Utilization Management Program Description

of

United HealthCare Services, Inc.

and

UnitedHealthcare Insurance Company

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UnitedHealthcare

SECTION A – INTRODUCTION, MISSION, OBJECTIVES AND SCOPE

The Utilization Management Program Description ("UMPD" or "Program") summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review ("UM/UR" or "UM") responsibilities and functions of United HealthCare Services, Inc., and UnitedHealthcare Insurance Company (collectively, "UHC"). The collective health benefit businesses that are supported are: UnitedHealthcare Employer and Individual (E&I) including Individual and Small Business Health Options Program (SHOP) Exchanges, UnitedHealthcare Medicare and Retirement (M&R) and UnitedHealthcare Community and State (C&S). In addition, the Program provides a structure to monitor the efficiency and quality of these UM services and includes other quality programs to ensure member access to quality care. Legal entity, state, product and client specific addenda and operational policies and procedures detailing processes and staff responsibilities supplement this description and further explain specific Program implementation.

UnitedHealthcare is a registered brand name associated with UHC. UnitedHealthcare uses Utilization Review (UR) licenses maintained by United HealthCare Services, Inc., and UnitedHealthcare Insurance Company. The UM Program service delivery model, including inpatient concurrent review staff, is implemented by operational staff in centralized office sites, and remote telecommuters.

I. UTILIZATION REVIEW

Utilization Review (UR) activities are supported by objective, evidence–based, nationally recognized medical policies, clinical guidelines and criteria. These policies, guidelines and criteria promote delivery of appropriate care to UHC members in the most appropriate setting at the appropriate time. Medical Directors, nursing and pharmacy staff work closely with health care providers to optimize health care outcomes.

II. MISSION AND SCOPE

UHC's mission is to help people live healthier lives and help make the health system work better for everyone. The Program offers a portfolio of best practice UM services and products designed to improve the individual member experience, improve population health, improve the provider experience, and reduce the costs of health care.

The UM Program provides a structure to monitor and facilitate the delivery of high quality, individualized care to members. The Program includes end-to-end processes such as:

- Intake/Notification
  - Prior Authorization/Prospective/Pre-Service Review/Clinical Coverage Review
  - Inpatient Care Management/Concurrent Review
  - Discharge Planning/Post-Acute
  - Letter Management Program
  - Post–Service Review

- Pharmacy Management
- Medical Technology Assessment Reviews
- External Review Services
- Physician Consultation
- Medical Claims Review
- Clinical Appeals

III. OBJECTIVES

UHC seeks to attain the goals of improving the member experience, improving quality of care, reducing the costs of health care, and improving the provider experience. Attaining these goals will result in healthier populations, in part because of new designs and programs that better identify problems and member-oriented solutions that connect members to care before acute or emergency care may be needed, and outside of acute health care settings. Stabilizing or reducing the per capita cost of care for populations will give businesses the opportunity to be more competitive, lessen the pressure on publicly funded health care budgets, and provide communities with more flexibility to invest in activities, such as schools and their current living environment, that increase the vitality and economic wellbeing of their inhabitants.

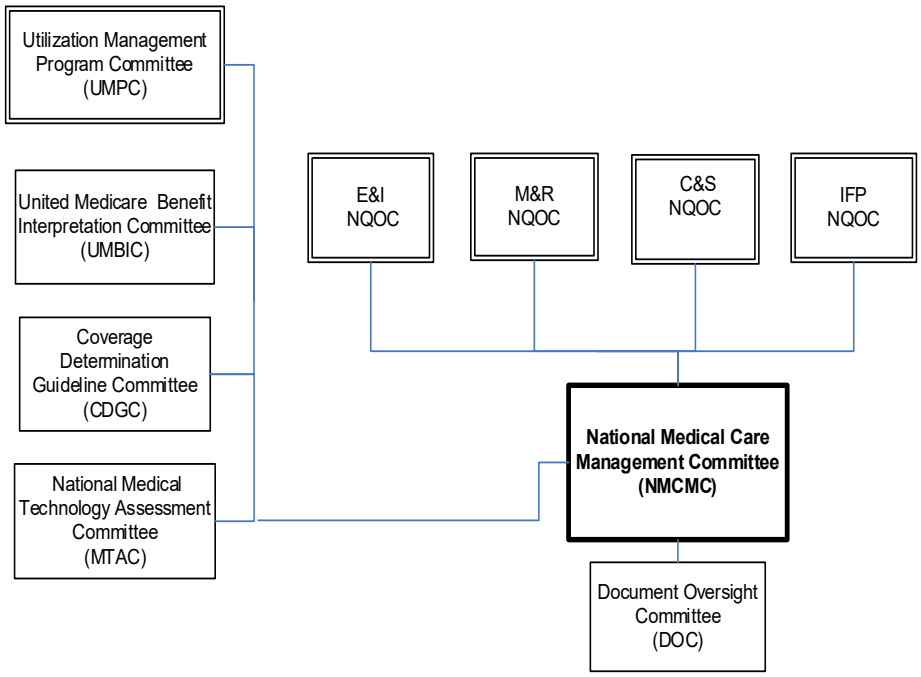
UM Program-focused objectives are to:

- Provide appropriate training and development opportunities to UM Staff;
- Standardize the implementation of the UM Program;
- Monitor staff participation in inter-rater reliability testing and evaluate/address outcomes;
- Monitor and evaluate the efficiency and effectiveness of processes through analysis and review of various metrics, including but not limited to timeliness and accuracy of decision- making, communication of decisions and satisfaction with UM processes;
- Ensure that mental health parity requirements are appropriately fulfilled; and
- Maintain compliance with applicable laws, regulations, and accreditation requirements.

SECTION B – PROGRAM STRUCTURE

IV. QUALITY OVERSIGHT COMMITTEE STRUCTURE

The UM Program activities are monitored through the UHC Health Benefits businesses National Quality Oversight Committee structure. The E&I, M&R, C&S and Individual Exchange (IFP) National Quality Oversight Committees have delegated to the NMCMC the authority to approve the UMPD.



V. DESCRIPTION OF COMMITTEES

National Medical Care Management Committee (NMCMC)

The National Medical Care Management Committee (NMCMC) is responsible for overseeing the implementation and evaluation of the UM Program. Functions of the NMCMC include, but are not limited to, the following:

- Review and approval of the UMPD on an ongoing basis and no less than annually;
- Oversee implementation of the UM Program;
- Evaluate the UM Program, no less than annually;
- Review and comment on the clinical policies, criteria and guidelines developed by the Medical Technology Assessment Committee or another appropriate committee;
- Oversee the Medical Technology Assessment Committee's activities;

- Approve UHC UM operational policies;
- Oversee the activities of the Document Oversight Committee which recommends UM operational policies that impact multiple departments and approves UM functional area procedural documents;
- Oversee activities of the Clinical Criteria Advisory Board which provides oversight of accurate and consistent use of third-party clinical criteria;
- Monitor and evaluate call center metrics, denial rates, clinical appeals including top clinical diagnosis, overturn rates, and overturn reasons, member concerns about the UM process, inter-rater reliability testing, under and over utilization and satisfaction with UM processes;
- Promote compliance with regulatory and accreditation requirements, including oversight of market conduct corrective actions, as applicable; and
- Provide feedback and recommendations to the UM process and UM quality improvement activities.

The NMCMC meets no less frequently than ten times per year but may convene on a more frequent basis, as needed. The NMCMC provides reports to the National Quality Oversight Committees for the benefit of the respective health plan.

Utilization Management Program Committee (UMPC)

The Utilization Management Program Committee evaluates and approves of the services and benefits to be included within the scope of prior authorization, concurrent review, and post-service review. The UMPC Charter sets forth the roles and responsibilities of the UMPC as well as the guiding principles that inform Committee determinations. The UMPC reviews and approves of prior authorization lists for each UHC health plan.

The UMPC includes the UHC Chief Medical Officer, the Chair of the National Medical Care Management Committee, the Chief Medical Officers of each UHC business segment, the UHC Senior Vice President for Medical Management, the Senior Vice President for Business Standardization and Adherence and the Director for Mental Health Parity among others. The UMPC meets at least six times per year or more frequently if needed.

National Medical Technology Assessment Committee (MTAC)

The Medical Technology Assessment Committee's (MTAC) reviews the scientifically based clinical evidence used in the development of UHC medical policies and clinical programs in an effort to ensure transparency and consistency and to identify safe and effective health services for UHC members. The MTAC Charter outlines the structure, objectives, responsibilities and scope of the activities carried out by the committee. The NMCMC reviews the medical policies and clinical programs endorsed by MTAC.

The MTAC review of the clinical evidence occurs in a timely manner to promote access to safe and effective health services for UHC members. The MTAC may convene once per calendar month and no less frequently than ten times per year.

The scope of the MTAC includes the functions listed below:

- Develop objective, evidence-based position statements on selected medical technologies (i.e., device/service/ technology/medically administered drug);
- Assess the evidence supporting new and emerging technologies;
- Review and approval of clinical criteria within new or existing medical policies to be utilized when performing a medical necessity review, when applicable;
- Review and maintenance of externally licensed guidelines;
- Consider and incorporate nationally accepted consensus statements and expert opinions into the establishment of national standards;
- Promote consistent clinical decisions about the safety and efficacy of medical care across all products and businesses;
- Communicate approved policies internally and externally;
- Review and approval of utilization review and clinical practice guidelines to align with internally developed medical policies and the UHC Hierarchy of Clinical Evidence. This includes internally developed guidelines, nationally recognized guidelines and specialty society guidelines; and
- Review and approval of medical policies and guideline related policies and procedures on an annual basis.

The MTAC is comprised of Medical Policy Development and Implementation Staff Members, Non- Voting Members, and Voting Members. Voting Members are UnitedHealth Group Medical Directors with diverse medical and surgical specialties and subspecialties from health plans, business segments, acquired entities, and clinical review units. Meetings must have a quorum. A quorum is defined by greater than 50% of voting members. The committee chair is not a voting member.

Coverage Determination Guideline Committee (CDGC)

The Coverage Determination Guideline Committee (CDGC) standardizes interpretation of benefit language for UHC E&I (Commercial and Exchange) products used in the development of UHC Coverage Determination Guidelines (CDG) and Benefit Interpretation Guidelines (BIG) to ensure transparency and consistency for UHC members. The CDGC reviews benefit language in a timely manner to promote access to effective health services for UHC members. The CDGC may convene once per calendar month and no less frequently than ten times per year.

The scope of the CDGC includes the functions listed below:

- Review standardized Coverage Determination Guidelines (CDGs) and Benefit Interpretation Guidelines (BIG) which will facilitate accurate and consistent benefit decisions used in the operational process' by Medical Claims Review, Clinical Coverage Review, Case Installation and Appeals departments (not an all-inclusive list);
- Include all entities in the review of CDGs that apply UHC coverage determinations, e.g., Optum, and other entities on other claims platforms

(e.g., Oxford, Community & State, and UHC of the West);
- Ensure compliance with state and federal laws applicable to coverage determination guidelines;
- Support the consistent benefit interpretation of UHC Commercial product documents such as the Evidence of Coverage (EOC), Certificate of Coverage (COC), Schedule of Benefits (SOB), for coverage determinations, including coding to map codes to benefit categories;
- Refer topics to MTAC or other appropriate committees for clarification or development of medical policies;
- Communicate approved policies internally and externally; and
- Review and approval of coverage determination and benefit interpretation guidelines on an annual basis.

United Medicare Benefit Interpretation Committee (UMBIC)

The United Medicare Benefit Interpretation Committee (UMBIC) standardizes interpretations of M&R product benefit language to support coverage determinations, where applicable.

The UMBIC functions include, but are not limited to:

- Develop standardized coverage determination policies (CDs) that facilitate accurate and consistent coverage decisions (including but not limited to Advanced Coverage Determination unit, Claims, Medical Claims Review, and Clinical Coverage Review departments). This includes all functional areas in the development of coverage determination policies that apply Medicare Advantage coverage determinations, [e.g., OptumRx, OptumInsight, andUBH];
- Adhere to state and federal laws and Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), that apply to coverage determination policies;
- Ensure consistent interpretation of M&R Evidence of Coverage (EOC) when used for coverage determinations;
- Submit topics to MTAC or other appropriate committees for clarification or development of medical policies;
- Communicate Medicare Advantage Coverage Summaries within M&R, including the placement of approved Medicare Advantage Coverage Summaries on the M&R internet sites;
- Analyze coverage determinations to provide feedback to the product benefits design process and pre/post service review departments;
- Identify potential modifications for inclusions/revisions of EOC; and
- Provide meeting minutes to the NMCMC on a quarterly basis.

Document Oversight Committee (DOC)

The Document Oversight Committee (DOC) oversees operational policies and procedures for UM/UR activities within the UM Program. The DOC's responsibilities include:

- Support functional operational areas in identification of the need for document creation and revision;

- Oversee project managers, DOC subcommittees, and process/document owners in decision making during the document development phase, such as:
    - Identification of internal policy and regulatory guidelines for development of procedures
    - Avoidance of duplicating or contradicting existing documents
    - Appropriate template use and formatting
    - Terminology compliance
- Review final document versions following director level or above approval to ensure regulatory and internal policy compliance;
- Ensure operational documents are posted where centrally located for staff access and staff are made aware of newly created documents or document revisions on a timely basis;
- Ensure National Training is advised of new or revised documents that will require training support on a timely basis;
- Ensure maintenance of a master list of documents including document number, title, owner, approval/effective/revision dates;
- Identify the need for operational policy revisions, development, and oversight of annual policy review/revision; and
- Comply with UCSMM Policy 01.11 - Document Oversight and Adherence and related Standard Operating Procedures.

The chairperson of the DOC is the Director for Document Oversight. The DOC meets monthly to review developing documents, need for creating documents, and documents being proposed by operations. The DOC reports to the NMCMC at least annually.

VI. DESCRIPTION OF PHARMACY COMMITTEES

The following Committees are involved in the development and oversight of utilization review activities for UnitedHealthcare Pharmacy (UHCP) pharmacy benefit services which provides management for E&I business. In addition to external physicians and pharmacists, Medical Directors and Chief Pharmacists serve on the UnitedHealthcare P&T Committee and the CMO and Medical Directors serve on the Prescription Drug List (PDL) Management Committee. Medical Directors are available on an ongoing basis to UM staff to review and discuss any clinical aspects of the program

UHC Quality Management (QM) Committee

The QM Committee provides oversight of the quality management program for UnitedHealthcare Pharmacy (UHCP). The UHCP leadership team has granted authority to the QM Committee for all quality management related activities and provides ongoing oversight of the QM Committee. These activities include:

- Develop, track and trend key indicators;
- Measure, monitor and evaluate UHCP services;
- Develop and implement corrective action plans and develop and approve quality improvement projects;
- Provide oversight for any entities delegated to provide services to UHCP;

- Maintain a comprehensive program description and ensure an annual review and evaluation of the program; and
- Provide regular reports to the UHCP leadership team and at least annual reports to the UHC Health Service National Quality Oversight Committee.

UHC Pharmacy Utilization Management (UM) Committee

The UnitedHealthcare UM Committee provides oversight of clinical programs and activities for UHC E&I including Individual and SHOP Program Exchanges, M&R and C&S business. UM activities include:

- Oversee development, evaluation, review and approval of clinical programs and program criteria. Program criteria is based upon peer reviewed clinical literature, randomized clinical trials, pharmacoeconomic studies, and outcome studies as applicable;
- Maintain a comprehensive program, description of activities and ensure an annual review and evaluation of criteria to ensure clinical programs are achieving desired results; and
- Report to the respective quality management committees and have a dotted line relationship with the UHC P&T Committee.

UHCP PDL Management Committee (PDL MC)

Functions of the PDL MC include for E&I:

- Make the final classification of a Food and Drug Administration (FDA) approved prescription drug to an assigned tier on the PDL;
- Make tiering decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL;
- Make the final determination on benefit exclusions and the implementation of programs to enhance the management of the pharmacy benefit; and
- Make program implementation decisions using the same types of evidence.

This information is provided by UHC decision support committees, including the P&T Committee. Supporting economic/financial analyses are directed by the Vice President, Pharmacy Management Strategies.

UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee

The UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee serves as an advisory body to UnitedHealthcare and its respective clients, by providing consultation for the clinical evaluation of drugs for placement on prescription drug list (PDLs), preferred drug lists and/or formularies and clinical programs associated with drug management. As necessary, the P&T Committee reviews and evaluates evidence-based clinical coverage guidelines for medications covered under both pharmacy and medical benefits including criteria, standards, clinical pathways, and educational intervention methods.

The Committee's role and functions are to review, evaluate and approve clinical recommendations regarding the following:

- Formularies and/or PDLs and evaluate the clinical designations of all therapeutic classes, at least annually;
- Clinical guidelines and/or criteria and procedures related to the timely use of, and access to, medications, at least annually;
- Medication policies, quality initiatives and other clinical pharmacy interventions;
- Clinical policies that guide utilization management tools for Formulary/PDL management, transition process and review of non-formulary drug requests, at least annually;
- Drug utilization management strategies;
- Clinical educational programs for clients' members, health care provider networks, plan participants, and pharmacy providers;
- Clinical guidelines (drug policies) impacting coverage for medications administered under the medical benefit; and
- Oncology Advisory Committee recommendations.

SECTION C – PROGRAMS, REVIEWS & SERVICES

VII. DESCRIPTION OF PROGRAMS

Intake

The Intake service includes receipt of provider/practitioner/member communications that notify UHC of planned and unplanned services as required by provider contract or member benefit plan. The Intake process supports other varied processes within UHC including referral into case and disease management programs, advanced notification and admission notification and prior authorization. Intake involves obtaining member demographic information, physician/provider identifying information, requested services, hospital/facility identifying information and network status of providers and facilities. The Intake service uses the information to build case files for the specific member and distributes the case files to the appropriate operational UM unit. Intake may administratively approve services per Program policies.

Advanced Notification

The Advanced Notification process is designed to:

a. Confirm member eligibility;
b. Initiate the clinical review process, if applicable;
c. Provide network status information to participating physicians and providers, as applicable; and
d. Identify and refer members to other Care Management activities, as applicable.

Depending on the product or type of plan, either physicians, other health care professionals,

non- facility providers rendering services or members are responsible for Advance Notification. Advance Notification is only required for those services on the Advance Notification and Prior Authorization list, as applicable. (See Administrative Guide posted on https://www.uhcprovider.com/). Select categories of inpatient admissions require both advance notification (from the physician) and admission notification (from the hospital). Hospitals, skilled nursing facilities and acute rehabilitation facilities are generally required to provide Admission Notification within 24 hours following each admission.

Clinical Coverage Review

The Clinical Coverage Review (CCR) service includes review and application of objective, evidence-based clinical criteria to members' clinical information on a case-by-case basis and benefit plans to determine benefit coverage for requested services in accordance with members' health benefit programs prior to delivery of the requested services. The primary goal is to provide consistent application of clinical criteria to member clinical information as informed by member benefit document language in adjudicating benefit coverage. The CCR service determines benefit coverage consistent with applicable laws and accreditation requirements, as required. The CCR service also uses applicable member benefit plan documents, evidence-based medical policy, CDGs as applicable and nationally recognized clinical guidelines and criteria. In addition, for Medicare products, the CCR service uses Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Cases requiring clinical review are forwarded to CCR nurses or physicians for review. Medical Technology Assessments, peer-reviewed medical literature, standardized coverage determination guidelines, evidence-based national guidelines, CMS NCDS, and LCDs and evidence-based criteria such as the Care Guidelines are used for clinical reviews. CCR Medical Directors offer peer-to-peer conversations with ordering physicians as needed if determinations are adverse or whenever requested by ordering physicians. All clinical adverse determinations are made by physicians. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements.

- **Prospective/Pre-Service Review**

Prospective or pre-service review are reviews that CCR service conduct at the request of providers or members for services that are not on the Advance Notification and Prior Authorization list. CCR service conduct the reviews prior to delivery of the service. The basic elements of pre- service review include member eligibility verification, benefit interpretation and may include review of medical necessity and appropriateness of care for making UM determinations regarding inpatient and outpatient services. The reviews are conducted by physicians if potential outcomes include clinical adverse determinations.

- **Prior Authorization/Pre-Certification**

Medical necessity determinations may be made for specific entities that require the process within their contract, Certificate of Coverage, Evidence of Coverage, Member Handbook, or Summary Plan Description. Prior authorization/Pre-Certification are

reviews for services that are on the UHC Advance Notification and Prior Authorization list that include assessments based on the information provided to determine whether the proposed services meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the provisions of the applicable health benefits plan. The CCR services uses applicable benefit plan documents, objective, evidence-based medical policy, standardized coverage determination guidelines and nationally recognized clinical guidelines and criteria. Notice of all review determinations is communicated in accordance with applicable state, federal or accreditation requirements.

Inpatient Management/Concurrent Review/Discharge Planning\Post-Acute

The Inpatient Care Management (ICM) and Skilled Nursing Facility (SNF) Specialist nurses review facility admissions on a case-by-case basis using objective, evidence- based clinical criteria to determine if the admissions are medically necessary under the provisions of the applicable health benefit plan. Medical necessity determinations may be made for specific entities that require the process within their contract, Certificate of Coverage or Summary Plan Description. Nurses consult with the ICM Medical Director to review cases if potential outcomes include clinical adverse determinations. Notice of all review determinations is communicated in accordance with applicable state, federal or accreditation requirements.

Post-Service Review

Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level ofcare;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and qualityissues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.

Medical Claim Review

Medical Claim Review (MCR) assesses clinical and coding accuracy support to claim operations. Selected claims are triggered by payment systems and forwarded for pre-payment review to ensure adherence with UHC and affiliated plans' medical, drug, and reimbursement policies as well as specific member commercial health benefit plan provisions that require clinical or medical coding knowledge or input to adjudicate. UHC is staffed with expert claim processors, coding specialists certified by the American Academy of Professional Coders (AAPC), registered nurses and board- certified physicians. A similar process is followed for M&R Medicare products in compliance with CMS regulations.

Medical Technology Assessment Reviews

The Medical Policies Team completes medical technology assessment reviews for current, new, and emerging technologies to support new, or changes to existing, medical policies.

Content is prepared using best available clinical evidence and is approved by the MTAC.

The MTAC reviews clinical information that is needed to support the use of benefit documents used to make coverage determinations and review clinical information that is used to support clinical programs required for accreditation or regulatory compliance. Evaluation of clinical evidence and development of policies occurs in a consistent and timely manner to assist with the provision of safe and effective services for all members.

The MTAC is made up of board- certified physicians representing multiple specialties and subspecialties. Additional medical expertise is obtained from Physician Consultant Services and the Scientific Advisory Boards. After MTAC approval, new revised and updated medical policies are posted on the Knowledge Library, an internet- based knowledge management application that is available to all staff. *Medical Policy Updates*, a monthly newsletter summarizes the policy changes and is posted on Knowledge Library.

The review of clinical guidelines defines the process used for review of locally developed or nationally recognized clinical guidelines by the MTAC. It describes the operational procedures for deciding when a local or nationally recognized clinical guideline is needed, and for moving the identified topic through the steps necessary for review, acceptance, and adoption.

The MTAC makes recommendations to be used in development of standards by providing:

- Evidence-based position statements on selected medicaltechnologies,
- Assessment of the evidence supporting new and emergingtechnologies,
- Review of externally licensed guidelines for clinicalaccuracy, and
- Assessments of the evidence supporting disease specificguidelines.

Pharmacy Management

UnitedHealthcare Pharmacy (UHCP) provides pharmacy benefit management and administrative services for the commercial products offered by UHC and its affiliates. Services are provided to commercial clients nationwide and include both fully insured and self- funded business. Policies and procedures are reviewed by applicable directors within UHCP, applicable Committees and approved by the Policy and Procedure Operations Committee (PPOC). Policies and procedures are reviewed on at least an annual basis by PPOC and any applicable committees.

All UM activities are performed by properly trained staff. The staff that perform UM activities are trained on the principles, procedures, and standards for conducting these activities. Coverage reviews are administered by appropriate health professionals, who must hold active and current licenses in good standing and without restriction. The purpose of UHCP's UM program is to support appropriate processes for reviewing requests for the coverage of pharmaceutical products for which UHC has instituted clinical review criteria. UHCP's UM activities work in concert with the greater utilization management activities of UHC and its affiliated companies.
Specific UM processes include:

- Notification/Prior Authorization: Clinical coverage review activities conducted through online analysis at point of sale and/or communication with the participant's prescribing provider or designee;
- Medical Necessity Review;
- Step Therapy; and
- Clinical Appeals Review.

Standard and automated coverage reviews are administered by appropriate health professionals, who must hold active and current licenses in good standing and without restriction. Pharmacy technicians can only administer standard and automated coverage review criteria via binary (yes/no) logic and under direct supervision of a pharmacist. All denials for standard and automated coverage decisions are administered by a licensed physician or licensed pharmacist in good standing and without restriction.

Standard and automated coverage review decisions are based solely on the information available at the time of the review. Only necessary clinical information is required or obtained to administer all specific coverage reviews. Only the section(s) of the medical record necessary for a specific case review are requested when making a determination for pharmacy authorization.

The Coverage Review Unit reviews the established criteria to determine if coverage should be approved or denied. If coverage is denied, denial letters are sent to both the physician and the member and contain an explanation of the clinical appeal process.

External Review Services – Physician Consultation Services (PCS)

External review services are available through relationships with several independent external review organizations or individual clinicians. Board–certified, licensed physician consultants from specialty areas of medicine, surgery, chiropractic, and podiatry are available to review individual cases as required by state mandate, regulatory agency guidelines and any voluntary external review program. A reviewing physician may not perform a review on one of his/her patients, the patients of his/her partners, cases in which he/she has had previous involvement or cases in which he/she has proprietary interest.

Specialties include, but are not limited to:

Cardiology	Gastroenterology	Ophthalmology	Psychiatry
Chiropractic	Internal Medicine	Orthopedics	Radiology
Dentistry	Neurology	Otolaryngology	Surgery
Dermatology	Neurosurgery	Pediatrics	Urology
Emergency Medicine	OB/GYN	Podiatry	
Family Practice	Oncology	Pulmonology	

When specific requirements of specialty or state licensure exist, or if there needs to be "independent" reviews for an appeal or peer review, consultants will be obtained through one of the contracted External Review Organizations. The internal medical director will make the final determination based on the consultation with the External Review Organization's recommendation.

SECTION D – DEPARTMENTAL ROLES & RESPONSIBILITIES

VIII. Departmental Resources

The staffing model that supports the UMPD consists of clinical, non-clinical, and administrative personnel. Distinct job functions, with defined roles, responsibilities, and accountabilities have been developed. The Program ensures that all physicians hold active unrestricted licenses. Peer clinical reviewers have an active unrestricted license as well as education, training, or professional experience in medical or clinical practice that is appropriate to render a clinical opinion for the conditions, procedures and treatment that will be reviewed. All clinical adverse determinations are made by physicians or other acceptable peer reviewers as allowed by regulatory and accreditation agencies. Key positions include the following:

- Chief Medical Officer, UnitedHealthcare. Provides overall clinical leadership for the Medical Management for UHC.
- Chief Medical Officer (CMO) for each UnitedHealthcare benefit business Employer & Individual, Medicare & Retirement, Individual Exchanges, and Community & State: A licensed physician who is the senior clinical executive within each respective line of business and is a member of the UHC Core Management Team.
- Chief Medical Officer for Medical Policy: Supports the development and review of medical policies, clinical practice guidelines and drug policy guidelines and also providing clinical support to the development of Coverage Determination Guidelines.
- Vice President, Clinical Coverage Review Medical Director (CCR): Responsible for the CCR program aligning the clinical coverage review programs based on the established notification list and for UR functions lines of business based on benefits and/or medical necessity where contractually indicated for the geographical area. Accountabilities include providing prior authorization review for required health care services, and or prospective/pre-service reviews upon member or provider request.
- Senior Vice President, Medical Management: Provides guidance and oversight for the services and benefits within scope of the UnitedHealthcare UM Program.
- Director, Mental Health Parity: Provides guidance to ensure that UM programs fulfill mental health parity requirements.
- Chief Pharmacy Officer (CPO): Provides guidance and oversight and is responsible for all clinical aspects of the UM program for the pharmacy benefits; and has periodic consultations with the clinical pharmacists and staff performing these activities. The Employer & Individual CPO is a member of the UHC P&T Committee and chairs the UHC Utilization Management and Quality Management Committees for pharmacy.
- Sr. National Medical Directors and Regional Chief Medical Officers (RCMOs) are licensed physicians and members of the Market Senior Management Team. They have responsibility for alignment of Market Medical Directors activities. The Regional Chief Medical Officers collaborate with Executive Management and Medical Directors to

provide expert consultation to the UM program development when necessary, and implementation. They oversee the implementation of affordability initiatives as well as development of alternative contracting arrangements and oversight of delegation management at the regional level.

- Operations Medical Directors: Licensed, board-certified physicians responsible for the utilization management functions for lines of business based on benefits and/or medical necessity where contractually indicated for geographical or function areas.
- Inpatient Care Management Medical Directors: Accountabilities include support to concurrent review of facility admissions.
- Clinical Coverage Review Medical Directors: Accountabilities include providing prior authorization reviews or prospective/pre-service decisions for requested healthcare services, including reviewing for network gap exceptions; and participating in the concurrent review processes to assist with coverage review of the facility setting.
- Medical Claim Review Medical Directors: Board certified physicians who provide clinical review post service. These decision makers are also distinct form those making initial determinations. Accountabilities include provide coverage review of services that are potentially experimental/investigational and clinical review of retrospective pre-payment coverage reviews in the absence of a notification or authorization.
- Appeals Medical Directors: Medical Directors provide clinical input into the appeal process. Appeal medical directors are different from the medical director who made the initial clinical adverse determinations. Accountabilities include providing clinical review of appealed concurrent and pre-service decisions for requested health care services and clinical review of post-service decisions for appealed payment decisions.

STAFF RESOURCES

Intake/Notification

Intake Coordinators and Pre-Service staff are non-clinical staff members who receive initial review requests and notifications and may perform initial screening of certain emergent or scheduled services identified by Summary Plan Descriptions, Evidence of Coverage or Certificates of Coverage prior to health care services being rendered. They are also responsible for opening a case in the appropriate Medical Management System with basic information.

Clinical Coverage Review (CCR)

Clinical Coverage Review supports the management of health care delivery by determining benefit coverage for requested services in accordance with member benefit programs. Clinical coverage also supports medical necessity determinations for specific, contracted entities that require the process within their Certificate of Coverage or Summary Plan Description.

Non-Clinical Staff: Staff Members who do not possess a health care license but are trained to receive review requests or to review cases for covered health services or provide UR using

structured clinical data and benefit plans.

Initial Clinical Reviewer: All staff who conduct initial clinical reviews are health professionals who possess active, unrestricted licensure and/or appropriate certifications. Nurses review against the benefit plans and medical policy, CMS NCDs and LCDs and collect clinical information necessary to facilitate and coordinate member services and support and monitor non- clinical staff functions related to pre-review activities.

Inpatient Coordinators (IPC): The Inpatient Coordinator (IPC) receives new inpatient Notifications at various intervals throughout the business day directly from the facility, web portal, Intake, Pre-Service, CCR and the on-site or telephonic Inpatient Care Manager (ICM). IPC key responsibilities are:

- Process new inpatient notifications;
- Accept assignment to specific nurses, facilities &/or markets as determined by site leadership;
- Monitor completion of system data of current inpatient cases; and
- Document in the appropriate clinical platform.

The IPC will not exercise clinical judgment or interpret clinical information. These non-clinical staff are monitored by licensed health care professionals, e.g., registered nurses. IPC procedures are reviewed and approved annually by a designated clinical director.

Inpatient Care Managers (ICM): The Inpatient Care Managers (ICM) provide the primary clinical interface with hospital staff and physicians. All ICM staff are health professionals who possess active, unrestricted licensure and/or appropriate certifications. Inpatient Care Managers review against nationally recognized evidence based clinical guidelines and criteria, CMS NCDs, and LCDs for Medicare products, and collect clinical information necessary to facilitate and coordinate member services. The ICM will engage in dialogue with the hospital staff and the attending physicians to assist in stewarding the member along the continuum of care. Upon request, staff will explain the medical management clinical review requirements and procedures.

Post-Acute Specialist

The Post-Acute Specialist provide the primary clinical interface with SNF/AIR/LTAC staff and physicians. They meet all the qualifications of the ICMs. The Post-Acute Specialist completes clinical reviews nationally recognized evidence based clinical guidelines and criteria to process Pre-Service requests for admissions into SNF/AIR/LTAC and monitor the member's progress towards short term and long-term goals throughout the stay. The Post-Acute Specialists collaborate with the post-acute provider on discharge planning to prevent unnecessary delays at discharge and identify members for referrals to appropriate post discharge care management programs.

Clinical Pharmacists (also Clinical Pharmacy Managers, Directors)

Clinical Pharmacists are licensed professionals who work directly with the staff to assist in facilitating delivery of services in the most appropriate and least restrictive manner. The

clinical pharmacists supervise and oversee non-clinical staff activities related to the pharmacy processes. Clinical Pharmacists develop the clinical programs to support the pharmacy benefit. These programs may be either utilization management-based programs, or patient safety related programs, or member and physician engagement initiatives. Clinical Pharmacists may also be involved in the clinical coverage reviews and appeal determinations.

SECTION E – SERVICE INITIATIVES/PATIENT SAFETY

IX. CLINICAL REVIEW CRITERIA, DEVELOPMENT AND APPROVAL

Clinical coverage decisions are based on the eligibility of the member, state and federal mandates, the member's COC, EOC or summary plan description, medical policy, medical technology assessment information, and for Medicare products CMS NCDs and LCDs and other evidenced-based clinical literature.

Determinations are made using evidence based clinical criteria to guide length of stay and level of care reviews. Application of clinical review criteria is integral to the UM processes of clinical coverage review and inpatient concurrent review. Clinical review criteria are internally accessible in the UHC Knowledge Library, an internal web-based resource, and on a fully licensed internet- based site that is available to all clinical staff. UHC may use clinical criteria from third party sources such as InterQual Guidelines. Third party criteria will also be made available to providers and members as required by law and permitted by the third party. UHC may also develop clinical review criteria with review and input from appropriate providers and based on current clinical principles and processes and evidence- based practices.

The UHC Medical Policy Committee reviews, evaluates and approves of clinical review criteria annually or more frequently as appropriate. The Medical Policy Committee submits approved clinical review criteria to MTAC for final review and approval.

MTAC is responsible for developing and approving all new and revised medical policies. Medical policies are developed to assist UM staff in accurately reviewing service requests within the context of the contract language in a plan document. New policies are developed in response to emerging technology or new treatments and are based on scientific evidence, where such evidence exists. Medical Policy updates are communicated to all UM staff through various means of communication: Knowledge Library updates, webcast, online learning modules and other appropriate learning methods.

Pharmacy clinical programs and criteria are developed by UHC clinical pharmacists. Selection of drug products and development of program criteria include review of peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data; published clinical practice guidelines,

comparisons of efficacy, side effects, potential for off label use, and thorough UHC claims data analysis.

Program review also includes a comprehensive efficacy comparison as well as the type and frequency of side effects and potential drug interactions among alternative drug products and will consider the likely impact of a drug product on patient compliance when compared to alternative products, and evaluation of the benefits, risks, and potential outcomes for members.

The clinical pharmacists responsible for program development present the clinical program and criteria to the UM Committee and P&T Committee. Select new programs are also presented to the PDL Management Committee prior to implementation. All criteria are reviewed by the UHC P&T Committee before implemented. At least annually, medical literature is reviewed to determine if criteria need to be modified based on new evidence for medications with clinical review criteria. Ad hoc reviews may be performed at any time when questions concerning any indication are raised by clinical staff or through the appeals process.

X. BEHAVIORAL HEALTH

United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, psychological/neuropsychological guidelines, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- **Clinical Criteria (Level of Care Utilization System-LOCUS) –** Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)**-Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder

benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.

- **Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) -** Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (American Psychological Association Psychological and Neuropsychological Billing and Coding Guide)** Comprehensive billing and coding guide developed by the APA used for making medical necessity determinations for behavioral health psychological and neuropsychological testing services.
- **Clinical Criteria (State or Contract Specific Level of Care Guidelines):** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- **Clinical Criteria (American Society of Addiction Medicine [ASAM]):** Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- **Clinical Criteria (Medicare Required Criteria):** Centers for Medicaid and Medicare (CMS) National and Local Coverage Determinations (NCDs/LCDs): Summary document of Criteria used to make medical necessity determinations for Medicare benefits.
- **Clinical Criteria (Optum Developed)**
    - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
    - Optum Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis, Electroconvulsive Therapy and Extended Outpatient Sessions.
    - Optum's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a "medical event".

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental

health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.

A complete description of behavioral health activities for all plans can be found in the UBH Behavioral Health UM Program Description which is reviewed and approved annually by the UBH Behavioral Health Corporate Clinical Quality & Operations Committee as applicable.

For all UHC plans, the UBH UM Program is designed to meet Federal and relevant State regulations, and the applicable utilization management requirements of the National Committee for Quality Assurance's Standards for the Accreditation of Managed Care Organizations and Utilization Review Accreditation Commission standards.

XI. MENTAL HEALTH PARITY

United is committed to meeting the requirements of the Mental Health Parity and Addiction Equity Act and applicable state laws (collectively MHPAEA) ensuring that mental health parity exists between medical/ surgical (M/S) and mental health/substance use disorder (MH/SUD) processes and that the non-quantitative treatment limitations for MH/SUD benefits are comparable to and no more restrictive than those for M/S benefits. UHC has adopted an internal MHPAEA framework to promote the prevention, detection, and resolution of suspected MHPAEA violations.

The NMCMC serves as the committee with members from both M/S and MH/SUD functional leadership in order to review and confirm that the processes relating to non-quantitative treatment limitations are in parity. The NMCMC meets on a regular basis and dedicates no less than two meetings a year to review compliance with MHPAEA and evaluate processes to ensure we are in parity.

UHC develops and maintains clinical policies that describe the generally accepted standards of medical practice, scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. Both M/S and MH/SUD benefits are administered using evidence-based, nationally recognized medical policies, clinical guidelines, and criteria. These clinical policies are available to members and providers.

XII. APPEALS

The UHC Appeals & Grievances Unit manages appeal requests for UHC E&I, including Individual and SHOP Exchanges, M&R and C&S lines of business. Operational policies and

procedures describe the specific appeals processes; for example, required turnaround times, administrative requirements, letter content, and reviewer requirements. When applicable, appeals processes meet Department of Labor (DoL) regulations. State laws are followed if they are more stringent than the DoL regulations.

Affiliated health plans manage appeal requests for their commercial businesses as described in their individual UM program descriptions. Appeals for government programs are managed under a separate process within UHC Appeals & Grievances that is compliant with applicable Medicare and Medicaid requirements.

Clinical input into the appeal process is provided by Medical Directors in the Appeals and Grievance functional Unit. Appeal medical directors are different from the medical directors who made the initial clinical adverse determinations.

XIII. Other Quality Type Programs

UHC operates quality programs outside of the UM Program to improve the quality of care accessible to UHC members and the overall member experience. Quality programs include transition of care, readmission management and population health services.

Transition of Care or Special Circumstances

UHC new members might be receiving treatment from non-contracted physicians. Policies for transition of care allow a member to continue his/her health care with the non-contracted physician, under certain circumstances and for a defined period of time. After that time, the member is assisted in finding a contracted physician who can provide the required care. The transition of care period applies only to current treatment for specific health issues as described in the "Qualifying Clinical Conditions" section of the Transition of Care Policy, or applicable policy. The Transition of Care Policy might also apply in special circumstances where there are substantial changes to the local network that affect a participant's current treatment plan.

Continuity of care is a standard UHC benefit offering which allows a covered member to continue seeing a provider who has terminated from the UHC Network. The member is given a defined period of time in which to transition to a new physician or other health care provider while still receiving network benefits under the terms of the employer health benefits or government program contract.

Care Management

Hospitalized members who have complex discharge planning needs or who may be at risk for a readmission, for post-discharge support, or other disease management needs may be referred to UHC programs designed to improve the members' health and well-being and provide general health education. For example, members are proactively assisted with a safe transition to home and other outpatient care management programs that UHC operates from time to time.

XIV. PROCESS IMPROVEMENT

Process improvement is a structured, disciplined approach to maintain consistent application of UM processes. It is designed to provide objective and systematic assessment of the UM Program by measuring the adherence to policies and procedures, licensing/regulatory standards, and customer services. Effective implementation of the UMPD is overseen by the NMCMC. Process improvement reviews include:

- Process audits conducted by clinical managers in regional service centers or by a centralized audit team;
- Inter-rater reliability assessments;
- Member surveys conducted by an external vendor;
- Participation in activities to meet accreditation and regulatory requirements; and
- Development of targeted, relevant action plans for continuous process improvement activities.

Medical directors, who are responsible for benefit coverage determinations and medical necessity determinations, participate in inter-rater reliability exercises, no less than annually, to ensure that benefit document language and clinical review criteria are being applied consistently. Results for inter-rater reliability programs are monitored and tracked for improvement opportunities.

SECTION F - ACCOUNTABILITY

Measurement and Reporting

Measurement and reporting are designed to support adherence to operational, regulatory and accreditation requirements. Reporting includes clinical, operational, and key performance metrics to ensure a comprehensive and balanced value approach.

Key performance indicators are monitored that reflect the impact of the Program activities. Measures include, but are not limited to:

- Timeliness of decision-making,
- Notification of decisions,
- Communication regarding UM activities with contracted practitioners and members, as applicable,
- Under and over utilization, and
- Satisfaction with UM processes.

When possible, data is collected centrally and systematically from the UM systems. Some selected process measures may be collected at the local level. Self-reported measures are subject to audit. The entire process is structured to ensure that methodologies are consistently applied, and that data are appropriately interpreted.

XV. DELEGATION OF UTILIZATION REVIEW FUNCTIONS

When UM activities are delegated to another organization, an evaluation of the

organization's capacity to perform the proposed delegated activities is performed prior to entering into a delegation agreement. Pre-delegation evaluations may include, but are not limited to:

- The formal, written agreement or description of delegated activities;
- The delegated organization's UM plan documents and related policies and procedures;
- The delegated organization's annual UM evaluation; and
- Activity reports, files, and other relevant documentation, as applicable.

The delegated organization's ongoing ability to perform delegated activities is evaluated at least annually. Reports of selected activities are reviewed on a periodic basis. As applicable, opportunities to improve performance are monitored on a regular basis. The delegation oversight is the responsibility of UHC. There are regional (2), national (1) committees which meet on a quarterly basis and individual California (1) committees which meet once a month to review active delegated entities performance and improvement action plans. These four Delegation Oversight Committees report into the National Delegation Oversight Committee (NDOC). The NDOC is an executive level committee responsible for monitoring and approving delegated activities for care providers and intersegment partners related to claims processing, credentialing, and medical management and may include complex care management, disease management, inpatient care, behavioral health, and pharmacy services.

XVI. CONFIDENTIALITY

The UMPD is designed to comply with the applicable policies of UHG, including the Code of Conduct, and those related to Ethics and Integrity. Through application of the policies related to Privacy, the Program seeks to retain the trust and respect of our customers and the public in handling of private information including health, financial, and other personal information in the conduct of our activities.

All employees, contracting practitioners, providers, and agents of UHG are required to maintain the confidentiality of member protected health information, including member demographic information, medical records, peer review and quality improvement records. All information used for UM activities is maintained as confidential in accordance with federal and state laws and regulations, including HIPAA Privacy requirements. Reasonable efforts are made to limit access to protected health information and other personal information to the minimum necessary to conduct operations.

XVII. CONFLICT OF INTEREST

All employees are prohibited from engaging in any activities that conflict with the responsibilities of UHC. Employees receive information and training on conflict of interest upon hire and must disclose any real or potential conflicts of interest to UHC. If UHC does not waive conflict of interest, employees must eliminate the conflict or resign from their position within UHC.

XVIII. FINANCIAL COMPENSATION

Financial compensation plans for professionals who make utilization decisions are not based on the quantity or types of adverse decisions rendered and do not contain incentives, direct or indirect, for any type of UM decision. Financial incentives for clinical decision-makers do not encourage decisions that result in under or over utilization of care or service.

XIX. ANNUAL EVALUATION

To determine if it remains current and appropriate, an annual evaluation of the UM Program is conducted. The annual UM evaluation reviews the Program structure, the Program scope, senior physician and behavioral health involvement in the Program, and member and practitioner experience. Each year, staff representatives from areas performing key UM functions participate in a collaborative effort to complete the UM evaluation. These include Intake, CCR, Inpatient Care Management, Appeals and Quality/Accreditation. Recommendations from senior UM leadership, including the UHC Chief Medical Officer, are also incorporated. The UM evaluations for the E&I and M&R lines of business are presented to the NMCMC for final review and approval. The UM evaluations for the C&S health plans are presented to the health plan Utilization Management and Quality Management Committees, as applicable. Recommendations resulting from the process of evaluating the UM Program are incorporated into the UM Program Description for the following year.