

PARAMOUNT/PROMEDICA MEDICARE PLAN

Toledo, Ohio

TO: The Members of the
Paramount Quality Steering Committee

DATE: October 7, 2020

SUBJECT: 2020 Utilization Management Program Description

Paramount annually reviews the formal description of its Care Management Program, revising and updating it as advised by the Medical Advisory Council (MAC). This description is comprehensive in nature, serving as the template from which Care Management policies and procedures are developed. In previous years, this program description incorporated all aspects of Care Management. However, starting this year (2020) each individual area (UM, CM, and Population Health) will create their own program description.

Changes to the Utilization Management Program Description for 2020:

- Page 6: Updated the Departmental Organization page to include information regarding the MyNavigator program for ProMedica employees and including overall roles and responsibilities.
- Page 15: Updated the Manager, Behavioral/Health Utilization/Care Management position
- Page 18: New job role of Quality Assurance Associate
- Page 18: New job role of Utilization Management Special Initiatives Coordinator
- Removed all Case Management and Population Health information, as these will be included on the separate program descriptions for each area.

At this time, we would appreciate your input and any additional recommendations to be included in the final 2020 Utilization Management Care Management Program Description.

Respectfully submitted,

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**Paramount Advantage
Paramount Care, Inc.
Paramount Care of Michigan, Inc.
Paramount Insurance Company
ProMedica Medicare Plan**

**UTILIZATION
MANAGEMENT
PROGRAM DESCRIPTION
2020**

2020 Utilization Management Program Description

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GOALS AND OBJECTIVES

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

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

- To 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 attainable quality of care.
- To educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.
- To ensure transition of care is addressed as members move through the healthcare continuum.

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

The desired goals of the Utilization Management program are:

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

CARE MANAGEMENT PROGRAM OVERVIEW

Paramount's Care Management Program is designed to promote members' experience of care, ensuring the delivery of high quality, cost efficient care, in alignment with the Triple Aim and the core elements of the population health management framework. Paramount follows an evidence-based approach to comprehensive case management, with an emphasis on population stream-associated interventions, risk stratification, and proactive member engagement. Departments within the Care Management umbrella include Utilization Management, Case Management (Intensive, NCQA Complex-a subset of Intensive and High-Risk) Population Health Management (Medium, Low, and Monitoring risk stratifications) and Pharmacy. The program is under the administrative and clinical direction of the Chief Medical Officer of Health Services, the Senior 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 Care Management Program annually, and updates occur as required.

For product lines on an HMO platform, the primary care provider and other collaborative providers are responsible for managing all aspects of the member's health care needs. All members select a primary care provider at the time of enrollment and are encouraged to establish and maintain a relationship with the provider. The member is instructed to contact the primary care provider whenever medical or behavioral health care is needed. The primary care provider is informed about the patient's needs and can make informed, appropriate decisions regarding treatment. The care management team provides assistance with navigating the health care system, as requested by individual members.

DELEGATION OF UTILIZATION & CASE MANAGEMENT

Delegation occurs when Paramount gives another organization the decision-making authority to perform a function that we would otherwise do ourselves. It is a formal process, contractual, and consistent with the National Committee for Quality Assurance (NCQA) accreditation standards and the Ohio Department of Medicaid (ODM) regulations. Paramount 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 June 1, 2013, Paramount *Advantage* delegated utilization management functions for dental prior authorizations to DentaQuest and optical benefits to EyeQuest. Case management of adults and utilization management for adults and children are delegated to Quality Care Partners (QCP) for members residing in 11 counties in central Ohio, effective July 1, 2013. Case management of children is delegated to Partners for Kids (PFK)/Nationwide Children's for members residing in 34 central/southeast counties of Ohio; effective September 1, 2013. Contracts for delegation with QCP and PFK will conclude June 1, 2020.

DEPARTMENTAL ORGANIZATION

Care management staffing is comprised of a multi-disciplinary team, collaborating to deliver a comprehensive, integrated approach with roles and responsibilities of team members delineated to prevent duplication of activities. These professionals include: registered nurses, licensed practical nurses, mental health/chemical dependency professionals (nurses and licensed social workers), health coaches, outreach coordinators, social worker assistant, and support staff.

Utilization Management staffing is organized by service performed and/or product lines served to maximize efficiency and cross training of staff. Staff is primarily responsible for organization determinations, provider appeals, transition of care between care settings, as well as referrals for case management for members identified with risk factors.

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

Utilization Management has a process for the identification and referral of high-risk members who may benefit from enrollment in Case Management. A risk-stratified pursuit list is used to proactively outreach and engage additional members in case management, enabling the mitigation of the risk for adverse health-related outcomes and medical expense through participation in the program.

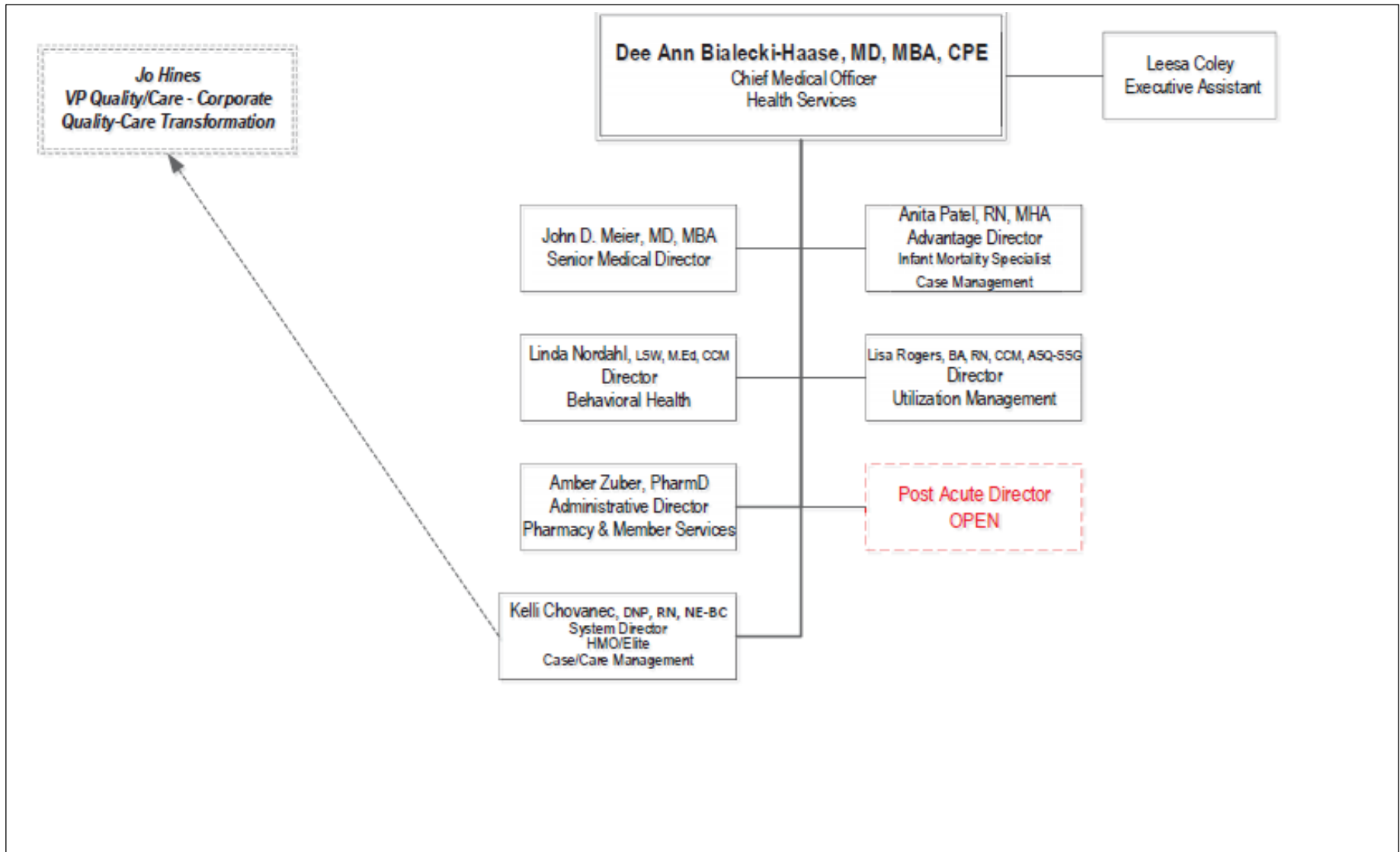
In addition to the Utilization Management (UM) Coordinator; the department consists of The Chief Medical Officer, the Senior Medical Director, a Director of Utilization, Directors of Case Management, a Director of Behavioral Health, a Behavioral Health UM/CM Manager, a UM/Operations Manager, Case Management Team Leaders (Medical/Behavioral Health), Genetic Counselor, Behavioral Health Coordinators, Clinical Compliance Coordinator, Quality Assurance Associate, an Acute Care/Readmission Appeals Analyst (Medical/Behavioral Health), Special Initiatives, UM Referral Coordinators, Social Determinant of Health Coordinator, UM Special Initiative Coordinators, UCM Project Coordinators, a UCM Operations Team Lead, Utilization/Case Management Assistant Coordinators, a UCM Educator and Staff Development resource, as well as Utilization/Case Management Departmental Support.

The MyNavigator program, initiated in January 2020 consists of the MyNavigator Director, Operations Specialist, Care Champion Clinical Lead, Care Champions for UM, CM (Case Management) and PHM (Population Health Management), as well as Health Advocates. In addition to the UM/CM/PHM services offered by Paramount care management teams, the MyNavigator team focuses on a comprehensive streamlined program to assist ProMedica's employee health plan members with all of their health plan related needs including but not limited to: understanding health benefits, coordinating care, navigating the health care system and offering best-in-class customer service.

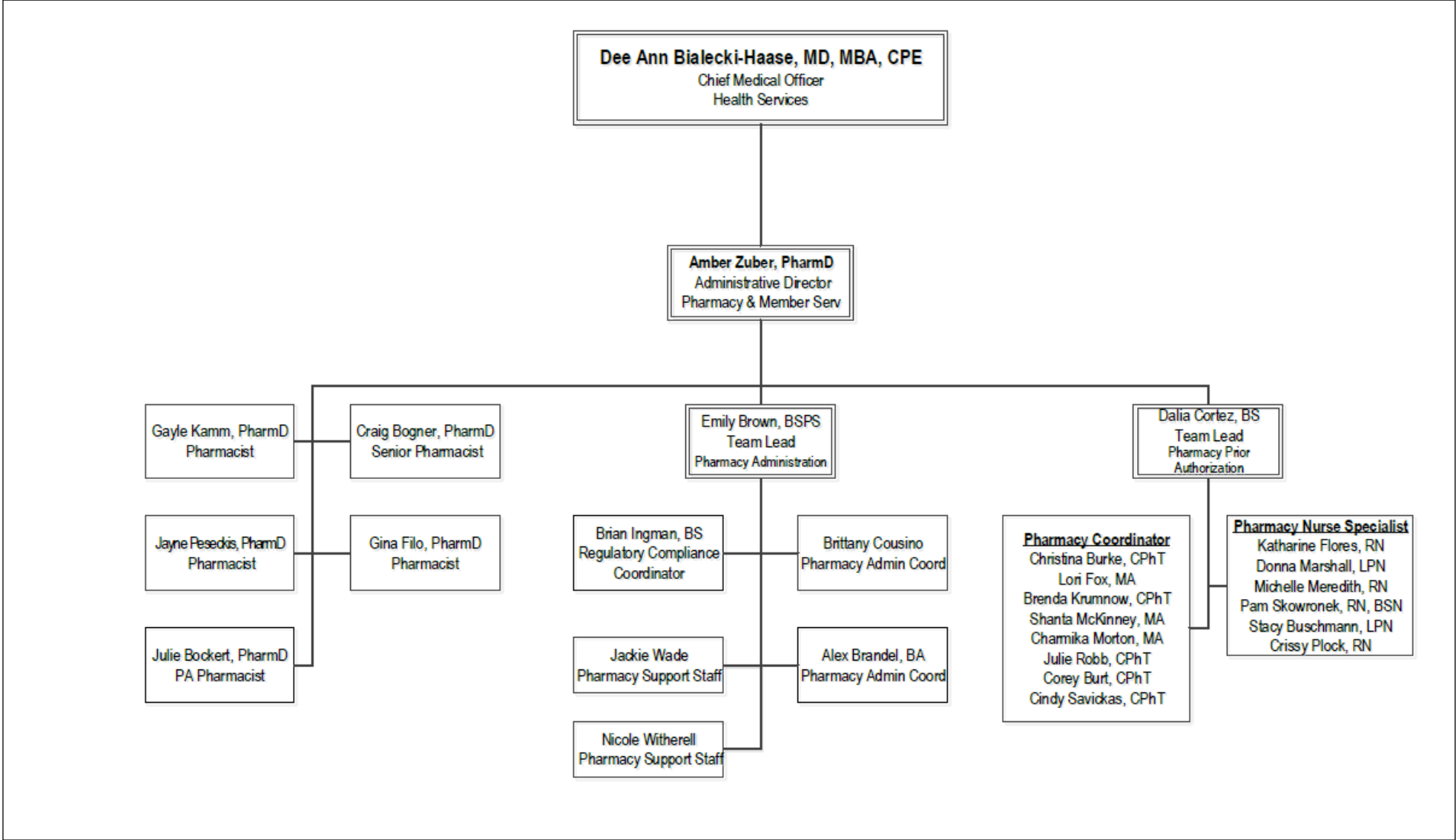
The Pharmacy Team collaborates within the structure of the care management department. This team has an Administrative Director of Pharmacy, Pharmacists, a Pharmacy Team Leader, Pharmacy Administrative Coordinators, Senior Pharmacy Administrative Coordinators, and Pharmacy Utilization Nurse Coordinators.

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

The departmental organizational charts are illustrated on the following pages:

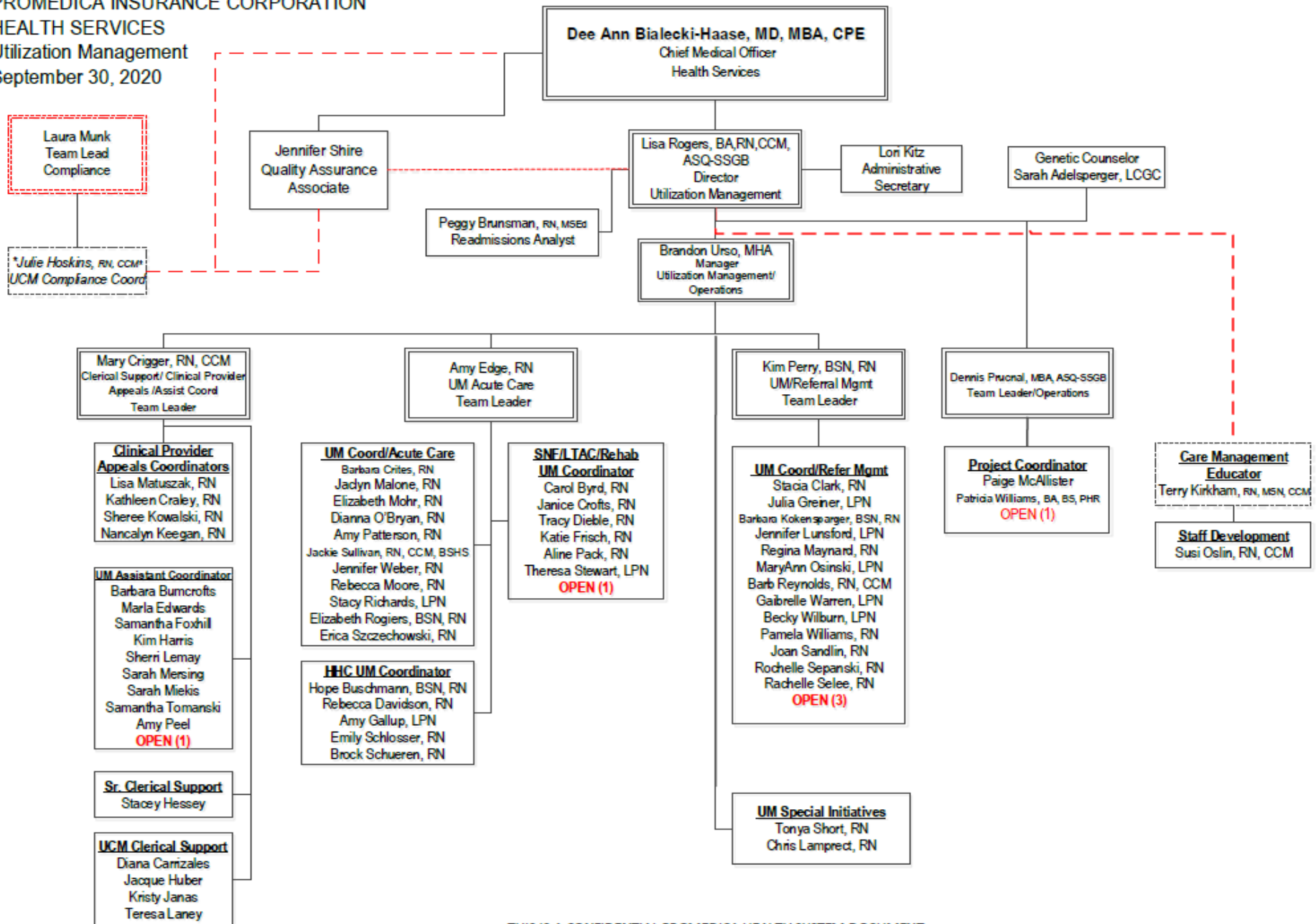


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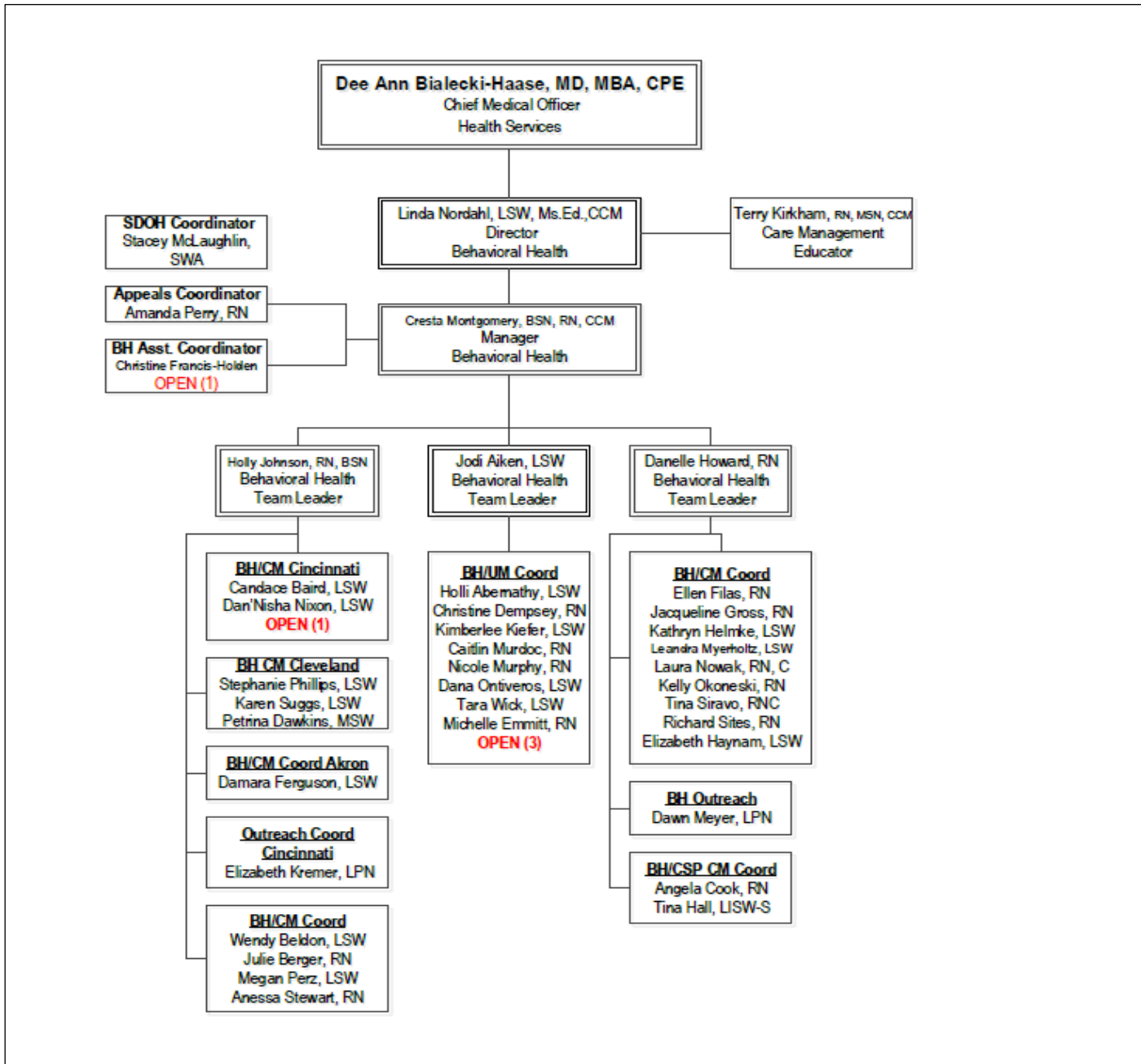


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PROMEDICA INSURANCE CORPORATION
 HEALTH SERVICES
 Utilization Management
 September 30, 2020



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Chief Medical Officer / Health Services

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

Senior Medical Director / Health Services

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

Director, Behavioral Health

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

Director, Utilization Management

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

Administrative Director of Pharmacy

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

Manager, Behavioral Health Utilization / Care Management

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

Manager, Utilization Management /Operations

The Utilization Management/Operations Manager has the primary accountability objective to serve as the departmental resource for outpatient prior authorizations, preadmission, concurrent, and retrospective review for inpatient admissions and home health care; along with conducting departmental quality improvement monitoring. This position also coordinates provider appeal determinations and acts as an interdepartmental liaison to ensure prompt resolution of UM issues with the goal of appropriate medical and utilization management oversight to optimize medical expense and member outcome.

Pharmacist

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

Care Management Department Educator

The Care Management Educator is a registered nurse whose accountability includes development of assessment, planning, implementation, and evaluation of orientation/training and annual competency training/testing for the Utilization Management department including leadership. The Educator prepares and updates training manuals and other educational materials on an ongoing basis or as critical changes occur. This role provides outstanding customer service and accepts responsibility in maintaining relationships that are equally respectful to all.

Care Management Staff Development

The Care Management Staff Development position is held by a registered nurse whose accountability includes assisting with development of assessment, planning, implementation, and evaluation of orientation/training and educational presentations and in-services. The Staff Development Coordinator assists with the preparation of and updating of training manuals and other educational materials on an ongoing basis or as critical changes occur. Provides outstanding customer service and accepts responsibility in maintaining relationships that are equally respectful to all.

Behavioral Health Utilization Management Team Leader

The Behavioral Health Utilization Management Team Leader is a registered nurse or social worker who empowers team members in order to improve productivity, collaboration, innovation and effectiveness to meet the needs of Paramount members. The working team leader acts as an interdepartmental liaison by creating a team environment to ensure prompt resolution of utilization management issues, questions and concerns.

Acute Care / Utilization Management Team Leader

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

Referral Management Team Leader

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

Clinical Appeals Coordinator and Support Staff Team Leader

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

Operations Team Leader

A working team leader who assumes the role for oversight of the implementation, coordination and design of long and short-term Care Management departmental projects, implementation of new software applications, and process improvement initiatives as related to Plan goals and objectives. Responsibilities also include the review and implementation of departmental and inter- departmental efficiencies related to utilization management care management workflows and operations.

Pharmacy Prior Authorization (PA) Team Lead

The Pharmacy PA Team Leader is responsible for staff supervision and the day-to-day operations of medication reviews and authorizations. The team leader acts as an interdepartmental liaison to ensure prompt resolution of utilization management issues, questions, and concerns. This position does regular monitoring to assess the work of the group for compliance with regulations set forth by various governing bodies such as Centers for Medicare and Medicaid Services (CMS) or Ohio Department of Medicaid (ODM).

Pharmacy Administrative Team Lead

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

Clinical Compliance Coordinator

The Clinical Compliance Coordinator is a registered nurse whose accountability objective is analyzing, reporting, monitoring, and assisting with incorporation of standards, guidelines, and regulatory requirements into the care management practice to meet state, federal, and accreditation compliance. The Coordinator will be responsible for assuring the clinical business units have efficiently operationalized regulatory requirements and will assist assigned business units in implementing changes to clinical processes to assure continued compliance with NCQA, federal and state regulations.

Quality Assurance Associate

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

Utilization Management Coordinator

The Utilization Management Coordinators are registered nurses, licensed practical nurses and social workers. Their accountability objective is to coordinate medical 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.

Provider Appeals Clinical Coordinator

The Provider Appeals Clinical Coordinator is a registered nurse whose primary role is to act as a liaison for all statewide appeals and other external type of provider appeals. The Coordinator will work collaboratively with claims, provider relations/provider inquiry, contracting, or other departments to ensure appeals are processed timely and in accordance with regulatory requirements. The Clinical Appeals Coordinator is also responsible for ensuring that all appeal letters that are generated comply with regulatory requirements, whether they be State or NCQA requirements.

Utilization Management Special Initiatives Coordinator

The Utilization Management Special Initiatives Coordinator is a registered nurse responsible for processing medical necessity reviews specific to Inpatient Sepsis, Emergency Room Professional Services and other initiatives created requiring proper leveling for claims payments. The Coordinator will also assist with Provider Appeals based on appeal type, appeal category, and member implications by completing a medical necessity review as indicated and processing the appeals based on the request from the provider. The position will work collaboratively with the Claims Department, Provider Relations, and other departments to ensure leveling reviews and provider appeals are processed timely and in accordance with regulatory compliance requirements.

Genetic Counselor Utilization Management Representative

The Genetic Counselor UM Representative has a Master's Degree in human genetics, genetic counseling or a related field requiring accreditation by the American Board of Genetic Counseling. The main accountability objective is to maintain expertise and provide professional genetic counseling for genetic testing authorization requests for members. The UM Representative provides program

Leadership to UM Coordinators and Medical Directors as well as the development/expansion of coordination within the UCM Department. In addition, this position coordinates referral authorizations and performs precertification, concurrent and retrospective medical management for designated services; identifying and referring members for potential case management in a timely manner.

Behavioral Health Utilization Management Coordinator

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

Coordinated Service Program Coordinator

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

Utilization Management Assistant Coordinator

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

Behavioral Health Assistant Coordinator

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

Pharmacy Administrative Coordinators

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

Pharmacy Regulatory Compliance Coordinator

The Pharmacy Regulatory Compliance Coordinator supports the Pharmacy Director in efforts to oversee and maintain departmental compliance, with primary responsibilities in delegation oversight, audit documentation and preparation, and vendor management

Pharmacy Nurse Specialists

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

Pharmacy Coordinators

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

UCM Project Coordinator

The Project Coordinators' accountability objective is to work independently to provide analytic support on projects and proposals. This position is responsible for task leadership and sub-task management on small to mid-size projects.

Acute Care / Readmission Appeals Analyst

The Acute Care/Readmission Appeals Analyst is a registered nurse whose primary responsibility is to identify members for potentially related readmission payment exclusion based on medical policy, analyzing data and creating recommendation for process improvement, transition of care and/or educational opportunities as identified. This position works with all productlines.

Utilization / Case Management Departmental Support

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

Associate Medical Director/Associate Clinical Director of Behavioral Health

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

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

Subspecialist Consultants

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

In addition, the plan utilizes a delegated medical review organization to provide medical determinations for a variety of subspecialty requests based on a formal workflow process.

UTILIZATION CARE MANAGEMENT PROCESS

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

The Chief Medical Officer, Senior Medical Director/Associate Medical Directors, Clinical Psychologists or 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 Provider (PCP) 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 Provider. Although in-Plan specialist referrals are not required by Paramount for claim payment, members are encouraged to seek their PCP's advice before seeking specialist consultation and treatment.

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

REFERRAL SYSTEM

- **Specialist Referrals** - The Primary Care Provider 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 require prior authorization. Paramount uses InterQual® criteria for Imaging, Procedures and Molecular Diagnostics. When InterQual® criteria does not exist within Paramount's purchased products, Medical Policy Steering Clinical Work Group or Pharmacy and Therapeutics Working Group develop criteria internally as appropriate. Also, utilized are CMS & ODM criteria. Additionally, potential cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and/or members, to issue coverage determinations.

INPATIENT CERTIFICATION (applicable to both Medical and Behavioral Health)

To assure that all admissions are appropriate, based on medical necessity, clinical judgement, and that the health care services are being provided in the most appropriate setting, the Plan reviews all hospital, long term acute care facility (LTAC), skilled nursing facility (SNF) and inpatient rehabilitation admissions. Urgent and emergency admissions are reviewed the first business day after the admission occurs. This review is received by telefax or portal from the Utilization Review Department at each facility.

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

The following methods of review are utilized:

- **Precertification** a review and assessment of clinical information, and determination of medical necessity, completed prior to the member's admission to Post-Acute care facilities such as Skilled Nursing, Long Term Acute Care and Rehabilitation facilities. Acute hospital admissions do not require precertification by the Utilization Management (UM) coordinator, but rather clinical is to be submitted after stabilization. In certain instances, elective procedures such as bariatric surgery, reduction mammoplasty, orthognathic/maxillofacial surgery and potentially cosmetic surgery require prior authorization/approval of the **procedure prior to the time of admission.**
- **Post-Service Initial (Inpatient)** - a review received after a member has been admitted to an acute care hospital and is the first clinical submission received following the guidelines notes above.
- **Concurrent-** a review and assessment of clinical information for determination of medical necessity, and is expected on the next review date assigned by the UM Coordinator at the time of the previous review. This occurs while a member is in the process of receiving the requested medical care of services.
- **Retrospective-** a review and assessment of clinical information for determination of medical necessity, completed after admission/services have been provided and received after expected first notification date.
- **Discharge Planning** - During the course of precertification and/or concurrent review, the Utilization/Case Management Coordinators will identify ongoing, continuing care needs that will be required after discharge. Collaboration occurs with facility staff and arrangements are made for these needs to be met through participating providers, e.g., skilled nursing and/or rehabilitation facilities, home health care, medical equipment and/or supplies
- **Transition of Care** - The Utilization/Case Management Coordinators will effectively and comprehensively identify, assess and assist high-risk members with transitions of care between settings in order to prevent unplanned or unnecessary readmissions, emergency

Department visits, and/or adverse outcomes. The goal of this program is to assure compliance with the discharge plan/required follow up care and to assist in the coordination of needed care/services to prevent adverse outcomes. Telephonic, in- person or written follow-up communication is conducted with identified at-risk members and/or their providers to ensure post discharge services have been provided.

- **Outpatient Certification** - Specified outpatient services are reviewed utilizing criteria developed by the Medical Policy Steering Clinical Workgroup and/or the Pharmacy and Therapeutics Working Group and approved by the Medical Advisory Council.
- **Behavioral Health Services** - Paramount reviews inpatient requests for mental health and detox services for all product lines using the utilization management functions, along with the tools/guidelines described above. To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal member outcomes.
- **Utilization Management Reporting System** - Relevant cost and utilization data is reported for review and analysis. Action is taken to correct any patterns of inappropriate under or overutilization.
- **Readmission** – Paramount Medical policy, PG0381, Hospital Readmissions, requires review of a subsequent admission to an acute, general, short term-hospital occurring within 30 days of the date of discharge from the same acute, general, short-term hospital for the same, similar, or related diagnosis. For adverse determinations, facilities have seven calendar days from the date of determination to request a Medical/Clinical Director peer-to-peer conference, per regulatory guidelines. The facility also has appeal rights in which timely filing limits apply.

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, www.paramounthealthcare.com.

OUTPATIENT CERTIFICATION (applicable to both Medical and Behavioral Health)

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 the 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/Care 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.

- **Behavioral Health**

Effective July 1, 2018 Paramount *Advantage* is fully responsible for the entirety of Behavioral Health services. To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal member outcomes. Outpatient behavioral health services are intended by the state to be provided by the community mental health and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) agencies. However, in the event that services are not available on a timely basis, or the member chooses to use a provider outside of the community system, the Plan must arrange for services outside the community network. The Plan maintains an adequate provider panel from which the member may choose in these instances.

For Paramount Advantage members, American Society of Addiction Medicine (ASAM) criteria are used to determine the level of care for Substance Use Disorder treatment (Partial Hospitalization, SUD Residential).

Utilization management functions for behavioral health services follow the same processes as medical utilization management. This includes Out-of-Plan specialist referrals, tertiary care and inpatient certification. Two licensed clinical Psychologists provide review determinations and oversight of utilization decisions. A listing of product specific prior authorization requirements can be found on the Paramount internet site. www.paramounthealthcare.com.

- **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 Provider.

In turn, Plan specialists are always responsible for communicating a treatment plan to the Primary Care Provider to assure that the Primary Care Provider 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 Provider after receiving **urgent** care services in any setting. The intent of this procedure is to allow the Primary Care Provider to coordinate any needed follow up care. Referrals are not required for payment of urgent care services received in an urgent care facility. Emergency room utilization is monitored and members noted with a pattern of overuse/abuse are referred to Case Management for investigation and follow-up.

- **Tertiary Care Services**

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

- **Out-of-Plan Referrals**

All requests for services outside the provider network are reviewed on an individual basis. Determinations are made based on the member's medical needs and the availability of the services within the network. Services available within the network are not approved outside the network except in cases where the patient's health care status could be negatively impacted by not approving the Out-of-Plan services. The Plan Chief Medical Officer/Senior Medical Director or Associate Medical/Clinical Directors make decisions of this nature. 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 potential cosmetic surgeries are common predetermination of benefit requests. The Plan's Chief Medical Officer/Senior Medical Director or Associate Medical Directors will 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's Chief Medical Officer/Senior Medical Director or Associate Medical/Clinical Directors or Prescription Drug Coordinators (Pharmacists) as appropriate.

- **Diagnostic Imaging**

Pre-established medical necessity/appropriateness criteria are utilized in the certification of some outpatient CT scans and MRI's, CTA of the coronary arteries, and MRA studies. Prior

authorization is not required when the diagnostic imaging studies are done as part of an emergency room visit for an emergency medical condition, an observation stay or an authorized inpatient stay.

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

- **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.

UTILIZATION MANAGEMENT DECISION/NOTIFICATION TIMEFRAMES

Paramount follows ODM, CMS 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:

	Decision Standard	Initial Notification	Written Notification
Precertification of non-urgent care. (Advantage Product Only)	Decisions for precertification of non- urgent care will be made within seven (7) calendar days of receipt of request.	Telephonic or electronic confirmation of the decision to the provider is made within three (3) calendar days after making the decision.	Written or electronic notification of the decision is given to the provider and member within three (3) calendar days after making the decision. For Paramount <i>Advantage</i> , written notification of a denial decision and the Notice of Action is sent to the practitioner and the member on the same day as the coverage determination except in those cases when the coverage determination occurs after the close of regular business hours. Written denial notification for coverage determinations made after regular business hours occur the next business day.

<p>Precertification of non-urgent care. (All Product Lines, Excluding Advantage)</p>	<p>Decisions for precertification of non- urgent care will be made within eleven (11) calendar days of receipt of request.</p>	<p>Telephonic or electronic confirmation of the decision to the provider is made within three (3) calendar days after making the decision.</p>	<p>Written or electronic notification of the decision is given to the provider and member within three (3) calendar days after making the decision.</p>
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<p>Precertification of non-urgent care. (All product lines when the health care practitioner submits the PA request electronically. (Senate Bill 129))</p>	<p>Decisions for precertification of non- urgent care will be made within seven (7) calendar days of receipt of request.</p>	<p>Telephonic or electronic confirmation of the decision to the provider is made within three (3) calendar days after making the decision.</p>	<p>Written or electronic notification of the decision is given to the provider and member within three (3) calendar days after making the decision.</p> <p>For Paramount Advantage, written notification of a denial decision and the Notice of Action is sent to the practitioner and the member on the same day as the coverage determination except in those cases when the coverage determination occurs after the close of regular business hours. Written denial notification for coverage determinations made after regular business hours occur the next</p>
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<p>Precertification of urgent care (Advantage product line)</p>	<p>Decisions for precertification of urgent care will be made within 48 hours of receipt of request.</p>	<p>Telephone or electronic confirmation of the decision is given to the provider within 48 hours of the receipt of the request</p> <p>In cases of a denial, members also need to be notified of the decision. (Reference U/CM Procedure <i>Denial of Services</i>, Section E, No. 3)</p> <p>NOTE: For Paramount <i>Advantage</i> members, if the member signed a liability statement specific to that service, the member would have financial responsibility. If the member did not sign the liability statement, the member will not have financial responsibility.</p>	<p>Written or electronic notification of the decision is given to the provider and member within 48 hours of the receipt of the request</p> <p>For Paramount <i>Advantage</i>, written notification of a denial decision and the Notice of Action is sent to the practitioner on the same day as the coverage determination except in those cases when the coverage determination occurs after the close of regular business hours. Written denial notification for coverage determinations made after regular business hours occur next business day.</p> <p>NOTE: For Paramount <i>Advantage</i> members, if the member signed a liability statement specific to that service, the member would have financial responsibility. If the member did not sign the liability statement, the member will not have financial responsibility. In addition, a letter would go out to the member along with a notice of action (NOA). Exception: Out of Plans do not require a NOA to be sent.</p>
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	Decision Standard	Initial Notification	Written Notification
Concurrent Urgent Review (Commercial and Marketplace Product Lines Only)	Decisions for concurrent urgent review will be made within 24 hours/ 1 calendar day of receipt of the request.	Telephone or electronic confirmation of the decision is given to the provider within 24 hours of the request Note: Oral notification must involve communication with a live person; the organization may not leave a voicemail.	Written or electronic notification of the decision is given to the provider and member within 24 hours of the request. For Denials: If the organization provides initial oral notification of a denial decision within 24 hours of a concurrent request it has an additional 3 calendar days following oral notification to provide written or electronic notification. Note: Oral notification must involve communication with a live person; the organization may not leave a voicemail.
Concurrent Review (Elite and Advantage Product Lines Only)	Decisions for concurrent review will be made within 72 hours/ 3 calendar days of receipt of the request.	Telephone or electronic confirmation of the decision is given to the provider within 72 hours of the request	Written or electronic notification of the decision is given to the provider and member within 72 hours of the request
Concurrent Review (Behavioral Health-Advantage Product Line Only)	Decisions for concurrent review of ACT, IHBT and SUD Residential services will be made within 48 hours/ 2 calendar days of receipt of the request.	Telephone or electronic confirmation of the decision is given to the provider within 72 hours of the request	Written or electronic notification of the decision is given to the provider and member within 72 hours of the request

Retrospective Review	Retrospective review decisions are made within thirty (30) calendar days of receipt of the request.	Telephone or electronic confirmation of the decision is given to the provider within thirty (30) calendar days of receipt of the request	<p>Written or electronic confirmation of the decision is given to the provider and member within 30 calendar days of the request</p> <p>Members will receive a copy of the denial letter only if the member will be financially liable for the services (Example: Out-of-Plan admissions).</p> <p>NOTE: For Paramount</p>
			<p><i>Advantage</i> members, if the services were retrospectively denied as not medically necessary, a NOA would not be issued.</p>
<p>PA requests for drugs given in a provider setting – Paramount <i>Advantage</i></p> <p>Elite and Commercial expedited request</p>	<p>Decisions for Paramount <i>Advantage</i> for drugs that require PA in a provider setting must be made within 24 hours of receipt of request.</p> <p>Decisions for Elite and Commercial expedited requests will be made within 72 hours of receipt of request.</p>	<p>Decision results must be communicated by telephone or electronically to the practitioner/provider the same day the decision is made.</p> <p>Decision results must be communicated by telephone or electronically to the practitioner/provider and member within 72 hours of receipt of request.</p>	<p>Written notification of a denial decision is sent to the practitioner and member the same day the decision is made.</p> <p>Written notification of an approval or denial decision is sent to the practitioner and member the same day the decision is made via UPS.</p> <p>Note: Per CMS, The enrollee (member) must receive the notice in the mail within 72 hours of receipt of request.</p> <p>Per NCQA, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.</p>

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.

Also tracked and monitored are the following UM reports:

- Authorizations and volumes by service type
- Authorization approval/denial rates
- Admits per 1000 by product line
- Readmissions per 1000 by product line
- Total ER visits by product line
- All facility/All Cause Readmissions within 30 days
- Total SNF Days
- Total authorizations by product line
- Average Turn Around Times by Product
- Authorization related pended claims

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

ACCESS TO UTILIZATION MANAGEMENT STAFF

Utilization 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. Staff is identified by name, title and organization name when initiating or returning calls regarding UM issues. Callers have the option of leaving a voice mail message either during or after business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other Plan Departments for Utilization 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 Chief Medical Officer, Senior 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 that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are also available on Paramount's internet site, www.paramounthealthcare.com. Physicians may review the InterQual® criteria at any participating hospital or by contacting the Director of Utilization. InterQual® criteria are also available to providers through the MyParamount Provider portal. The individual needs of the member and the resources available within the local delivery system are considered when applying Utilization Management criteria.

Inpatient Certification

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

Outpatient/Other Certification

For Paramount Advantage members, American Society of Addiction Medicine (ASAM) criteria are used to determine the level of care for Substance Use Disorder treatment (Partial Hospitalization, SUD Residential).

Where it exists, current InterQual® Procedures 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 Medical Policy Steering Clinical Work Group, or the Pharmacy and Therapeutics Working Groups and/or CMS/ODM criteria. At least annually, the Working Groups and applicable participating subspecialists review the criteria. The Medical Advisory Council takes the Working Group's recommendations for modifications into consideration during the approval process. The Utilization and Case Management Coordinators use the criteria during the prior authorization process. The internally developed criteria are available on Paramount's internet site, www.paramounthealthcare.com.

Medical Policy Development

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

All issues/procedures addressed/reviewed are used as a basis for establishing written medical policies to be maintained within the Paramount Medical Policies on the Paramount internet site and/or within the Paramount Providers Prior Authorization Criteria/Benefit Description on the Paramount internet site.

Medical Policy Objectives:

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

Diagnostic Imaging

The current edition of InterQual® Imaging Criteria is used as the basis for authorization of the following outpatient imaging studies:

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

Genetic Testing

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

availability of information in published scientific literature.

Durable Medical Equipment

Medicare guidelines are used in the prior authorization of select durable medical equipment for the Commercial/Marketplace 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 care management staff review all requests for organ transplants. The members and providers are advised of the most appropriate Center of Excellence transplant facility for evaluation based on the member's benefits, geographic location and support system.

For Paramount *Advantage* members, based on the ODM provider agreement, providers may submit prior information for the purposes of the UCM Coordinator assisting the member with identifying available providers, initiating case management services and addressing any compensation issues, however, when identifying available providers that could ultimately impact where the transplant is performed, Paramount does not solely consider the provider's panel status but also considers the proximity to a member's residence, support system and the network of providers who have coordinated the member's care.

The Care Manager coordinates 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 corneal transplants are excluded from Consortium review. The Plan's determination of medical necessity for Commercial and Medicaid member transplant is based on the Transplant Consortium's determination, thus providing an outside, impartial, expert evaluation. Once the patient receives Consortium approval, the patient is enrolled in United Network for Organ Sharing (UNOS). The patient's acceptance into UNOS serves as the Plan's medical necessity determination. For Paramount Elite members, Paramount follows CMS guidelines requiring transplants to be performed at CMS approved Centers of Excellence without the involvement of the Consortium.

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

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 Provider
- Specialist physician
- Facility Utilization Review Department

- Patient chart
- Home health care agency
- Physical, occupational or speech therapist
- Social Worker
- Registered Nurse
- Behavioral health/chemical dependency provider
- Patient or responsible family member

The information needed will often include the following:

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

The Utilization/ Management Coordinator and Case Manager will use this information, along with clinical judgment, departmental policies and procedures, needs of the individual member and characteristics of the local delivery system, including the availability of the proposed services within the network service area, to make a decision. The Utilization Management Coordinator and Case Manager have the authority to approve services based on medical necessity. If the decision is outside the scope of the Utilization Management Coordinator and Case Manager's authority, the case is referred to the Medical Director/Associate Medical Directors for a determination. The Chief Medical Officer/Senior Medical Director/Associate Medical Directors, Clinical Psychologists 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.

PRESCRIPTION DRUG UTILIZATION MANAGEMENT

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

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

The prescribing practitioner begins the process to request an authorization by reaching out to Paramount (or Paramount's delegated entities) via phone, fax, or electronic portal. For requests handled internally, Paramount's Pharmacy Department staff collects all pertinent medical information and Paramount's UM decisions are based upon appropriateness of care and clinical criteria, as well as existence of coverage. The Pharmacy Coordinators and Pharmacy Nurse Specialists are authorized to approve services, if criteria are met.

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

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, high volume of prescriptions or visits to medical professionals, previous enrollments 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 filling their prescriptions for a minimum period of twenty four (24) months. Exceptions are made for emergency situations. Behavioral Health Case Management follows all members enrolled in CSP. These members are transitioned to other Managed Care Plans if they change plans during the CSP enrollment.

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. The Pharmacy and Therapeutics Working Group investigate pharmaceuticals.

If the new technology/pharmaceutical or new application of an existing technology/pharmaceutical is addressed in the above documents, the new technology will be reviewed with the Medical Policy

Steering Committee followed by policy creation which is then reviewed and approved by the Chief Medical Officer, Senior Medical Director and presented to the Medical Policy Steering Clinical Workgroup and Associate Medical/Clinical Directors.. 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.

CONFIDENTIALITY

Paramount has written policies and procedures to protect a member's personal health information (PHI). The Utilization/Care Management Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency and duration of health care services. We are required by law to protect the privacy of the member's health information. Before any PHI is disclosed, we must have a member's written authorization on file. Within the realm of utilization review and case management, access to a member's health information is restricted to 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.