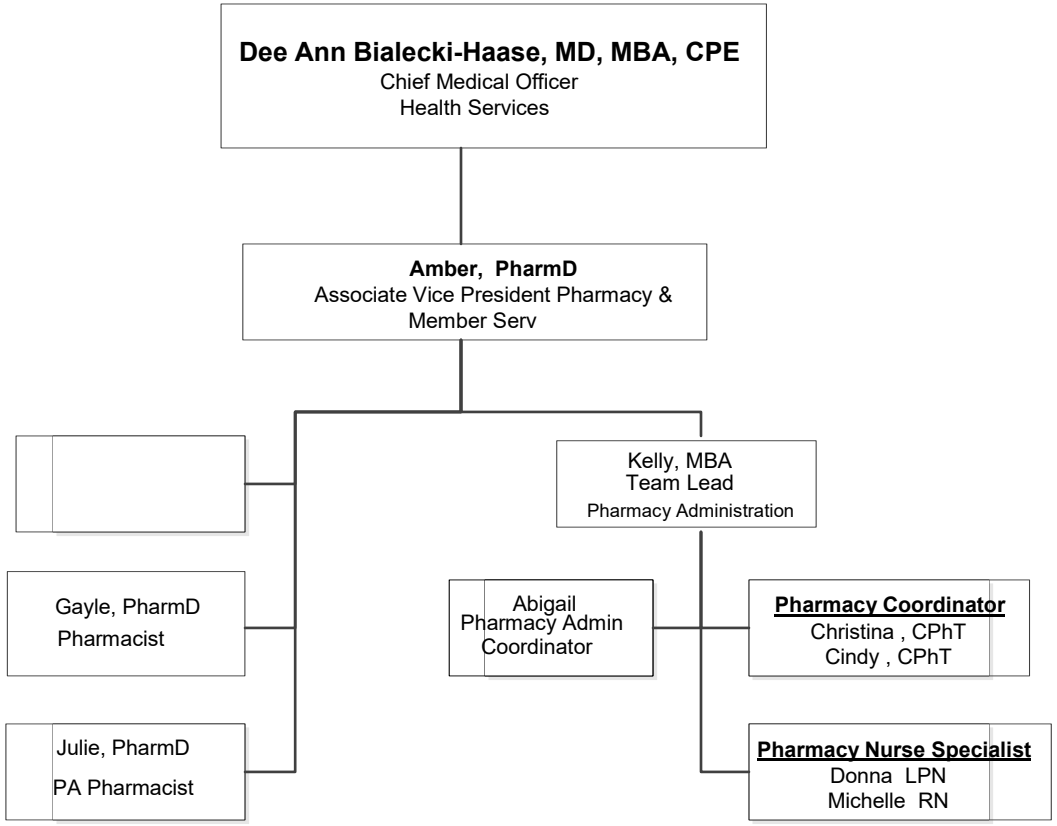
The Directors and Managers collaborate to provide leadership and oversight to the entire Paramount Health Services Program.

The departmental organizational charts are illustrated on the following pages:

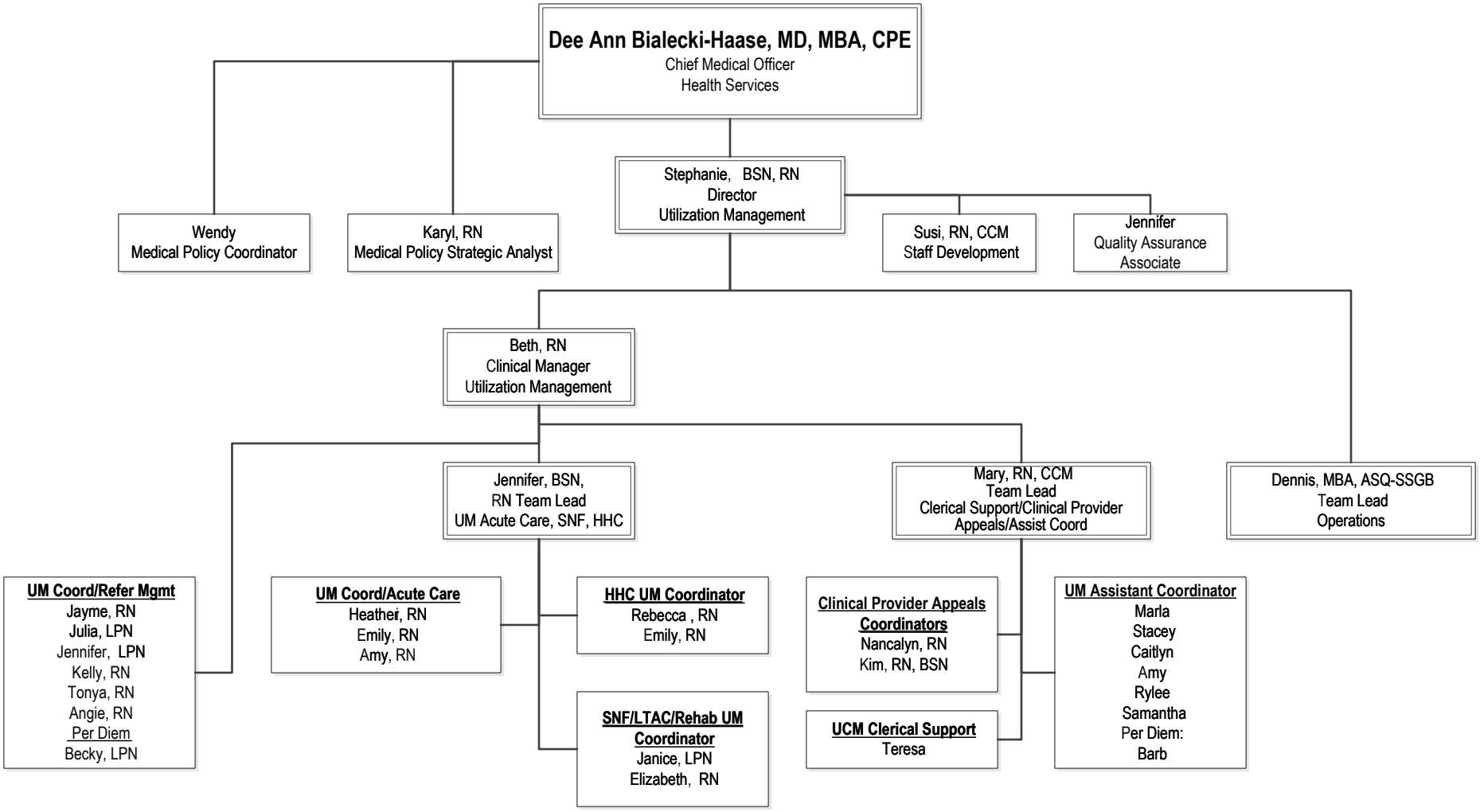
PARAMOUNT
HEALTH SERVICES
Chief Medical Officer / Direct Reports
January 2024



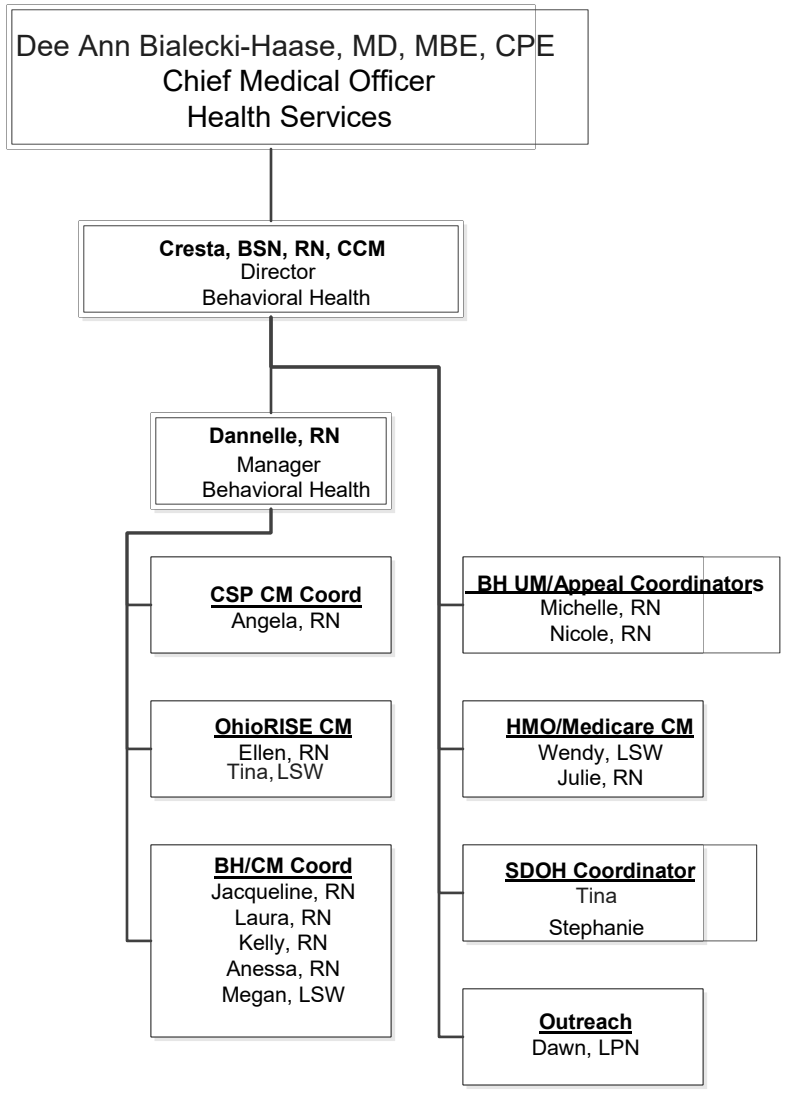
PARAMOUNT
HEALTH SERVICES
PHARMACY SERVICES
December 2023



PARAMOUNT
HEALTH SERVICES
Utilization Management
January 2024



PARAMOUNT
HEALTH SERVICES
Behavioral Health
December 2023



Per Diem:
BH Assst. Coordinator

Christine

Chief Medical Officer / Health Services

The Chief Medical Officer is a licensed physician whose accountability objective is to provide oversight and manage the Pharmacy, Utilization, Case Management, Quality Improvement and Disease/Condition Management departments; to provide strategic planning, operational oversight, and financial/clinical integration; to support and advance organizational goals and outcomes. The Chief Medical Officer also provides determinations for cases which do not appear to meet the Plan's guidelines and criteria to ensure members receive the most appropriate care in the most cost- effective setting.

Director, Behavioral Health

The Director of Behavioral Health is a registered nurse with case management certification. The director's primary objective is to provide guidance in the development and implementation of Paramount's behavioral health utilization management (UM), and case management (CM) programs. This position provides overall leadership and oversight to the Paramount Behavioral Health Programs. This position strives to foster and maintain relationships with key community advocacy groups as well as state and federal entities to progress organizational initiatives, strategic business development and bring the voice of the community to internal processes and procedures to improve the health and well-being of our members.

Director, Utilization Management

The Director of Utilization Management is a registered nurse whose accountability objective is to lead utilization management to ensure coordinated delivery of high quality, safe, medically necessary, cost-effective, and integrated health care, as well as safe transitions of care to all Paramount members; facilitating oversight of delegated clinical utilization functions; and ensures member and provider satisfaction with health care.

AVP of Pharmacy

The AVP of Pharmacy is responsible for coordinating and monitoring all aspects of the pharmacy program for Paramount members. Responsibilities include oversight of the daily pharmacy program operations, contracted Pharmacy Benefits Manager (PBM), the utilization management of prescription drugs, oversight of any groups delegated to provide a pharmacy program as well as providing clinical support to the care management team and other departments.

Manager, Behavioral Health Utilization / Care Management

The Behavioral Health Utilization/Care Management Manager is a registered nurse or social worker; Certified Case Manager, whose responsibilities include developing operational and administrative policies, procedures, standards, and objectives for care management. In addition, this position acts as an interdepartmental liaison to ensure prompt resolution of behavioral health care management and utilization management issues, questions and adherence with the Ohio Department of Medicaid and the Center for Medicare & Medicaid Services regulatory requirements relative to utilization and care management.

Clinical Manager, Utilization Management

A working Manager who serves as an operations and clinical resource, and is responsible, for staff supervision and day-to-day operations of the prior authorization, referral management, transplant, genetics, acute care/post-acute care utilization management, provider appeals, claims, and operational compliance functions. Acts as interdepartmental liaison to coordinate and implement team, department, business unit, and corporate objectives, projects, and initiatives.

Pharmacist

The Pharmacists are registered pharmacists (typically a Doctor of Pharmacy) whose accountability objectives are to promote the clinically appropriate use of pharmaceuticals and to ensure the optimal performance of the Pharmacy Benefit Management (PBM) utilized by Paramount. He/she also provides systematic and relevant feedback to Paramount administration regarding pharmacy spends and trend patterns. Review of drug utilization reports, Formulary compliance reporting, and production of member and/or physician communication pieces are additional responsibilities.

UM Educator

The Utilization Management Educator is a registered nurse whose accountability includes development of assessment, planning, implementation, and evaluation of orientation/training, educational presentations, in-services, auditing of new hires. This position is involved in system testing and assists in root cause analysis. The UM Educator prepares and updates training manuals, workflows and other educational materials on an ongoing basis or as critical changes occur.

Acute Care / Post-Acute Care Utilization Management Team Leader

The Utilization Management Team Leader is a registered nurse whose accountability objective is to serve as a clinical resource, provide staff supervision, and support the day-to-day operations of the acute care, post-acute/HHC care utilization management team. The working team leader acts as an interdepartmental liaison to ensure prompt resolution of utilization management issues, questions, and concerns.

Clinical Appeals and Support Staff Team Leader

The Clinical Appeals Coordinator and Support Staff Team Leader is a registered nurse whose accountability objective is to serve as a clinical resource, provide staff supervision, and support the day-to-day operations, and workflow for the clinical appeal coordinator staff responsible for provider appeals. This position supports the UM Manager/ Director in implementation of new processes and workflows for provider appeals. This working team leader also serves as a clerical resource and is responsible for supervision and coordination of the day-to- day operations for the support staff team. Act as an interdepartmental liaison to ensure departmental operational efficiencies and regulatory compliance are met.

Care Management Operations Team Leader

The Care Management Operations Team Lead has the responsibility and oversight for the coordination and design of long and short-term Utilization and Case Management departmental projects, data analytics, and process improvement initiatives as related to Plan goals and objective.

Pharmacy Administrative Team Lead

The Pharmacy Administrative Team Lead is responsible for supporting the Associate Vice President of Pharmacy in effectuation of department goals, tasks, and initiatives in non-clinical pharmacy projects, as well as provide leadership to Pharmacy Administrative Coordinators, and Pharmacy utilization management Staff and the operations of the pharmacy utilization management processes. This team leader acts as an interdepartmental liaison for projects involving pharmacy benefits and design, financial analysis, delegation oversight, regulatory compliance, and electronic capabilities.

Quality Assurance Associate

The Quality Assurance Associate coordinates and performs onsite compliance and UM quality assurance/competency reviews, informal reviews, desk reviews, data analysis, and report processes to agencies; CMS, ODM, NCQA, ODI, etc. The position communicates with agencies regarding deadlines, services, audit results, reviews, or clarification and follow-up of submissions under review. The Quality Assurance Associate performs UM audits for delegated entities and directs the preparation of additional information or responses as requested by agencies.

Utilization Management Coordinator

The UM Coordinator reviews submitted clinical information for prior authorization requests, acute care initial, concurrent and post-discharge, LTAC, SNF, rehab, home health authorizations, and outpatient/ambulatory services. Assist with transition of care needs including referrals to case management, behavioral health, population health, and disease management.

Provider Appeals Clinical Coordinator

The Provider Appeals, Clinical Coordinator will be responsible for the coordination, workflow, clinical review for readmission and provider appeals received at the plan. The appeals coordinator completes air ambulance medical necessity reviews. Supporting Manager / Director in implementation of new processes and workflow for provider clinical authorization appeals. Support Medicare, Medicaid, NQCA, ODI and other regulatory guidance as assigned. Process provider appeals based on the request from the provider as indicated on the Clinical Appeals Form. Uphold regulatory compliance and contractual regulations regarding timely filing appeal submissions. Work collaboratively with Claims, Provider Relations, Member Appeals, Provider Contracting, Compliance or other departments to ensure appeal processed timely and in accordance with regulatory requirements.

Behavioral Health Utilization Management Coordinator

The Behavioral Health Coordinator is a registered nurse, licensed social worker or licensed independent social worker who ensures that Paramount members receive the right amount of treatment in line with evidence-based criteria at the right time while completing preadmission, concurrent and retrospective review for inpatient and outpatient services and identify high-risk members who have complex case management needs due to mental health and substance dependency issues. In addition, the UM coordinator will assist in discharge planning and transition of care activities along the continuum of care.

Coordinated Service Program Coordinator

The Coordinated Service Program (CSP) Coordinator is a registered nurse, licensed social worker or licensed independent social worker whose principal responsibly is to maintain quality of care and improve the safety of Medicaid members by monitoring the use of health care services and prescription medication dispensing patterns, taking the necessary action to coordinate medical and pharmacy services in accordance with regulatory requirements. The CSP Coordinator monitors member’s activity to avoid duplication of services, inappropriate or unnecessary utilization of medical services, fraud, and excessive use of prescribed medications.

Utilization Management Assistant Coordinator

The Utilization Management Assistant Coordinator reviews, evaluates, and enter administrative authorizations for specific acute hospital, home health care admissions or specified prior authorization requests, including authorization data entry and related recordkeeping/documentation and ensures department regulatory compliance. Other duties include providing telephone queue line coverage with triage of calls to the appropriate UM team member and/or appropriate Paramount department; identifies members for potential care management.

Behavioral Health Assistant Coordinator

The Behavioral Health Assistant Coordinator supports the behavioral health team by completing data entry of authorizations and related record keeping and/or follow up, uploads documentation into the appropriate software application. In addition, the Behavioral Health Assistant Coordinator will outreach to providers and request current additional supporting clinical information. Other duties include providing telephone queue line coverage with triage of incoming calls prior to transfer to the appropriate behavioral health team member as well as preparing, sending and receiving mailings.

Pharmacy Administrative Coordinators

The Pharmacy Administrative Coordinators assist with pharmacy-related data collection, review, and quality improvement processes within the Pharmacy area. Other duties include web-page maintenance and issue resolution assistance to other departments.

Pharmacy Nurse Specialists

The Pharmacy Nurse Specialists are registered nurses or licensed practical nurses whose accountability objective is to conduct the review process for Pharmacy prior authorization of specialty medications and craft denial letters for these requests as appropriate. This position acts as a referral source of potential cases for case management.

Pharmacy Coordinators

The Pharmacy Coordinators are certified medical assistants and/or pharmacy technicians whose accountability objective is to conduct the review process for Pharmacy prior authorization, including non-formulary, quantity limit, clinical prior authorizations, and step therapy requests. This position acts as a referral source of potential cases for case management.

Utilization / Case Management Clerical Support

The Utilization/Case Management Departmental Support Staff's accountability objective is to provide administrative, clerical support for the UM/CM Department by coordinating the distribution of the incoming daily UM/CM requests, managing daily inpatient reports and sorting, filing, faxing, organizing/mailing material to providers and members of all Paramount product lines.

Associate Medical Director/Associate Clinical Director of Behavioral Health

Associate Medical Directors are physician(s) who are board certified in his or her designated area of practice whose principle accountability is to provide guidance in the development and administration of the Plan's Utilization Management and Quality Improvement Programs. The Associate Clinical Director(s) of Behavioral Health is a doctoral level clinical psychologist whose principle accountability is to provide guidance in the development and administration of the Plan's Behavioral Health Program.

The Associate Medical Director/Associate Clinical Director of Behavioral Health also provide determinations for cases which do not appear to meet the Plan's guidelines and criteria to ensure members receive the most appropriate care in the most cost-effective setting. These physician(s)/ psychologist(s) also review and make recommendations regarding policies and procedures.

Subspecialist Consultants

The Plan maintains additional consulting arrangements for the purpose of case-specific review when the Medical Director or Associate Medical/Clinical Directors need a subspecialist's expertise. Formal arrangements have been made with a variety of subspecialist consultants in specialty areas including, but not limited to, allergy, cardiology/cardiology (EPS), cardiovascular surgery, dentistry, dermatology, endocrinology, gastroenterology, general surgery, hematology/oncology, neurology, neurosurgery, OB/GYN, ophthalmology, oral surgery, orthopedics, pathology, pediatric orthopedics and pulmonology, pediatric/adolescent psychiatry, physical medicine, plastic surgery, podiatry, psychiatry, radiology, retinology, vascular medicine, and vascular surgery. In addition, all members of the Medical Advisory Council are available for consultation with the Medical Director or Associate Medical/Clinical Director as needed.

DELEGATION OF UTILIZATION MANAGEMENT

Delegation occurs when Paramount gives another organization the decision-making authority to perform a function that we would otherwise do ourselves. It is a formal process, contractual, and consistent with the National Committee for Quality Assurance (NCQA) accreditation standards and the Ohio Department of Medicaid (ODM) and Centers of Medicare and Medicaid Services (CMS) regulations. Paramount does not delegate management of complaints, grievances and/or appeals. Paramount conducts pre-delegation reviews to ensure compliance and monitors delegated operations through mutually defined reporting and formal goal-based evaluations. An agreement specific to the function(s) delegated is mutually agreed upon and defines the parameters, responsibilities, and expectations of Paramount, including consequences of failure and/or inability to carry out these functions. The Delegation/Quality Oversight Committee(s) ensures proper management of any contracted delegates.

UTILIZATION CARE MANAGEMENT STRUCTURE

Paramount’s Utilization/Care Management Department maintains departmental policies and procedures. These policies and procedures are reviewed on an annual basis and updated on an as needed basis. The policies and procedures provide documentation of the framework of authority on which the Utilization/Care Management Program operates. The UM Coordinator is authorized to make decisions providing that he/she is operating within the framework described within these policies and procedures. The Utilization Management Coordinator is authorized to approve services based on established criteria. Paramount’s UM decisions are based upon appropriateness of care and service criteria as well as existence of coverage. UM staff and Associate Medical/Clinical Directors are not financially or otherwise compensated to encourage underutilization and/or adverse determinations. Appropriately licensed professional staff performs assigned UM functions.

The Chief Medical Officer, Associate Medical Directors, Clinical Psychologists or Pharmacists, as appropriate, are the only plan representatives with the authority to deny authorization for a service based on medical necessity/appropriateness. In addition, the Clinical Director of Behavioral Health Services (doctoral level clinical psychologist, psychiatrist, or certified addiction medicine specialist) has the authority to deny authorization for behavioral health care services based on medical necessity/appropriateness.

To avoid any conflict of interest and ensure impartiality in the decision-making process in relation to medical or behavioral health care determinations, the UM coordinator confirms the medical director reviewing the case is not the member's primary care provider nor an immediate partner.

Paramount is fully responsible for Behavioral Health services. To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal member outcomes. Outpatient behavioral health services are intended by the state to be provided by the community mental health and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) agencies. However, in the event services are not available on a timely basis, or the member chooses to use a provider outside of the community system, the Plan must arrange for services outside the community network. The Plan maintains an adequate provider panel from which the member may choose in these instances. Utilization management functions for behavioral health services follow the same processes as medical utilization management. This includes Out-of-Plan specialist referrals, tertiary care, and inpatient certification. A Licensed clinical Psychologist provide review determinations and oversight of utilization decisions. A listing of product specific prior authorization requirements can be found on the Paramount internet site. www.paramounthealthcare.com.

To eliminate the fragmentation that often occurs within an unmanaged health care delivery system, the Primary Care Provider (PCP) is encouraged to coordinate all aspects of a member's health care. Conversely, the member is responsible for coordinating his/her medical and behavioral health care through the Primary Care Provider. Although in-Plan specialist referrals are not required by Paramount for claim payment, members are encouraged to seek their PCP's advice before seeking specialist consultation and treatment.

The following provides an overview of the various activities within the Utilization Management (UM) Structure.

INPATIENT CERTIFICATION (applicable to both Medical and Behavioral Health)

To ensure all admissions are appropriate, based on medical necessity and/or clinical judgement and that the health care services are being provided in the most appropriate setting. The Plan reviews all hospital, long term acute care facility (LTAC), skilled nursing facility (SNF), substance use disorder (SUD) residential and inpatient rehabilitation admissions. We are notified of urgent and emergency admissions the first business day after the admission occurs. This review is received by telefax or portal from the Utilization Review Department at each facility. The review is conducted with in established turnaround times.

Pre-established medical necessity/appropriateness criteria are utilized to ensure consistency in the certification process. Upon determining an admission meets criteria, the UM Coordinator assigns a length of stay in anticipation of the concurrent review process. The admission continues to be reviewed at appropriate intervals until the member is medically appropriate for discharge to the next level of care or discharged to home with or without additional services required. The facility will be requested to provide updates to the discharge plan to allow care management involvement in the transition of care. Authorization of the admission includes all physician and ancillary services rendered during the inpatient stay. Excluded are those services that are not a covered benefit, such as convenience items.

The following methods of review are utilized:

- **Precertification -** a review and assessment of clinical information, and determination of medical necessity, completed prior to the member's admission to post-acute care facilities such as Skilled Nursing, Long Term Acute Care and Rehabilitation facilities. Acute hospital admissions do not require precertification by the Utilization Management (UM) coordinator, but rather clinical is to be submitted after stabilization. In certain instances, elective procedures such as bariatric surgery, reduction mammoplasty, orthognathic/maxillofacial surgery and potentially cosmetic surgery require prior authorization/approval of the procedure prior to the time of admission.

- **Post-Service Initial (Inpatient) -** a review received after a member has been admitted to an acute care hospital or a floor to SNF presumptive admission and is the first clinical submission received following the guidelines above.

- **Concurrent -** a review and assessment of clinical information for determination of medical necessity and is expected on the next review date assigned by the UM Coordinator at the time of the previous review. This occurs while a member is in the process of receiving the requested medical care of services.

- **Retrospective -** a review and assessment of clinical information for determination of medical necessity, completed after admission/services have been provided and received after expected first notification date.

Inpatient certification also encompasses the following:

- **Discharge Planning** - During precertification and/or concurrent review, the Utilization/Case Management Coordinators will identify ongoing, continuing care needs required after discharge. Collaboration occurs with facility staff and arrangements are made for these needs to be met through participating providers, e.g., skilled nursing and/or rehabilitation facilities, home health care, medical equipment and/or supplies.

- **Transition of Care** - The Utilization/Case Management Coordinators will effectively and comprehensively identify, assess, and assist high-risk members with transitions of care between settings to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The goal of this program is to ensure compliance with the discharge plan/required follow up care and to assist in the coordination of needed care/services**.** Telephonic, or written follow-up communication is conducted with identified at-risk members and/or their providers to ensure post discharge services have been provided. Utilization Management has a process for the identification and referral of high-risk members who may benefit from enrollment in Medical or Behavioral Health Case Management and/or Population Health.

- **Readmission** - Paramount Medical policy, PG0381, Hospital Readmissions, requires review of a subsequent admission to an acute, general, short term-hospital occurring within 30 days or timeframes based on provider contract language, of the date of discharge from the same acute, general, short-term hospital for the same, similar, or related diagnosis. Readmissions, depending on the member's product line, may result in the subsequent admission being combined with the initial/previous admission or a denial of the subsequent admission facility charges. For adverse determinations, facilities can request a Medical/Clinical Director peer- to-peer conference based on product line and regulatory guidelines. The facility also has appeal rights in which timely filing limits apply.

OUTPATIENT CERTIFICATION (applicable to both Medical and Behavioral Health)

Specified outpatient services are reviewed utilizing criteria developed by the Medical Policy Sub Work Group and/or the Med/Tech Pipeline Workgroup and approved by the Medical Advisory Council. Prior authorization is conducted for select outpatient procedures including behavioral health services, advanced imaging, home health care, genetic testing, specific self-injectable drugs, surgical procedures, and durable medical equipment to ensure appropriateness of the service, availability of coverage and medical necessity. A list of services requiring prior authorization can be found on Paramount's internet site: Paramount prior-authorization-list

- **Specialist Referrals**

  Paramount does not require In-Plan specialist referrals. Members are strongly encouraged to coordinate their specialist care with their Primary Care Provider. In-Plan specialists are responsible for communicating a treatment plan to the Primary Care Provider to ensure that the Primary Care Provider is aware of all aspects of the patient's care. Out-of-Plan providers are required to request prior authorization before services are rendered to provide Paramount the opportunity to evaluate whether In-Plan specialists are available.

- **Emergency Room Services**

  Paramount maintains an Emergency Health Services (POLICY # UCM-5) policy that defines the process for the provision of emergency care. Emergency Services are defined as treatment of a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

  a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy
  b. Serious impairment to bodily functions
  c. Serious dysfunction of any bodily organ or part

  Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition. The member is instructed to contact his/her Primary Care Provider after receiving **urgent** care services in any setting. The intent of this procedure is to allow the Primary Care Provider to coordinate any needed follow up care. Referrals are not required for payment of urgent care services received in an urgent care facility. Emergency room utilization is monitored, and members noted with a pattern of overuse/abuse are referred to Case Management for investigation and follow-up.

- **Tertiary Care Services**

  All referrals to Plan tertiary care centers are reviewed on an individual basis. The member's medical needs and the availability of the requested services within the non- tertiary care network are taken into consideration. Formal or informal consultation with a participating specialist, if available, is required prior to considering a referral for tertiary care services. The Plan Chief Medical Officer or Associate Medical/Clinical Directors take the participating specialist's recommendations for referral to a tertiary care center into consideration when he/she makes the determination. It is important to note that the member's Primary Care Provider should be notified of the referral.

- **Out-of-Plan Referrals**
  All requests for services outside the provider network are reviewed on an individual basis. Determinations are made based on the member's medical needs and the availability of the services within the network. Services available within the network are not approved outside the network except in cases where the patient's health care status could be negatively impacted by not approving the Out-of-Plan services or an in-plan provider is not available. The Plan's Chief Medical Officer or Clinical Directors make decisions of this nature. Specific guidelines are in place for UM Coordinators to approve certain out-of-Plan requests.

- **Diagnostic Imaging**
  Pre-established medical necessity/appropriateness criteria are utilized in the certification of some outpatient CT scans and MRI's, CTA of the coronary arteries, and MRA studies. Prior authorization is not required when the diagnostic imaging studies are done as part of an emergency room visit for an emergency medical condition, an observation stay or an authorized inpatient stay.

  Physician groups are reviewed annually for Imaging "Gold Card" status. This designation allows the ordering physician to bypass imaging medical necessity reviews when the study is done at a network facility.

UTILIZATION MANAGEMENT DECISION / NOTIFICATION TIMEFRAMES

Paramount procedures are developed to ensure decision and notification timeframes for all utilization management determinations, including standard and expedited requests. Paramount follows the most current ODM, CMS and NCQA guidelines. Where regulatory and accreditation bodies differ, Paramount uses the most restrictive timeframe to ensure compliance with all requirements.

UTILIZATION MANAGEMENT REPORTING SYSTEM

Product-line specific, high level, summary cost and utilization data are reviewed and analyzed routinely by multiple levels of UM leadership with focus on the following:

- Inpatient Admissions/Discharges/Readmissions/1,000
- Hospital outpatient services/1,000
- ED visits/1,000 (not resulting in admission)
- Primary Care visits/1,000
- Specialty Care visits/1,000
- Prescription Drug services

**Behavioral health data is included

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports can be reviewed. Reports are structured to be available on a patient/product specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting process, including but not limited to the above listing allows for identification of opportunities and implementation of process improvement strategies.

UTILIZATION MANAGEMENT PERFORMANCE MONITORING

The Utilization Management and the Quality Assurance Associate monitors the consistency of the UM staff in handling approval, denial and inpatient decisions and reports the results to the UM Management Team. Turnaround time of UM decisions, including verbal and written notification is also monitored. Staff auditing is performed on a regular basis to ensure compliance in accordance with ODM, CMS, and NCQA standards. Periodically, reviews are conducted by the Chief Medical Officer and Clinical Directors for the consistency of medically appropriate determinations. On an annual basis, UM Coordinators and Clinical Director Staff, performing InterQual® reviews in their daily job responsibilities or utilizing InterQual® criteria sets to review cases are given Interrater Reliability (IRR) tests specific to the InterQual® criteria they utilize to determine the consistency and competency of their decision-making. Telephone queue line statistics are tracked and reported to UM Management, specific to number of calls received, abandonment rate and average speed of answer. Additional monitoring of the Utilization Care Management Program is performed through comments from the Member Satisfaction Survey, the Physician and Office Manager Satisfaction Survey.

ACCESS TO UTILIZATION MANAGEMENT STAFF

Utilization Management staff is available Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m. (a minimum of eight (8) hours per day) to answer questions regarding UM decisions, authorization of care and the UM program via both local and toll-free telephone and telefax numbers as well as local and toll-free numbers which are TDD/TTY equipped. Language assistance/interpretation is also available for members to discuss UM issues. Telephone lines are staffed with professionals who have access to most information/resources needed to provide a timely response. Staff is identified by name, title and organization name when initiating or returning calls regarding UM issues. Callers have the option of leaving a voice mail message either during or after business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other departments for UM questions.

MEDICAL NECESSITY

According to Plan policy, medical necessity/appropriateness is defined as those services determined by the Health Plan or its designated representative to be:

- preventive, diagnostic, and/or therapeutic in nature,
- specifically relates to the condition which is being treated/evaluated,
- rendered in the least costly medically appropriate setting (e.g., inpatient, outpatient, office), based on the severity of illness and intensity of service required,
- not solely for the Member's convenience or that of his or her physician and
- supported by evidence- based medicine.

MEDICAL NECESSITY CRITERIA

The Utilization Management Program is conducted under the administrative and clinical direction of the Chief Medical Officer and the Medical Advisory Council. Therefore, it is Paramount's policy that all medical appropriateness/necessity criteria are developed, reviewed, and approved by the physician entities prior to implementation. Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the Utilization Management

Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are also available on Paramount's internet site, https://www.paramounthealthcare.com/providers/claims-andauthorizations/outpatient-prior-authorization.

Physicians may review the InterQual® criteria at any participating hospital or by contacting the Director of Utilization. InterQual® criteria are also available to providers through the MyParamount Provider portal. The individual needs of the member and the resources available within the local delivery system are considered when applying Utilization Management criteria.

Inpatient Certification

The Utilization Management Program uses the current edition of the InterQual® Level of Care Criteria (Acute Pediatric; Acute Adult) Behavioral Health Psychiatry (Adult, Child, Adolescent, Geriatric) and Behavioral Health Substance Use Disorders (Acute Detox) as the basis of the inpatient certification process. The InterQual® criteria are also applied in reviewing the appropriateness of admissions for skilled nursing facilities, long term acute care facilities, and rehabilitation facilities

Outpatient/Other Certification

Current NCD, LCD, and InterQual® criteria are used to determine medical necessity for outpatient services, as well as home health care services. When absent from the NCD and/or InterQual® criteria sets, internal criteria is developed and utilized for certification based on current evidencebased medical literature and are developed by the Medical Policy Steering Clinical Work Group, or the Pharmacy and Therapeutics Working and/or CMS criteria. At least annually, the Working Groups and applicable participating subspecialists review the criteria. The Medical Advisory Council takes the Committee's recommendations for modifications into consideration during the approval process. The Utilization Management Coordinators use the criteria during the prior authorization process. The internally developed criteria are available on Paramount's internet site, https://www.paramounthealthcare.com/providers/claims-andauthorizations/outpatient-prior-authorization

Medical Policy Development

Medical Policies evaluate coverage determination, technology reviews, behavioral health procedures, and devices, utilizing but not limited to the following resources, as applicable: Centers for Medicare and Medicaid Services policy (NCD, LCD, MLN, Appendix, etc.), HAYES Medical Technology Directory®, Food and Drug Administration (FDA), Federal and State guidelines, current medical/behavioral health scientific literature, practice guidelines/policy statements from professional groups and societies (i.e. American College of Obstetricians and Gynecologists (ACOG), American College of Medical Genetics and Genomics (ACMG), American Society of Clinical Oncology (ASCO), National Comprehensive Cancer Network (NCCN), and National Society of Genetic Counselors (NSGC), and practicing subspecialty physician input along with industry standards. Coverage determinations will be based on the following criteria: safety, efficacy, cost, and availability of information in published scientific literature.

All issues/procedures addressed/reviewed are used as a basis for establishing written medical policies to be maintained within the Paramount Medical Policies on the Paramount internet site and/or within the Paramount Providers Prior Authorization Criteria/Benefit Description on the Paramount internet site:
https://www.paramounthealthcare.com/providers/claims-andauthorizations/outpatient-prior-authorization

Medical Policy Objectives:

- Establish coverage and/or denial criteria as it relates to benefits, covered services, utilization, and medical criteria.
- Identify procedure codes used to represent the service.
- Review all current literature and/or reimbursement information prior to the policy development (i.e., Medicare, Hayes Technology, other carriers, etc.).
- Identify type of provider and/or facility the policy will affect, and how it will impact healthcare services.
- Identify the areas of financial impact related to the implementation of a specific medical policy.
- Determine member and provider liability, and if the service should be allowed or denied.
- Establish reimbursement criteria, decide level of pre-determination, and consider other utilization issues to allow a service.
- Identify how services will be edited and configured in the current claims processing systems.
- Define the medical decision-making as administrative, financial, applying bundling edits, or other methods available.
- Determine the method of response if provider and member conflict occur (multiple appeal processes).
- Establish a method to communicate and disclose medical policies, internally and externally, throughout the organization.

Diagnostic Imaging

The CMS NCD/LCD criteria and the current edition of InterQual® Imaging Criteria is used as the basis for authorization of the following outpatient imaging studies:

- CT Scans
- MRI
- MRAs
- CTA Coronary Arteries
- Nuclear Cardiac Stress Testing

Genetic Testing

Genetic Testing medical policies evaluate current genetic testing technologies and their applications utilizing but not limited to the following resources, as applicable: Centers for Medicare and Medicaid Services policy (NCD, LCD, MLN, Appendix, etc.), HAYES Medical Technology Directory®, Food and Drug Administration (FDA), Federal and State guidelines, current medical/behavioral health scientific literature, practice guidelines/policy statements from professional groups and societies (i.e. American College of Obstetricians and Gynecologists (ACOG), American College of Medical Genetics and Genomics (ACMG), American Society of Clinical Oncology (ASCO), National Comprehensive Cancer Network (NCCN), and National Society of Genetic Counselors (NSGC)), and practicing subspecialty physician input along with industry standards. Coverage determinations will be based on the following criteria: safety, efficacy, cost, and availability of information in published scientific literature.

Durable Medical Equipment
Medicare guidelines are used in the prior authorization and approved limits of select durable medical equipment for the Commercial/Marketplace and Medicare product lines.

Transplants
It is Paramount's policy that care management staff review all requests for organ transplants in conjunction with the Paramount medical policy PG0461 Transplant Prior Authorization and Notification and without the involvement of the Consortium

For Paramount Elite members, organ transplantation is covered when performed in a facility approved by Medicare as meeting institutional coverage criteria, Medicare National Coverage. The Centers for Medicare & Medicaid Services has stated that, under certain limited cases, exceptions to the criteria may be warranted if there is justification and if the facility ensures safety and efficacy objectives.

Care Management as well as Paramount's interdepartmental transplant team follow all members approved for transplant closely. This team consists of a Chief Medical Officer, Care Managers, and representatives from Finance, Claims and Actuarial. The purpose of the team is to ensure ongoing medical necessity for transplant, employer group high dollar alert (if self-insured), reinsurance notification and to ensure appropriate claims payment.

Appeals/Grievance
Members and providers are informed of appeal and/or grievance rights and processes, product line specific, by virtue of the denial notification issued by the UM coordinator. Product specific appeals processes meet all regulatory and accreditation requirements. Appeals information can also be found in the member handbook, a member's Explanation of Benefits (EOB) the provider's Explanation of Payment (EOP), the provider manual and the Paramount website.

Medicare appeals are member centric and managed by Member Services if submitted within 60 days of the denial notification. Additional supporting information can be submitted, and the appeal request can be expedited if the medical condition warrants. After 60 days, if additional documentation is submitted, the UM team will review as a new request.
Provider appeals, dealing with clinical authorization denials and claims denials related to the requirement of a medical necessity review, are managed by the UM appeals team. Timelines for submission and responses are established based on product lines as well as provider contract status.

MEDICAL NECESSITY DETERMINATIONS

Medical necessity determinations are made based on information gathered from many sources. Each case is different; however, these sources may include some or all the following:

- Primary Care Provider
- Specialist physician
- Facility Utilization Review Department
- Patient chart
- Home health care agency
- Physical, occupational or speech therapist
- Social Worker
- Registered Nurse
- Behavioral health/chemical dependency provider

- Patient or responsible family member

The information needed will often include the following:

- Patient name, ID#, age, gender
- Brief medical history
- Diagnosis, co-morbidities, complications
- Signs and symptoms
- Progress of current treatment, including results of pertinent testing
- Providers involved with care
- Proposed services
- Referring physician's expectations
- Psychosocial factors, home environment
- Social Determinants of Health

The Utilization Management Coordinator will use this information, along with clinical judgment, departmental policies, and procedures, needs of the individual member and characteristics of the local delivery system, including the availability of the proposed services within the network service area, to make a decision. The UM Coordinator can approve services based on medical necessity and established criteria. In making determinations based on contract benefit exclusions/limitations, the Member Handbook and Group Services Agreement are used as references.

If an approval determination is not reached, the UM Coordinator summarizes the criteria and findings, forwarding this information to the appropriate practitioner for further review. This licensed practitioner makes the final determination. Alternatives for denied care/services are given to the requesting provider and member; based on the criteria set used or individual case circumstances.

Following an initial adverse determination (denial) based on a medical necessity review for inpatient and/or outpatient vice requests, a provider is offered a peer-to-peer consultation. Additional documentation may be submitted, and a new request will be reviewed/determined for non-Medicare products.

The following practitioner types are used for review of the specified UM denial decisions:

- *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials
- *Doctoral-level clinical psychologists or certified addiction-medicine specialists*: Behavioral healthcare denials.
- *Pharmacists:* Pharmaceutical denials.
- *Dentists:* Dental denials.
- *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.

NEW TECHNOLOGY ASSESSMENT

The Plan investigates all requests for new technology or a new application of existing technology using the *HAYES Medical Technology Directory*® as a guideline to determine whether the new technology is investigational in nature. If further information is needed, the Plan utilizes additional sources, including Medicare policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. The Pharmacy and Therapeutics Working Group investigate pharmaceuticals.

If the new technology/pharmaceutical or new application of an existing technology/pharmaceutical is addressed in the above documents, the new technology will be reviewed with the Medical Policy Steering Clinical Work Group followed by policy creation. If a decision cannot be made to create a policy, then a committee of specialists may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Medical Advisory Council. All policies are reviewed and presented for approval by the Chief Medical Officer and the Medical Advisory Council. The decision will be based on safety, efficacy, cost, and availability of information in published literature regarding controlled clinical trials.

CONFIDENTIALITY

Paramount has written policies and procedures to protect a member's personal health information (PHI). The Utilization/Care Management Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency, and duration of health care services. We are required by law to protect the privacy of the member's health information. Before any PHI is disclosed, we must have a member's written authorization on file. Within the realm of utilization review and case management, access to a member's health information is restricted to employees who need to know the information to provide assigned functions. A full description of Paramount's Notice of Privacy Practices may be found on our website: https://www.paramounthealthcare.com/legal-privacy-compliance/confidentialitypolicy.

PRESCRIPTION DRUG UTILIZATION MANAGEMENT

Paramount utilizes CVS Caremark™ as its Pharmacy Benefit Manager (PBM), and relies on their services for benefit configuration, claims processing, and pharmacy network management. Additional PBM responsibilities include Pharmacy Utilization Management (UM) and/or formulary development for Medicare plans, Marketplace plans, and select Commercial plans. For Medicare beneficiaries with drug benefits, Part D vs. Part B determinations are also required using specific coverage criteria set by the Centers for Medicare and Medicaid Services (CMS). Additionally, Paramount delegates medical drug UM to Magellan Rx for all product lines.

For Commercial plans, Paramount employs a variety of UM approaches to member benefits, including quantity limits, dollar limits, step therapies, and prior authorizations on certain drugs as well as formulary management to help contain cost. UM protocols, including prior authorization criteria and formularies are established and maintained by Paramount's Pharmacy and Therapeutics (P&T) Working Group, which is comprised of local practicing physicians and pharmacists, and is a subcommittee of the Medical Advisory Council.

The prescribing practitioner begins the process to request an authorization by reaching out to Paramount (or Paramount's delegated entities) via phone, fax, or electronic portal. For requests

handled internally, Paramount's Pharmacy Department staff collects all pertinent medical information and Paramount's UM decisions are based upon appropriateness of care and clinical criteria, as well as existence of coverage. The Pharmacy Coordinators and Pharmacy Nurse Specialists are authorized to approve services, if criteria are met.

The Senior Medical Director, Associate Medical Directors and Pharmacists, as appropriate, are the only plan representatives with the authority to deny requests for authorization of services based on medical necessity and appropriateness. Verbal and/or written notification of these decisions are communicated to both the provider and member. Paramount follows federal, state and National Committee for Quality Assurance (NCQA) decision and notification timeframes for all utilization management determinations. Where regulatory and accreditation bodies differ, Paramount will use the most restrictive timeframe to ensure compliance with all requirements.