

Utilization Management

Utilization Management Program

PacifiCare Behavioral Health monitors and evaluates all aspects of the behavioral health care delivered by its network providers. The PBH Utilization Management Program is designed to ensure that members receive access to timely, appropriate and affordable quality mental health care and services. The PBH UM Program is one component of the comprehensive PBH Quality Improvement Program. Key aspects of service addressed in the UM Program are Medical Necessity, appropriateness, availability, and accessibility. Since all PBH services are offered in the context of a defined benefit plan, an additional but critical aspect of service addressed by the PBH UM Program is the efficiency of services to members. PBH's Utilization Management Committee is charged with annual review and implementation of the UM Program, regular review of UM data, and implementation of corrective actions whenever indicated.

Utilization Management Activities

The PBH UM Committee reviews and analyzes utilization data for individual, group and facility providers and for all levels of care and across all lines of business. It also evaluates member and provider satisfaction and dissatisfaction with the UM processes. Utilization management data sources include, but are not limited to:

- ◆ PBH Internal Utilization Reports
- ◆ Complaints and Appeals Summaries
- ◆ Member Satisfaction Surveys
- ◆ Provider Satisfaction Surveys
- ◆ Timeliness of Intake, Assessment and Referral Reports
- ◆ Provider Accessibility Reports
- ◆ Annual Audits of UM Delegated Group Practices

◆ Utilization Reports Submitted by UM Delegated Group Practices

The PBH UM Committee reviews the data collected against PBH clinical guidelines, contractual stipulations, and national and community norms to assess the performance of its providers. Problems which appear to be quality-of-care related are referred to the Quality Improvement Department for investigation. Utilization patterns which are outside of the norm as established by the UM Committee are further investigated by the UM Committee or its designees and, when appropriate, a Corrective Action Plan (CAP) is developed in cooperation with the provider. Once corrective actions are implemented, follow-up monitoring occurs to ensure that desired improvements have been achieved and that performance continues to satisfy established criteria and guidelines. If this process fails to resolve the problem to the satisfaction of the UM Committee, the issue may be referred either to the PBH Credentialing Committee or to the PBH Peer Review Committee for further action, which can include suspension of referrals, restriction of privileges, or termination from the network.

Although utilization management data are used to assess provider performance, in no instance is this data used arbitrarily to take punitive action against a provider. Utilization data are not used in provider profiling. When problems are identified, PBH attempts to work in a collaborative fashion with the provider to correct the problem, and provider input into this process is encouraged.

Financial Incentives for UM Decision-Making

PacifiCare Behavioral Health, Inc. (PBH) makes utilization management decisions based solely upon the appropriateness of the care and service for its members. PBH does not offer any incentives, financial or otherwise, as a reward for issuing denials of care or limiting care such that barriers to care or service are incurred or that under-utilization of services results. Practitioners acknowledge and abide by PBH's policies regarding utilization decision-making based only upon Medical Necessity and the appropriateness of care and services.

Provider Dispute Resolution Process (Western and Northwestern Regions Only)

PBH provides a process for providers to appeal claims payment and treatment authorization determinations made by PBH. These appeals are reviewed in a timely and impartial manner and PBH makes every effort to resolve such matters in a period of not more than thirty (30) business days.

This process exists to resolve disputes that may arise between a provider and PBH. In addition to this process, or as an alternative to this process, providers

may also serve as member advocates or member representatives in the PBH Member Appeals Process. This participation must be designated by the member or legal guardian.

Expedited Appeals

PBH will expedite the review of any appeals involving PBH denials of treatment authorization for requests for facility-based care. Expedited appeals may be initiated telephonically, however it will be necessary for PBH to request copies of all relevant medical records and/or other clinical information. Expedited appeals are reviewed within the following timeframe:

- ◆ Within twenty-four (24) hours of receipt of all information necessary to render a determination

Determinations will be communicated by telephone and in writing to the provider(s) and member/family within twenty-four (24) hours of the completion of the review.

Routine Appeals

Appeals must be initiated in writing by providers, or provider representatives, within eighteen (18) months of the date(s) of service. Appeals received after this time will not be considered for payment.

Appeals for the Western Region may be sent to:

PacifiCare Behavioral Health of California, Inc.
P.O. Box 55307
Sherman Oaks, CA 91413-0307
Attn. Appeals Department

Appeals for the Northwest Region may be sent to:

PacifiCare Behavioral Health, Inc.
P.O. Box 3009
Hillsboro, OR 97123-3009
Attn. Provider Appeals

Upon receipt of an appeal, a PBH Appeals Coordinator will ensure that all information necessary to render a determination (i.e. clinical documentation) is possessed by PBH. The appeal will then be reviewed by a PBH Medical Director (or designee). The PBH Appeals Coordinator will send written notice of the appeal determination to the provider within thirty (30) business days of PBH's receipt of the appeal.

If the provider is dissatisfied with the outcome of the initial appeal, he/she may dispute the initial determination by submitting a written request for a second level appeal review. The request must be received by PBH within thirty (30) business days of the provider's receipt of the first level appeal determination (PBH considers the letter to be "received" by the provider seven (7) days after the letter is sent by PBH). The request should be sent to the above address. If the appeal involves a PBH denial of treatment authorization, the attending physician or treating provider must provide a letter documenting the clinical rationale for his/her appeal.

Upon receipt of a second level appeal, a PBH Appeals Coordinator will ensure that all information necessary to render a determination (i.e. clinical documentation, letter from provider) is possessed by PBH. The appeal will then be reviewed by a PBH Medical Director (or designee). The PBH Appeals Coordinator will send written notice of the appeal determination to the provider within thirty (30) business days of PBH's receipt of the appeal.

Please note that no single PBH Medical Director or other licensed behavioral healthcare professional is involved in more than one level of the appeal review process. Additionally, a PBH Medical Director or other licensed behavioral healthcare professional who issues an initial denial of treatment authorization will not be involved at either level of the appeal review process. All appeal determinations involving the Medical Necessity or clinical appropriateness of behavioral health treatment are made by licensed behavioral healthcare professionals. The clinical criteria used in determining Medical Necessity are available upon request.

Provider Dispute Resolution Process (Southwest Region and Colorado Only)

In the Southwest Region and Colorado, the provider appeal process is not delegated to PacifiCare Behavioral Health. Providers in these regions who wish to appeal a PacifiCare Behavioral Health utilization management decision must do so by contacting the member's medical plan in their area.

Clinical Reviewer Available to Discuss Denials

PBH makes available to practitioners an appropriate reviewer (psychiatrist, clinical psychologist, certified addiction medicine specialist) to discuss by telephone determinations based on Medical Necessity or clinical appropriateness. Practitioners and facilities are notified by phone and letter of the name and phone

number of the reviewer making denial decisions. Written notification of denial decisions, including the reason for each denial, is sent to the practitioner/facility.

New Technology Assessment

PacifiCare Behavioral Health identifies and evaluates proposed advancements in behavioral health treatment in order to ensure that PBH members receive the highest quality care to meet their individual needs. The Technology Assessment Committee, a subcommittee of the PBH Utilization Management Committee, is responsible for review and evaluation of proposed advancements. The Technology Assessment Committee is comprised of the PBH Corporate Medical Director (chair), PBH Director of Clinical Services (co-chair), PBH Regional Medical Directors, PBH Director of Quality Improvement, and practitioners associated with a university or research institute who are subject-matter experts.

The committee meets annually or more often as needed and reviews requests for evaluation of proposed advancements submitted in writing from the PBH Professional Advisory Committee, the PBH Consumer Advisory Committee, the PBH Executive Clinical Group, PBH staff, PBH network providers and PBH members. The only advancements that are considered for inclusion in the category of approved services are those that have been subjected to rigorous scientific study as determined by the Technology Assessment Committee and have been shown to have demonstrated effectiveness and acceptable risks.

The committee forwards a report of their actions to the Utilization Management Committee, which in turn forwards actions to the Corporate Quality Improvement Committee. The Medical Director reviews these recommendations for final approval. The Quality Improvement Committee reports any newly approved service to the Provider/Network Management Department. The Provider/Network Management Department ensures network ability to provide the new services and establishes contractual rates for reimbursement. Findings are also forwarded to the PBH Legal and Regulatory Department for inclusion in the Evidence of Coverage and Disclosure form as either a covered benefit or an exclusion.

The member, staff member, provider, or Advisory Committee who initiated the request is notified in writing of the outcome of the Medical Director's decision.