UTILIZATION MANAGEMENT
PROGRAM DESCRIPTION

Approved by the Medical Advisory Council
June 11, 2013
Paramount’s Utilization Management Program is designed to ensure the delivery of high quality, cost efficient health care for the members. The program is under the administrative and clinical direction of the Vice President Medical Director and the Medical Advisory Council. 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 Medical Advisory Council evaluates and approves the Utilization Management Program annually. Updates occur as required.

For product lines on an HMO platform, the Primary Care Physician is responsible for managing all aspects of the member’s health care needs. To this end, all members select a Primary Care Physician at the time of enrollment and are encouraged to establish a relationship with the physician as soon as possible. The member is instructed to contact his/her Primary Care Physician whenever medical or behavioral health care is needed. Thus, the Primary Care Physician is informed about his/her patient’s needs and can make informed, appropriate decisions regarding treatment.

The following provides an overview of the various functions of the Utilization Management Program.

- **Referral System**
  
  - **Specialist Referrals** - The Primary Care Physician (PCP) may request a consultation from a participating specialist physician at any time. No referral is required from Paramount prior to consultation with any participating specialist.

  - **Emergency Room Services** - No referrals are required for treatment of an emergency 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.

  Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

  - **Out-of-Plan Referrals** - These requests are reviewed individually and determinations are made based on the patient’s medical needs and the availability of services within the Provider Network to meet these needs.
• **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.

• **Predetermination of Benefits/Outpatient Certification** – Certain procedures, durable medical equipment and injectable medications are prior authorized. Paramount uses InterQual® criteria for Imaging, Procedures and Molecular Diagnostics. When InterQual® criteria does not exist within Paramount’s purchased products, criteria are developed internally by the Technology Assessment Working Group or Pharmacy and Therapeutics Working Group as appropriate. Additionally, potentially cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and members, to issue coverage determinations.

• **Inpatient Hospital Certification**
  
  • **Prospective Review** - Using InterQual® Level of Care Criteria, elective inpatient hospitalizations are reviewed to assure that the services are provided in the appropriate setting.

  • **Concurrent review** - InterQual® Level of Care Criteria are utilized to evaluate the quality and appropriateness of care and to assess the medical necessity of continued stay.

  • **Retrospective review** - Analysis of patient care data for medical necessity, quality of care and appropriateness of setting after the care has been delivered will identify patterns of health care services of institutions, physicians, and members.

  • **Discharge Planning** - Patients who require continuing care after release from the hospital are identified and appropriate services are arranged through participating home care, medical equipment and other providers.

• **Outpatient Certification** - Specified outpatient services are reviewed utilizing criteria developed by the Technology Assessment Working Group and/or the Pharmacy and Therapeutics Working Group and approved by the Medical Advisory Council.

• **Case Management** - Plan Case Managers facilitate the provision of the medically complex and/or high cost member’s care in collaboration with the Primary Care Physician and interdisciplinary care team to ensure that quality medical care is provided in the appropriate setting. The case management program is integrated with the Plan’s disease management programs, providing member-specific interventions to high-risk participants.

• **Behavioral Health Services** - Paramount reviews inpatient and outpatient mental health/chemical dependency services for all product lines using all of
the utilization management functions and tools/guidelines described above. (Ambulatory care for Medicaid members is generally excluded by the Ohio Department of Job and Family Services.) To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal member health outcomes.

- **Utilization Management Reporting System** - Relevant cost and utilization data is reported for review and analysis. Action is taken to correct any patterns of potential or actual inappropriate under- or overutilization.

Appropriately licensed, professional staff performs all of the above functions.

Providers may review criteria upon request by contacting the Director of Utilization Management. Internally developed criteria are also available on Paramount’s Internet site.

**DELEGATION OF UTILIZATION & CASE MANAGEMENT**

Delegation occurs when Paramount Advantage gives to 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 NCQA accreditation standards and ODM regulations. Paramount Advantage does not delegate management of complaints, grievances and 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 Medical Advisory Council oversees activities delegated to the pharmacy benefits manager, case management, and utilization management functions.

Effective 6/1/2013 Paramount Advantage delegates utilization management functions for dental prior authorizations to DentaQuest. Case management and utilization management functions (excluding prescription drugs) for children are delegated to Health Network Cincinnati Children’s (HNCC) for members residing in eight counties in southwest Ohio effective 7/1/2013. Case management of children is delegated to Partners for Kids (PKF)/Nationwide Children’s for members residing in thirty-four central/southeast counties of Ohio effective 7/1/2013. Case management of adults and utilization management for adults and children are delegated to Quality Care Partners (QCP) for members residing in eleven counties in southwest Ohio also effective 7/1/2013.
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, hospitals, and other ancillary providers. The goal of utilization management is to assure appropriate utilization, which includes evaluation of both potential overutilization and underutilization.

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

- To assure 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 and inefficient scheduling of resources.

- To assure fair and consistent Utilization Management decision-making.

- To focus resources on a timely resolution of identified problems.

- To assist in the promotion and maintenance of optimally achievable quality of care.

- To educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.

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

The Utilization/Case Management (U/CM) Department is comprised of registered nurses, licensed practical nurses, mental health/chemical dependency professionals (nurses and social workers), medical assistants and support staff. Staffing ratios for utilization management functions have been maintained as follows:

1 Utilization Management coordinator to 8,000 members (regardless of product line)

The ratio for case management functions will be as follows:

1 Case Management Coordinator to 100 case management cases (regardless of product line)

For Paramount Advantage High Risk Case Management, the staffing ratio of 1:25 is required. This ratio is inclusive of members of the interdisciplinary care team (ICT).

An analysis of the current caseload, the mix of case management cases and the demographics of the enrolled population is performed monthly. Based on this analysis, the anticipated percentage of case management cases by product line membership is as follows:

<table>
<thead>
<tr>
<th>Product Line</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial HMO</td>
<td>0.5%</td>
</tr>
<tr>
<td>Paramount Advantage</td>
<td>5.0%</td>
</tr>
<tr>
<td></td>
<td>(inclusive of members enrolled in Paramount’s Disease Management Programs)</td>
</tr>
<tr>
<td>Paramount Elite and Early Retiree</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

These ratios are reassessed at least annually and adjusted as needed. In addition to the Utilization Management (UM), Elite and HMO/Advantage Case Management (CM) Coordinators, the department consists of a Director, a Case Management Manager, an Elite Case Management Manager, a Referral Management Manager, Behavioral Health Coordinators, UM Referral Coordinators, Social Services Coordinators, Health Risk Assessment/triage Coordinator, Pharmacy Program Director, Prescription Drug Program Coordinators, Pharmacy Utilization Nurse Coordinators, Pharmacy Utilization Coordinators, Utilization/Case Management Project Coordinator, Utilization/Case Management Staff Support and Utilization/Case Management Departmental Support. Level II positions are available for many job descriptions within Utilization/Case Management. In addition to routine duties, these positions serve as a resource for other departments and act as a first point of contact for internal/external inquiries in the absence of the Manager.

The departmental organizational chart is illustrated on the following page.
Utilization/Case Management Organizational Chart

Vice President,
Medical Director

Utilization/Case Management Director

Associate Medical/Clinical Directors
Pharmacy Program Director

U/CM Project Coordinator

U/CM Staff Support & Clerical Support

Elite CM Manager

Elite CM Coordinators
Level I & II

Elite Social Services Coordinator
Level I & II

Health Risk Assessment/ triage Coord.

Behavioral Health Coordinators
Level I & II; Health Home Behavioral Health Coord.

CM Manager, Comm./Advantage

Comm./Advantage CM Coord.
Level I & II

Referral Management Manager

Acute Care UM Coordinators
Level I & II

UM Coordinators
Level I & II

UM Referral Coordinators

Behavioral Health Coord.
UTILIZATION/CASE MANAGEMENT DIRECTOR

The Utilization/Case Management Director is a registered nurse. The director’s accountability objective is to manage the U/CM Department to provide ongoing, effective and efficient assessment of all aspects of patient care to help ensure the coordinated delivery of high quality, safe, cost-effective medical and behavioral care to all Paramount members.

REFERRAL MANAGEMENT MANAGER

The Referral Management Manager is a registered nurse whose accountability objective is to serve as the departmental resource for outpatient prior authorizations, preadmission, concurrent and retrospective review for inpatient admissions and home health care, PPO utilization and to conduct departmental quality improvement monitoring. This position also coordinates provider appeal determinations and acts as an interdepartmental liaison to ensure prompt resolution of UM issues and questions.

COMMERCIAL/ADVANTAGE CASE MANAGEMENT MANAGER

The Commercial/Advantage Case Management Manager is a registered nurse and Certified Case Manager whose accountability objective is to serve as a clinical resource and to provide supervision for staff and the day-to-day operations of the case management functions. In addition, this position ensures compliance with the Ohio Department of Job and Family Services provider agreement relative to care/case management requirements.

ELITE CASE MANAGEMENT MANAGER

The Elite Case Management Manager is a registered nurse and Certified Case Manager whose accountability objective is to serve as a clinical resource and to provide supervision for staff and the day-to-day operations of the case management and social services functions. In addition, this position acts as an interdepartmental liaison to ensure prompt resolution of case management issues and questions. This position ensures compliance with the CMS regulations relative to case management.

UTILIZATION MANAGEMENT COORDINATOR

The Utilization Management Coordinators are registered nurses and licensed practical nurses. Their accountability objective is to coordinate medical and pharmacy prior authorization requests, to perform preadmission, concurrent and retrospective review for inpatient admissions and outpatient services, to identify cases for case management and to ensure the delivery of high quality, cost-effective medical care to all Paramount members.
UTILIZATION MANAGEMENT REFERRAL COORDINATOR

The Utilization Management Referral Coordinators are certified medical assistants whose accountability objective is to conduct intake/data entry of prior authorization requests and coordinate the review process for Pharmaceuticals. This position acts as a referral source of potential cases for case management.

PHARMACY PROGRAM DIRECTOR

The Pharmacy Program Director 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), utilization management of prescription drugs, oversight of any groups delegated to provide a pharmacy program and providing clinical support to the care management team and other departments.

PHARMACY UTILIZATION NURSE COORDINATOR

The Pharmacy Utilization Nurse Coordinators are registered nurses and licensed practical nurses whose accountability objective is to conduct the review process for Pharmacy prior authorization, step therapy, high dollar requests and specialty injectables (both covered under the Pharmacy and Medical benefit). This position acts as a referral source of potential cases for case management.

PHARMACY UTILIZATION COORDINATOR

The Pharmacy Utilization Coordinators are certified medical assistants whose accountability objective is to conduct the review process for Pharmacy prior authorization, step therapy and high dollar requests. This position acts as a referral source of potential cases for case management.

HMO/ADVANTAGE CASE MANAGEMENT COORDINATOR

The Case Management Coordinators are registered nurses whose accountability objective is to facilitate, coordinate and evaluate the ongoing care of a specific caseload of patients throughout the Continuum of Care, to collaborate with members of the health team, the patient and the family to assure cost-effective, high quality, appropriate care for the patient during the entire episode of illness and for post discharge services and to monitor and evaluate patient outcomes, including self-management.

PARAMOUNT ELITE CASE MANAGEMENT COORDINATOR

The Paramount Elite Case Management Coordinators are registered nurses whose accountability objective is to facilitate, coordinate and evaluate the ongoing care of a specific caseload of Paramount Elite members throughout the Continuum of Care, to collaborate with the health care team, the members and their families to assure cost-
effective, high quality, appropriate care during the episode of illness and to monitor utilization and evaluate outcomes, including self-management.

“ELITE” HEALTH RISK ASSESSMENT/TRIAGE COORDINATOR
The “Elite” Health Risk Assessment/Triage Coordinator is a registered nurse whose accountability objective is to coordinate identification of “Elite” members for Health Risk Assessment (HRA) screening; conduct intake and address HEDIS and Star Rating criteria during the HRA intake process and completion of the comprehensive general assessment to facilitate referrals to case management and social services as indicated.

ELITE SOCIAL SERVICES COORDINATOR
The Social Services Coordinator is a licensed social worker whose accountability objective is to provide service coordination for Medicare beneficiaries with a Skilled Nursing Facility/Extended Care Facility stay and those members with specialized non-medical needs identified from completed health risk appraisal survey responses and/or nursing/behavioral case management, as well as to act as a resource person for community programs and services.

BEHAVIORAL HEALTH UTILIZATION/CASE MANAGEMENT COORDINATOR
The Behavioral Health Coordinator is a registered nurse, licensed social worker, licensed independent social worker or professional counselor whose accountability objective is to perform preadmission, concurrent and retrospective review for inpatient and outpatient services and/or to perform case management for plan high risk or complex mental health and chemical dependency cases. In addition, this position acts as a liaison between the Plan and the community mental health board and board-funded alcohol and other drug addiction service providers.

MEDICAID HEALTH HOME BEHAVIORAL HEALTH COORDINATOR
The Medicaid Health Home Behavioral Health Coordinator is a RN, LSW, LISW, LBSW or LMSW whose accountability objective is to coordinate with Medicaid Health Homes (Community Mental Health Center-CMHC) to ensure that Advantage members with serious and persistent mental illnesses (SPMI), serious mental illnesses (SMI), and severe emotional disturbances (SED) with/without co-morbidities are receiving behavioral health and medical care to treat the whole person. This position is responsible for coordination of services, integration of care plan, and data sharing with the Health Home to prevent duplication of services and prevent fragmentation of care.
UTILIZATION/CASE MANAGEMENT PROJECT COORDINATOR

The Utilization/Case Management Project Coordinator is a registered nurse whose accountability objective is oversight and coordination of the design of long and short-term U/CM departmental projects as related to Plan goals and objectives.

UTILIZATION/CASE MANAGEMENT STAFF SUPPORT

The Utilization/Case Management Staff Support’s accountability objective is to provide administrative, clerical support for the U/CM Department.

UTILIZATION/CASE MANAGEMENT DEPARTMENTAL SUPPORT

The Utilization/Case Management Departmental Support's accountability objective is to support the U/CM Department by coordinating the distribution of the incoming daily UM/CM requests.

MEDICAL DIRECTOR, ASSOCIATE MEDICAL DIRECTOR, ASSOCIATE CLINICAL DIRECTOR

The Medical Director and Associate Medical Directors are physicians 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 Medical Director/Associate Medical Directors review and make recommendations regarding policies and procedures. The Associate Clinical Director 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 Medical Director, Associate Medical/Clinical Director also provides medical determinations for cases that do not appear to meet the Plan's guidelines and criteria to assure that the member receives the most appropriate medical/behavioral care in the most cost-effective setting.

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, dermatology, gastroenterology, OB/GYN, orthopedics, otolaryngology, pathology, podiatry, radiology, plastic surgery, dentistry, pediatric pulmonology, endocrinology, general surgery, neurology, neurosurgery, ophthalmology, retinology, urology, vascular surgery, behavioral health, cardiovascular surgery and cardiology. In addition, all members of the Medical Advisory Council are available for consultation with the Medical Director or Associate Medical/Clinical Director as needed.
PRESCRIPTION DRUG PROGRAM COORDINATOR

The Prescription Drug Program Coordinator is a registered pharmacist or doctor of pharmacy whose accountability objectives are to promote the clinically appropriate use of pharmaceuticals and to assure the optimal performance of the Pharmacy Benefit Management (PBM) services vendor utilized by Paramount. He/she also provides systematic and relevant feedback to participating physicians regarding individual prescribing patterns. Review of drug utilization reports, Risk Alert letters and formulary compliance reporting and production of articles for the monthly newsletters are additional responsibilities.
Paramount’s Utilization/Case Management Department maintains departmental policies and procedures. These policies are reviewed on an annual basis. In addition, procedures are reviewed annually and updated on an as needed basis. The policies and procedures provide documentation of the framework of authority in which the Utilization/Case Management Program operates. The Utilization/Case Management Coordinator is authorized to make decisions providing that he/she is operating within the framework described within these policies and procedures. The Utilization/Case Management Coordinator is authorized to approve services. Paramount’s utilization management decisions are based only upon appropriateness of care and service and existence of coverage. Utilization Management staff and Associate Medical/Clinical Directors are not financially or otherwise compensated to encourage underutilization and/or denials. Paramount does not delegate utilization management decision-making to any third party entity.

The Medical Director/Associate Medical Directors or Prescription Drug Coordinators (Pharmacists), as appropriate, are the only Plan representatives with the authority to deny payment 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 payment for behavioral health care services based on medical necessity/appropriateness.

To eliminate the fragmentation that often occurs within an unmanaged health care delivery system, the Primary Care Physician is responsible for coordinating all aspects of the member’s health care. Conversely, the member is responsible for coordinating his/her medical and behavioral health care through the Primary Care Physician. 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.

OUTPATIENT CERTIFICATION

Specialist Referrals

Although Paramount does not require in-Plan specialist referrals for claim payment, members are strongly encouraged to coordinate their specialist care with their Primary Care Physician.

In turn, Plan specialists are always responsible for communicating a treatment plan to the Primary Care Physician to assure that the Primary Care Physician is aware of all aspects of the patient’s care.

Emergency Room Services

Paramount maintains an Emergency Health Services 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.

The Plan also covers Emergency Room Services if referred by an authorized Plan representative, PCP or Plan Specialist. 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 Physician after receiving urgent care services in any setting. The intent of this procedure is to allow the Primary Care Physician 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 quarterly and members 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 participating specialist's recommendations for referral to a tertiary care center are taken into consideration by the Plan Medical Director or Associate Medical/Clinical Directors when he/she makes the determination. It is important to note that the member's Primary Care Physician must also agree with 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 that are 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. Decisions of this nature are made by the Plan Medical Director or Associate Medical/Clinical Directors. Specific guidelines are in place for UM/CM Coordinators to approve certain out-of-Plan requests.

**Predetermination of Benefits**

Prior to services being rendered, Members and/or providers may request a determination as to whether a specific procedure is covered. Requests for potentially cosmetic surgeries are common predetermination of benefit requests. The Medical Director or Associate Medical Directors make the determination as to whether a procedure is considered cosmetic. The UM/CM Coordinators can deny a procedure only if it is specifically referenced as a benefit exclusion.
Additionally, several procedures, durable medical equipment and injectable medications require prior authorization. The UM/CM Coordinators can approve these services if specific medical necessity criteria are met. All others decisions, including denials, are made by the Plan Medical Director/Associate Medical/Clinical Directors or Prescription Drug Coordinators (Pharmacists) as appropriate.

**Diagnostic Imaging**

Preestablished medical necessity/appropriateness criteria are utilized in the certification of elective outpatient CT scans, CTA of the coronary arteries, MRIs, MRA's and Nuclear Cardiology 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 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.

**Genetic Testing**

Pre-established medical necessity/appropriateness criteria are utilized in the certification of elective genetic testing. Prior authorization is not required for those genetic tests needed for potential organ transplant recipients.

**INPATIENT CERTIFICATION**

To assure that all hospital admissions are medically appropriate 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 and inpatient rehabilitation admissions. Elective admissions may be reviewed before the member enters the hospital. Urgent and emergency admissions are reviewed the first business day after the admission occurs. This review process is performed by telephone or by telefax with the Utilization Review Department at each hospital.

Preestablished medical necessity/appropriateness criteria are utilized to assure consistency in the certification process. Upon determination that an admission meets criteria, the UM/CM Coordinator assigns a length of stay in anticipation of the concurrent review process. The admission continues to be reviewed at appropriate intervals until discharge planning results in the patient's discharge. 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:

**Prospective Review**

Elective inpatient care may be reviewed prior to the admission to assure that the services are provided in the most appropriate setting. Preestablished medical necessity/appropriateness criteria are applied. The admission is then either approved or the provider is encouraged to reschedule the services in a more appropriate setting.
Concurrent Review

Ongoing, inpatient care is reviewed to evaluate the quality and appropriateness of care and to assess the medical necessity of the continued stay. Again, preestablished criteria are utilized. At this time, discharge planning may also be initiated to plan for continuing care after discharge.

Retrospective Review

Retrospective chart review is performed after the patient is discharged from the facility. It is usually implemented at those times when the hospital Utilization Review Department has been unable to provide enough information to demonstrate that the care meets the criteria for inpatient stay. This method of review is also performed when members have been admitted and discharged from a facility during a time period when Plan staff was not available (i.e., weekends, holidays).

Discharge Planning

During the course of precertification or concurrent review, the Utilization/Case Management Coordinator will often identify ongoing, continuing care needs for a patient that will be required after discharge. In these cases, 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. Within a few days of discharge from an acute care setting, follow up phone calls are made to select members who are at risk for readmission. The goal of this program is to assure compliance with the discharge plan/required follow up care and assist in the coordination of needed care/services to prevent adverse outcomes.

OTHER OUTPATIENT CERTIFICATION

Prior authorization is conducted for select outpatient procedures and durable medical equipment to ensure appropriateness of the service and availability of coverage. A list of services that require prior authorization can be found on Paramount’s Internet site, www.paramounthealthcare.com.

Coverage for specific self-injectable drugs is provided under either the medical or prescription drug benefit to decrease disease progression and avoid future costly medical care. Prior authorization is conducted to assure that the pharmaceutical is the most appropriate, cost-effective intervention.

The Utilization/Case Management Department reviews all home health care services prospectively and concurrently to assure that the services provided are medically necessary and being provided in the most appropriate setting.
PRESCRIPTION DRUG UTILIZATION MANAGEMENT

Paramount utilizes Express Scripts as its Pharmacy Benefit Manager (PBM). Quantity limits, dollar limits, step therapy and prior authorization (criteria established by the Pharmacy and Therapeutics Working Group, a subcommittee of the Medical Advisory Council) are placed on certain drugs. Additionally, for Medicare beneficiaries with drug benefits, Part D vs. Part B determinations are required using specific coverage criteria set by the Centers for Medicare and Medicaid Services (CMS). The utilization management process is activated by the pharmacist, ordering physician or member when the member accesses these drugs. The UM staff collects all pertinent medical information and has the authority to approve coverage if criteria are met. All other determinations are made by the Medical Director, Associate Medical Director or Prescription Drug Program Coordinator (Pharmacist). All UM processes, including verbal and written notification of the decision to the provider and member, are followed in making the determination.

CASE MANAGEMENT

Approximately 1% of a Plan's members will utilize approximately 25% of the Plan's resources. The Case Management Program was established to more effectively manage this segment of the population. Members are reviewed for potential case management when specific criteria are triggered. The Case Management Coordinator will review the case to determine if a positive impact can be made in the quality and cost-efficiency of the care. A full description of this program is provided beginning on page 24 of this document.

PARAMOUNT ADVANTAGE COORDINATED SERVICES PROGRAM (CSP)

An Advantage member may be enrolled in CSP if a review of his/her utilization demonstrates a pattern of receiving controlled substances at a frequency or in an amount that exceeds medical necessity. Reasons for enrollment may include the use of multiple pharmacies, multiple controlled substances, multiple visits to emergency rooms, a high volume of prescriptions or visits to medical professionals, previous enrollment in CSP or recommendations from medical professionals indicating that the member has demonstrated fraudulent or abusive patterns of medical service utilization. Members are locked in to a designated pharmacy for the purpose of filling their prescriptions for a minimum period of eighteen (18) months. Exceptions are made for emergency situations. All members enrolled in CSP are followed closely by Behavioral Health Case Management.

BEHAVIORAL HEALTH SERVICES

Paramount conducts utilization and case management for mental health/chemical dependency services provided to all commercial and Medicare members.

Paramount Advantage mental health/chemical dependency services are managed by Paramount's Behavioral Health Coordinators in cooperation with community mental health and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) certified agencies. The state of Ohio does not capitate the Plan for the provision of outpatient/ambulatory mental health/chemical dependency services. These services are
intended by the state to be provided by the community mental health and ODADAS agencies. However, in the event that services are not available on a timely basis, the Plan must make arrangements for services outside this network. When this occurs, the Plan is financially liable for the services and follows them closely to assure that quality care is being provided in the most appropriate setting. In addition, the Plan is responsible for the provision of inpatient mental health/chemical dependency services.

Utilization and case management functions for behavioral health services follow the same processes as general medical. This includes out-of-Plan specialist (psychiatrist/psychologist) referrals, tertiary care and inpatient certification. Outpatient prior authorization is conducted for partial hospitalization and intensive outpatient treatment. Paramount does not operate a centralized behavioral health triage service

**UTILIZATION MANAGEMENT DECISION/NOTIFICATION TIMEFRAMES**

Paramount follows federal, state and NCQA decision and notification timeframes for all utilization management determinations. Where regulatory and accreditation bodies differ, Paramount will use the strictest/shortest timeframe to assure compliance with all requirements. The following is a summary of Paramount’s decision and notification timeframes:

<table>
<thead>
<tr>
<th>Request Type</th>
<th>Decision standard</th>
<th>Verbal/e-notification</th>
<th>Written notification to practitioner &amp; member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent Pre-Service</td>
<td>Within 2 working days from receipt of request</td>
<td>Within 3 working days of making the decision</td>
<td>Within 3 working days of making the decision.</td>
</tr>
<tr>
<td>Urgent Pre-Service</td>
<td>Within 1 calendar day</td>
<td>Same day as decision</td>
<td>Within 2 calendar days of making the decision</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Within 25 calendar days of receipt of request</td>
<td>None required</td>
<td>Within 5 calendar days of making the decision</td>
</tr>
<tr>
<td>Advantage Drug requests covered under medical or pharmacy benefit</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request (denials only)</td>
</tr>
</tbody>
</table>

**UTILIZATION MANAGEMENT REPORTING SYSTEM**

Product-line specific, high level, summary cost and utilization data is reviewed and analyzed monthly for the following areas:

- Discharges/1,000
- Percentage of members receiving any mental health service
  - 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

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 are reviewed. Reports are structured so that they are available on a
patient 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 system allows for focused problem identification and resolution.

Paramount's Pharmacy Benefit Coordinator routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Pharmacy utilization is also monitored by individual physicians and across practice and provider sites. Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

**UTILIZATION MANAGEMENT PERFORMANCE MONITORING**

The Referral Management Manager monitors the consistency of the UM/CM staff in handling approval, denial and inpatient decisions. Turnaround time of UM decisions, including verbal and written notification is also monitored. Medical Director and Associate Medical/Clinical Director decisions are periodically reviewed by a physician for consistency of medical appropriateness determinations. Telephone service, as related to the percentage of calls that go into the hold queue, abandonment rate and average speed of answer is tracked. Additional monitoring of the Utilization Management Program is performed through comments from the Member Satisfaction Survey, the Physician and Office Manager Satisfaction Survey, Case Management Member Satisfaction Survey, the quarterly appeals reports and the monthly Member Service survey cards.

**ACCESS TO UM STAFF**

Utilization and Case Management staff is available Monday through Friday (excluding holidays) from 8:00 a.m. to 6:00 p.m. to answer questions regarding UM decisions, authorization of care and the UM program. The Department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. 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. 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 Plan Departments for UM and Case Management 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 (i) preventive, diagnostic, and/or therapeutic in nature, (ii) specifically relates to the condition which is being treated/evaluated, (iii) rendered in the least costly medically appropriate setting (e.g., inpatient, outpatient, office), based on the severity of illness and intensity of service required, (iv) not solely for the Member's convenience or that of his or her physician and (v) is supported by evidence-based medicine.

MEDICAL NECESSITY CRITERIA

The Utilization Management Program is conducted under the administrative and clinical direction of the Vice President Medical Director 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 annually 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 web site. InterQual® criteria are available to providers through Paramount Direct. 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 2013 edition of the McKesson InterQual® Level of Care Criteria (Acute Pediatric; Acute Adult; Behavioral Health Chemical Dependency & Dual Diagnosis (Adult & Adolescent); Behavioral Health Psychiatry (Adult, Child, Adolescent, Geriatric); Residential and Community-Based Treatment (Adult, Adolescent & Child) as the basis of the inpatient certification process. In addition, the InterQual® criteria are applied in reviewing the appropriateness of admissions for inpatient rehabilitation services, admissions to skilled nursing facilities, mental health and chemical dependency partial hospitalization, intensive outpatient and ambulatory services and for home health care services. It is the practice of local participating hospitals to utilize the InterQual® criteria during their internal Utilization Review process. Physicians may review the InterQual® criteria at any participating hospital or by contacting the Director of Utilization/Case Management.

Outpatient/Other Certification

Where it exists, 2013 InterQual® Procedures and Molecular Diagnostics (MdX) criteria are used to determine medical necessity for outpatient services. When absent from the InterQual® criteria sets, internal criteria for certification are based on current evidence-based medical literature and are developed by the Technology
Assessment or the Pharmacy and Therapeutics Working Groups. At least annually, the criteria are reviewed by the Working Groups and applicable participating subspecialists. The Medical Advisory Council takes the Working Group’s recommendations for modifications into consideration during the approval process. The criteria are used by the Utilization and Case Management Coordinators during the prior authorization process. The internally developed criteria are available on Paramount’s internet site, www.paramounthealthcare.com.

Diagnostic Imaging

The 2013 edition of McKesson InterQual® Imaging Criteria is used as the basis for authorization of the following elective, outpatient Imaging studies:

- CT Scans
- MRIs
- MRAs
- Nuclear Cardiology
- CTA Coronary Arteries

Genetic Testing

The 2013 edition of McKesson InterQual® Molecular Diagnostics (MdX) Criteria is used as the basis of authorization for genetic testing.

Durable Medical Equipment

Medicare guidelines are used in the prior authorization of select durable medical equipment for the Commercial and Medicare product lines. Medicaid guidelines are used for Paramount Advantage members. A list of durable medical equipment that requires prior authorization can be found on Paramount’s internet site, www.paramounthealthcare.com.

Transplants

It is Paramount’s policy that all requests for organ transplants be reviewed by the Medical Director or Associate Medical Director and Case Manager and the members are directed to the most appropriate Center of Excellence transplant facility for evaluation based on benefits.

The Case Manager works with the facility transplant coordinator to send the transplant recommendation to either the Ohio Solid Organ Transplant Consortium or the Ohio Hematopoietic Stem Cell Transplant Consortium, as appropriate, prior to approval by the Plan. Renal and cornea transplants are excluded from Consortium review. The Plan’s determination of medical necessity will be based on the Transplant Consortium’s determination, thus providing an outside, impartial, expert evaluation. Once the patient has been approved, the patient is enrolled in the
United Network for Organ Sharing (UNOS). The patient's acceptance into UNOS serves as the Plan's medical necessity determination.

All members that are approved for transplant are followed closely by Case Management as well as Paramount’s interdepartmental transplant team, consisting of Medical Directors, Case Managers and Financial, Claims and Actuarial representatives. The purpose of the team is to ensure ongoing medical necessity for transplant, employer group high dollar alert (if self-insured), and reinsurance notification and to ensure appropriate claims payment.

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 and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics Working Group.

If the new technology/pharmaceutical or new application of an existing technology/pharmaceutical is addressed in the above documents, the information is taken into consideration by the Medical Director or Associate Medical/Clinical Directors at the time of benefit determination. If the new technology/pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director or Associate Medical/Clinical Directors may confer with an appropriate specialist consultant for additional information. This information will be presented to the Technology Assessment or Pharmacy and Therapeutics Working Group, subcommittees of the Medical Advisory Council, to provide a recommendation to the physician Council regarding coverage. The decision will be based on safety, efficacy, cost and availability of information in published literature regarding controlled clinical trials. If a decision cannot be made, a committee of specialists may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Medical Advisory Council.
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 of the following:

- Primary Care Physician
- Specialist physician
- Hospital Utilization Review Department
- Patient chart
- Home health care agency
- Skilled nursing facility
- Physical, occupational or speech therapist
- 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

The Utilization/Case Management Coordinator will use this information, along with good nursing 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 Utilization/Case Management Coordinator has the authority to approve services based on medical necessity. If the decision is outside the scope of the Utilization/Case Management Coordinator's authority, the case is referred to the Medical Director/Associate Medical Directors for a determination. The Medical Director/Associate Medical Directors or Prescription Drug Coordinators (Pharmacists), as appropriate, are the only Plan representatives with the authority to deny payment for services based on medical necessity/appropriateness. Psychiatrists, doctoral-level clinical psychologists, or certified addiction medicine specialists have the authority to deny payment for behavioral health care services based on medical necessity/appropriateness. Alternatives for denied care/services are given to the requesting provider and member and are based on the criteria set used or individual case circumstances. In making determinations based on contract benefit exclusions/limitations, the Member Handbook and Group Services Agreement are used as references.
CONFIDENTIALITY

Paramount has written policies and procedures to protect a member's personal health information (PHI). The Utilization/Case 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 those employees that need to know that information to provide these functions. A full description of Paramount’s Notice of Privacy Practices may be found on our website at: www.paramounthealthcare.com.
CASE MANAGEMENT

The purpose of the Case Management Program at Paramount is to identify and manage members at high risk for complex, costly, or long-term health care needs. Through a logical process and utilizing the contracted provider network, the Case Management Coordinator (CMC) will coordinate medically appropriate services in a supportive, cost-effective environment. The Case Management Program has two components: Complex Case Management and Routine Case Management. All Case Management activities will maintain the member’s privacy, confidentiality and safety. The CMC will advocate for the member and adhere to ethical, legal and accreditation/regulatory standards while reinforcing the member’s Rights and Responsibilities as noted in the Member Handbook.

The desired outcomes of this program are:
- Treatment of the member in the least restrictive setting and manner
- Improve self-management knowledge and skills regarding disease/condition
- Return of the member’s health to the maximum potential
- Promote positive health outcomes
- Increase in member satisfaction
- Support for the Primary Care Physician
- Utilization of participating providers
- Reduction in the cost of care
- Reduction in unplanned hospital admissions and inappropriate emergency room use

Definitions:

A. Complex Case Management:
Complex case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis requiring an extensive use of resources. These members need help navigating the system to facilitate appropriate delivery of care and services, including community resources.

B. Routine Case Management:
Members that do not qualify for complex case management may be eligible for routine case management. Routine case management focuses on chronic disease conditions that require monitoring and education to help members manage their conditions. This may include members in an acute care setting with continuity of care post-hospital discharge issues, members with inappropriate emergency room use and members with high or intense hospital utilization. This category includes all referred members, including Members with Special Health Care Needs (MSHCN) and ODJFS required conditions.

C. Care Management:
This level of management is for identified members who require less intensive case management, have declined case management services but still need to be followed for utilization management, or for members that are unreachable. Members are notified that care management is an opt-out program. Instructions on how to opt out of the program are mailed to the member.
STANDARDS OF CARE: The Case Management process will include (Resource: CMSA Standards of Practice for Case Management):

A. **Case Identification:**
   1. Identification of Members for Case Management (CM):
      a. Members may be recommended to CM by telephone, e-mail, letter, fax, CCMS from the following sources:
         - Member Services
         - Health Care Providers (hospital discharge planners, physicians, navigators, home care providers, social work)
         - UM Coordinators
         - Member self-referral
         - Disease Management referrals either through the automatic process or by a disease management coordinator
         - High Dollar Report
         - Ohio Department of Job and Family Services (ODJFS) Programs and reports – SSI, CCR, Prior Auth, FFS data (Snapshot Tool)
         - Emergency Room claims/data – two or more ED visits within 180 days (within a rolling 12 month period) with a primary diagnosis of any of the following conditions: Asthma, CAD, CHF, Diabetes, Non-Mild Hypertension, COPD, Severe Mental Disorder or Substance Abuse
         - One inpatient hospital readmission within 90 days (within a rolling 12 month period)
         - Three or more acute inpatient hospitalizations (within a rolling 12 month period)
         - Elite Post Enrollment Health Risk Assessment
         - Advantage new member screening
         - Advantage Disease-specific reports
         - ProMedica Call Center daily reports (24/7 line)
         - Pharmacy Specialty and Controlled Substance Drug reports
         - Inpatient Census reports
         - Profiling reports to identify “at risk” members
         - Prenatal Claims Report
   
      2. Advantage Case Identification – Identify Members with Special Health Care Needs (MSHCN). The purpose is to ensure that appropriate care management services are provided to MSHCN who have specific diagnoses and/or who require high cost or extensive services.

      3. Case Evaluation
         a. Acute case referrals will be screened within two business days for case management.
         b. Member will be contacted for the appropriate General Assessment (GA) within 10 business days of the referral except members that cannot be reached.
         c. Referred cases are opened or rejected within 10 business days of referral. Variances to this timeframe are documented.
         d. An Adult or Pediatric general assessment is created within 10 business days of opening the case.
e. The member must agree to case management services either verbally or in writing. Members may refuse to participate in Case Management.

f. Members that cannot be contacted in 3 (three) telephone calls within 10 business days will be mailed a Case Management “Unable to Reach” letter and a health questionnaire. No member response to the letter and questionnaire within 10 business days from the date of the mailing will result in a rejection for case management. Exception: Advantage members are placed in low/medium care management and sent an opt-out letter.

g. Reviews that are generated from Disease Management will have 15 days to evaluate for CM. If the member does not meet criteria for CM, refuses CM or is unable to be reached, the review is sent back to the Health Coach in Disease Management for follow up. Reviews that are identified via monthly reports (i.e., HRAs, Advantage monthly reports) have 30 days to be completed.

h. To ensure ODJFS compliance, Advantage members that have been identified for case management and agree to case management services must be assessed and placed into CM within 90 days of effective date of enrollment for new members and within 90 days from the date they were identified for CM for existing members.

4. Identification of Case Type:
Members are assessed for Complex or Routine Case Management

a. Complex Case Management
   - 3 or more hospital admissions within 6 months for the same or related diagnosis
   - Major or multiple system failure
   - Multiple Trauma
   - Med/Surg inpatient cases with extenuating complications
   - Head or spine injuries with potential residual deficits (includes CVA)
   - Severe burns over 20% of the body surface
   - Complicated coordination of care or discharge planning (any disease/condition)
   - Cancer with critical event or treatment requiring the extensive use of resources
   - Chronic diseases with co-morbidities or complications leading to high dollar claims or high utilization
   - High risk pregnancy
   - Transplant – solid organ or bone marrow (excludes corneal)
   - Major mental health (severe, persistent mental illness) or substance abuse disorder or critical event: may be characterized by suicidal or homicidal ideation or behaviors, inability to carry out activities of daily living independently, or persistent issues with compliance with treatment plan or medications
   - Extensive use of health care and/or community resources
   - Newborn/Pediatric with critical event or diagnoses requiring the extensive use of resources (includes CSHCN)
   - *Advantage* NICU babies with a length of stay greater than 10 days
b. Routine Case Management
Member does not meet Complex Case Management but may benefit from the Case Management process for health care education, coordination of care and services and improved utilization of health care services. Examples include:

- Chronic diseases
- Co-morbidities
- Short term medical condition with coordination of care needs
- Hospice cases
- ER Diversion
- Polypharmacy
- Advantage members enrolled in the Coordinated Services Program (CSP – Controlled Substance Abuse Program)

B. Problem Identification
1. Assessment – The initial CCMS comprehensive assessment (Adult or Pediatric GA) that includes documentation of the member’s specific health care needs, health care history, functional level, educational level, cultural and linguistic needs and support system will be the base for the member’s individualized plan of care. Assessments identify nursing diagnoses and nursing interventions. The care treatment plan has mutually agreed-upon goals and interdisciplinary interventions. The case manager monitors for complications and addresses educational needs.
   a. Appropriate CCMS Case Type Specific Assessments (CTSA) will be completed within 10 days of opening the case.
   b. Members that disenroll and re-enroll with the Plan will have new assessments created. All members will have the appropriate general assessment completed annually.
   c. Members and their Providers will be notified in writing via an introduction letter that the member has been identified as meeting the criteria for case management, including their enrollment into case management and how to opt out of case management. The CMC will include her business card with the letter.
   d. All assessment questions are to be addressed with the appropriate actions taken. It is at the discretion of the CMC to select these radial buttons which trigger the system to create appropriate problems, interventions and goals.

C. Planning
The CMC will develop a formal plan of care within 10 business days of the member being opened in active case management. The goal of planning is to develop an appropriate and fiscally responsible plan of care that enhances quality, access and cost effective outcomes. The formal plan of care will be developed in collaboration with the member. The PCP and other health care providers will be given the opportunity to participate in the development of the care plan.
   a. Plan of Care:
      - Problems, short and long term goals and interventions will be reviewed and prioritized with the member in order to develop an individualized and prioritized plan of care. Problems, interventions and goals are identified and dated.
      - The individualized plan of care will be based upon evidence based medicine.
• The plan of care will include prioritized long and short term goals and will be time-specific.
• The plan of care will include action-oriented interventions (i.e., education, referrals, etc.) and will be time-specific.
• Identify potential barriers to goal attainment.
• Self-management, when appropriate, will be part of the plan of care (i.e., COPD Action Plan, Asthma Action Plan).
• Continue to involve the member/caregiver in the ongoing plan of care.
• A team meeting with the Care Plan Team (PCP, member, family, CMC, discharge planner, Plan Medical Director and other appropriate providers) may be of benefit for development and implementation of the care plan.
• Printed copies of the Plan of Care may be provided to the member and providers, as appropriate.
• Life Care Planning
• CCMS reminders are generated to notify the case manager of the case next review. Reports are run monthly to identify members that do not have an active reminder.
• Cases are monitored for compliance with the completion of the assessments and development of the care treatment plans.

Members that require specialized care over a prolonged period of time and have a life threatening, degenerative or disabling condition may select a specialist as a primary care physician. The specialist must agree to act in the capacity of a primary care physician. The member's current primary care physician must be in agreement that it would be in the best interest of the member to have the specialist act as the member's primary care physician. These requests are reviewed and approved on a case-by-case basis by Paramount's Medical Director/Associate Medical Director or Director of Utilization/Case Management.

b. Facilitation/Coordination of the Plan of Care: The process by which specific case management activities and/or interventions are initiated that will lead to accomplishing the goals and meeting the needs identified in the plan of care. The CMC and health care team will work with the member to provide access to services.

Activities/Interventions:
• Co-management of CM cases with Behavioral Health when indicated
• Ensure that referrals are in place, if required
• Utilize health care providers to provide interventions as identified by the plan of care
• Facilitate member education and understanding to prevent risk behaviors and to promote positive outcomes. Education may be provided by:
  - Home Health Care Agencies
  - Formal classes available at participating hospitals to assist the members in management of acute or chronic illness/injury
  - Paramount Disease Management Programs
  - Utilize educational material that has been approved by Paramount
• Identify and encourage use of government programs and community resources as appropriate
• Facilitate transportation either as a covered service or through community resources
• Vendor management and fee negotiation.
• All members have direct access to in-Plan without requiring a Plan referral. Prior authorization is required for all out of Plan services. All Advantage members will be notified of direct access to specialists as found in their member handbook and this notification will be documented in CCMS and the plan of care. In the event of a member inquiry, Member Services or Plan providers will provide information regarding their right to directly access specialists. This information is included in the PCPs orientation materials.
• A minimum of one face-to-face visit per quarter is required for Advantage members in high risk case management.

c. Communication: The CMC will facilitate coordination of communication between service provider, member/family, including an accountable point of contact to help obtain medically necessary care, assist with health related services and coordinate care needs. Coordination will include (not all inclusive):
  • Communication and coordination of care between PCP and specialists
  • Continuity of care communication as the member moves between multiple levels of care
  • Access to interpretive/translator services
  • Interdisciplinary Care Team meetings

D. Monitoring – The process of ongoing assessment and documentation to monitor the plan of care for determination of the plan’s effectiveness.
• Member contact may be daily if necessary, but minimum of twice a year. Frequency of member contact will be documented in CCMS.
• Prompts for case follow up will be generated by CCMS goals, reminders and CTSA strats.
• Communication with member for updating of health status and progress toward goals
• Communication with health care team to review plan of care, additional problems and updates to the plan of care.
• Regular communication with the health care team to address continuity of care, barriers to care and plan of care revisions.
• Monitor health care service delivery and utilization according to the plan of care.
• Team meeting with the Care Plan Team for modification of the care plan as appropriate.
• Education review for member adherence and understanding.
• Progress toward self-management
• Medication adherence
• Monitor disease-specific diagnostic tests, etc.
• Monitor that routine health care screenings are obtained.
• Monitor appointments are kept with the PCP and specialist. If the member fails to keep scheduled appointments, a call may be placed to the member and the reason for the missed appointment is determined. If the CMC is unable to reach the member by phone, a Paramount Advantage representative may be asked to make a personal visit to the member’s home for education. For other Paramount members that cannot be reached, a letter may be sent.

E. Evaluation – The process to measure the member’s response to the plan of care.
• Evaluation at appropriate intervals to determine the care plan’s effectiveness in meeting outcomes and needs (i.e., gaps in care, barriers, lack of participation).
• The plan of care may be modified or changed as determined by the evaluation.
• The case intensity will be reviewed for appropriate type: Complex, Routine and Advantage Low/Medium and changed as per evaluation. The CMC’s documentation in CCMS will demonstrate the rationale for the level of care.

F. Discharge from case management occurs when:
• The member and the CMC are satisfied that the member’s goals have been met, the member will be notified by phone and/or in writing that case management is no longer needed.
• The member no longer wishes to participate.
• The member is no longer working toward his/her goals.
• The member is no longer covered by the Plan.
• The member’s needs are being met by other services.
• The member’s problems and goals are at the level of Disease Management.

At the time of discharge from case management, the member and their PCP are sent a case management discharge letter. The member is also sent a satisfaction survey. The survey is not required if:
• Member disenrolled
• Member expired
• Member is in care management
• Special circumstances approved by the Manager

G. Outcomes - CM outcomes must be measureable and goal oriented to demonstrate the benefit of the CM Program and to identify areas for improvement.
1. The annual CM Member Satisfaction Survey will measure member satisfaction with the CM program and the CMC. Complaints or inquiries will be directed to the appropriate Manager for review and follow up.
2. Complaints and/or inquiries received by Member Services will be documented in a Maccss SF and tracked through the Member Services Appeals, Grievances and Complaint area.
3. Cost Savings Report
4. Decreased hospital admissions for members after 3 months of active CM (specific to disease case managed)
The Case Management Procedure and Advantage Case Management Program will be submitted annually for review and approval by ODJFS. Any subsequent changes to an approved case management program will be submitted to ODJFS in writing for review and approval prior to implementation.

RECONSIDERATION OF ADVERSE DECISIONS

In the event of an adverse UM decision, the denial notice to the practitioner contains information on how to activate the reconsideration process. Reconsiderations may be telephonic or in writing and are conducted between the provider or health care facility and the reviewer who made the adverse determination. Reconsideration determinations are made within two (2) business days after receipt of the request. If the reviewer cannot be available within two (2) business days, the reviewer may designate another reviewer. The determination may be expedited if the seriousness of the medical condition of the member requires an expedited decision. In order to expedite the decision, the practitioner must certify that waiting the standard two (2) business days for a determination, and therefore receipt of the requested services, will result in 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.

Verbal and written notification of the determination will be made within two (2) business days of making the decision. Information on how to appeal an adverse reconsideration decision on behalf of the member is included with the denial letter to the practitioner. The appeals process is outlined below.

THE MEMBER APPEAL PROCESS

There may be instances where either a member, a member’s Legal Representative or an Authorized Person is not satisfied with a coverage decision made by the Plan. Paramount has established policies and procedures for registering and responding to member grievances and appeals. All UM denials contain a product-line specific appeals insert that explains to the member and provider how to appeal the denial determination. The product-specific appeals processes meet all regulatory and accreditation (NCQA) requirements. Product-specific appeals information can be found on Paramount’s website: www.paramounthealthcare.com.