Section 7
Utilization Management

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Overview

This section defines AllWays Health Partners' policies and procedures regarding authorization requests and highlights guidelines associated with prior authorizations and notifications.

AllWays Health Partners' Utilization Management (UM) program is designed to ensure the provision of the highest quality of health care to our members while at the same time promoting appropriate, efficient and cost-effective resource utilization. As such, AllWays Health Partners' UM program focuses on:

- Evaluating requests for services by determining the medical necessity, appropriateness, and effectiveness of the requested services
- Promoting continuity of patient care through the facilitation and coordination of patient services to ensure a smooth transition for members across the continuum of health care
- Analyzing utilization statistics to identify trends and opportunities for improvement
- Reviewing, revising and developing medical coverage policies to ensure that utilization management criteria are objective and based on medical evidence, and that AllWays Health Partners members have appropriate access to new and emerging efficacious technologies

Referrals, prior authorization, notification, concurrent review, retrospective review, and discharge planning are all elements of AllWays Health Partners' utilization management program.

AllWays Health Partners recognizes that underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, AllWays Health Partners promotes appropriate utilization of services. AllWays Health Partners' utilization management decisions are based on appropriateness of care and service and the existence of coverage. AllWays Health Partners does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does AllWays Health Partners provide financial incentives to UM decision makers to encourage decisions that result in underutilization.

The treating provider, in conjunction with the member or designee, is responsible for making all clinical decisions regarding the care and treatment of the member. AllWays Health Partners' Clinical Department is responsible for making all utilization decisions in accordance with the member's plan of covered benefits and established medical necessity criteria.

AllWays Health Partners network providers are contractually prohibited from holding any AllWays Health Partners member financially liable for any service administratively denied by AllWays Health Partners for the failure of the provider to obtain the required prior authorization or notification for the service, or for services denied because the provider failed to submit supporting clinical documentation with their request.

AllWays Health Partners periodically reviews the services for which prior authorization is required as practice patterns in the network warrant. Providers are notified of changes via the monthly eNewsletter, AllWays Health Partners' website, and/or written communications.

Requesting and Obtaining an Authorization or Referral

To determine prior authorization, referral and notification requirements for general services, see the Prior Authorization, Notification, and Referral Guidelines on allwaysprovider.org.

Most Surgical Day Care (SDC) services do not require authorization. A consolidated list of SDC procedures requiring authorization can be found in the Surgical Day Fact Sheet on allwaysprovider.org.

Not all DME and orthotics require authorization. See the Prior Authorization List for DME, Medical Supplies, Oxygen Related Equipment, Orthotics, Prosthetics, and Hearing Aids on allwaysprovider.org.

Submission through allwaysprovider.org

All in-network referrals, authorizations and notifications must be submitted through AllWays Health Partners online authorization tool, accessed through the provider portal, allwaysprovider.org. Clinical documentation to support authorization requests can also be submitted through allwaysprovider.org. To expedite decision making, complete clinical information supporting medical

necessity should be uploaded with the request on allwayprovider.org.

Authorization or referral requests to a non-AllWays Health Partners network provider cannot be submitted through allwaysprovider.org and require fax or mail submission.

Authorization requests that cannot be submitted online may be faxed to: 617-586-1700

Valid Prior Authorization Requests

A valid prior authorization request is defined as one where:

- The request is initiated by the primary care provider (PCP), treating specialist, or the treating provider
- The provider is part of the AllWays Health Partners network
- The member is actively enrolled with AllWays Health Partners at the time of the service
- The appropriate authorization template is completed for those service requests that require submission through allwaysprovider.org
- The appropriate authorization form is completed for service requests that are still faxed or mailed
- A physician prescription is included with a request for enteral formulas, infusion therapy, and DME
- Clinical documentation to support medical necessity is included

Confirmation of Requested Authorizations

Network providers obtain confirmation of received authorization requests and UM decision-making from our online provider portal, allwaysprovider.org, including the authorization identification number, authorization decision, number of days/visits, and the duration approved or denied. Authorization reports specific to a member, individual authorization, or an aggregate of all requests made by the servicing provider are available through allwaysprovider.org.

Only those requests made by the requesting servicing provider may be viewed by the requesting servicing provider.

Existence of an authorization identification number does not ensure that a request has been approved. All requests are assigned an authorization identification number for tracking purposes independent of the approval status. It is imperative that providers validate the status of a specific authorization request.

The AllWays Health Partners *Service Authorization Report* informs the provider that a request was either:

- Approved (A) based on medical necessity, benefit coverage, and member eligibility
- Closed (C) due to a change in level of care (i.e., an observation stay that escalates to an inpatient admission) or administrative error
- Denied (D) based on medical necessity or administrative guidelines
- Pended (P) awaiting clinical review or more information
- Medreview (M) awaiting clinical review or more information

All authorization decisions resulting in an adverse determination are also communicated to the requesting provider by phone and in writing.

Utilization Management Methods

Referrals

AllWays Health Partners promotes a health care delivery model that supports PCP coordination and oversight of care. AllWays Health Partners recognizes that its members are best served when there is coordination between specialty and primary care clinicians.

To ensure reimbursement, care provided by a Specialist requires a referral from the AllWays Health Partners Primary Care Physician (PCP). The AllWays Health Partners PCP is the only provider authorized to make referrals to Specialists within AllWays Health Partners' network. The PCP should notify AllWays Health Partners of the referral before the initial recommended specialty visit and no later than 90 days after the initial specialty visit. Without the required referrals, payment is subject to denial.

Specialty referrals are allowed when all of the following occur:

- The PCP determines such referrals are appropriate
- The specialist participates in the AllWays Health Partners network

- The specialist agrees to a treatment plan for the Member
- The specialist provides the PCP with all necessary clinical and administrative information on a regular basis
- The services provided are consistent with the terms of the AllWays Health Partners subscriber agreement

Some services such as family planning, gynecologist or obstetrician for routine, preventive, or urgent care, behavioral health services, and emergency services do *not* require a referral.

PCPs are required to enter referral request information as follows:

- For AllWays Health Partners network specialists, referrals should be submitted through allwaysprovider.org
- For out-of-network Specialists, referrals are submitted by fax or mail **and are subject to prior authorization**
- Referrals are *not* required for the following:
  - Emergency services
  - A gynecologist or obstetrician for routine, preventive, or urgent care
  - Family planning services provided by an AllWays Health Partners provider or clinic
  - Outpatient and diversionary BH services
  - Routine vision
  - PPO members

Prior Authorization (Prospective Review)

Prior authorization allows for the efficient use of covered health care services and helps to ensure that members receive the most appropriate level of care in the most appropriate setting.

AllWays Health Partners identifies certain services as requiring prior medical necessity review and approval subsequent to meeting established criteria. Prior authorization processes support care management involvement by connecting the utilization management registered nurse with the provider and member prior to the delivery of services. Certain requested services, procedures, or admissions require prior authorization. Prior authorizations are based on medical necessity and are not a guarantee of payment. Requests for services requiring prior authorization must be submitted prior to delivery of service. Failure to obtain required prior authorization can result in a denial of payment to the provider.

For elective services, such as admissions and surgical day, AllWays Health Partners requires at a minimum, submission five business days prior to the admission. Authorization determinations for elective services can take up to 14 calendar days to ensure adequate time for review and processing (See "UM Time Frame for Decision-making and Notification.")
Prior authorization is not required for:

- Emergency room care
- Observation
- Emergent acute inpatient admissions

AllWays Health Partners requires notification by the end of the next business day for:

- Observation
- *Emergent acute inpatient admissions

*Notification for emergency admissions must include supporting clinical documentation at the time of notification. AllWays Health Partners makes a determination whether the members presenting condition met criteria for acute inpatient admission or should have been managed under observation.

Requests for prior authorization services are forwarded to a utilization management registered nurse for review. The utilization management registered nurse will determine whether the requested service meets established review criteria guidelines. The utilization management registered nurse or designated support staff will contact the servicing provider or PCP whenever there is a question regarding the requested type of service or setting. Additional clinical information may be required in order to make a medical necessity decision.

Prior authorization approvals are made by AllWays Health Partners utilization management registered nurses based on medical necessity criteria. Prior authorization denials (adverse determination) for medical necessity are made only by an AllWays Health Partners Medical Director or a designated physician reviewer, based upon medical necessity criteria, the specific needs of the individual patient, and the availability of local resources.

Durable Medical Equipment (DME)

DME purchases and rentals must be requested by the member's PCP, AllWays Health Partners treating provider, or an approved vendor.

Some DME items are not subject to authorization requirements. For a list of services that require prior authorization, please review AllWays Health Partners DME Prior Authorization list on allwaysprovider.org. This list also includes medical supplies, oxygen related equipment, orthotics, and prosthetics that require prior authorization.

DME prior authorization requests are submitted through allwaysprovider.org. The physician's prescription and supportive documentation for the requested DME must be attached to the electronic request. A valid authorization request, supportive documentation, and a physician's prescription are required before a requested service can be approved.

Providers need to submit requests including supporting information and a prescription directly to the participating vendor. AllWays Health Partners staff works directly with the vendors to insure efficient and timely filling of requests.

Enteral Products

Authorization requests for enteral products are submitted through AllWays Health Partners' online authorization tool, accessed at allwaysprovider.org. A valid authorization request and completed Medical Necessity Review Form for Enteral Nutrition Products (Special Formula) indicating the specific product and quantity are required before a determination can be made to approve a requested service.

Prior Authorization Requests Submitted Directly to a Delegated Entity

eviCore Healthcare

The following elective outpatient services require prior authorization through eviCore Healthcare:

- Outpatient Radiology/High Tech Imaging
- Selected Cardiac Imaging & Diagnostic Services
- Selected Molecular & Genetic Testing
- Radiation Therapy

When these services are rendered as part of a hospital emergency room, observation stay, surgical care or inpatient stay, they are not subject to prior authorization requirements.

Submit requests directly to eviCore by:

- Accessing online services at www.evicore.com. After a quick and easy one-time registration, you can initiate a request, check status, review guidelines, and more.
- Calling eviCore toll-free, 8 AM to 9 PM ET at: 888-693-3211

Once approved, the authorization number can be found on allwaysprovider.org. eviCore approves by the specific facility performing the study and by the specific CPT code(s). It is the responsibility of the rendering/performing facility to confirm that they are the approved facility for rendering the service and the specific study authorized by CPT code. Any change in the authorized study or provider requires a new authorization. Failure to obtain authorization or submit supporting documentation to establish medical necessity could result in an administrative denial of services to the provider.

Sleep Studies and Therapy Management

SMS (Sleep Management Solutions) and their parent company, CareCentrix (CCX) provides sleep study and therapy management services for all AllWays Health Partners product lines. Testing may be approved in the patient's home, using a Home Sleep Test (HST) or in an in-network sleep lab using a polysomnogram.

Submit requests directly to SMS by:

- Visiting the SMS website http://www.sleepmanagementsolutions.com and accessing the secure Sleep Portal to submit the request
- Phoning SMS/CCX Monday-Friday, 8 AM to 5 PM ET, at: 886-827-5861

For information on billable codes, access AllWays Health Partners' Provider Payment Guideline for Sleep Studies and Therapy Management.

Behavioral Health Services

Optum manages the delivery of behavioral health services for AllWays Health Partners members.

See the Behavioral Health Provider Manual and access their web site on allwaysprovider.org.

Concurrent Review
Concurrent review is required for subsequent days of care or visits or services beyond the initial authorization or required notification. Concurrent review must be conducted via allwayprovider.org where indicated. For services that cannot be conducted via allwaysprovider.org, you may fax, or mail.

Most requests for concurrent services are submitted through allwaysprovider.org. Follow the *Provider Portal User Guide* for revising authorizations. Those service requests that are not accepted through the Provider Portal must be faxed or mailed to AllWays Health Partners. See "Submission through Fax or Mail" explained earlier in this section for details. All concurrent requests must be supported by clinical documentation to determine medical necessity. Failure to obtain authorization or submit supporting documentation to establish medical necessity could result in an administrative denial of services to the provider.

Concurrent review includes utilization management, discharge planning, and quality of care activities that take place during an inpatient stay, an ongoing outpatient course of treatment or ongoing home care course of treatment (for example, acute hospital, skilled nursing facilities, skilled home care, and continuous DME supplies/equipment).

The concurrent review process also includes:

- Collecting relevant clinical information by chart review, assignment of certified days and estimated length of stay, application of professionally developed medical necessity criteria, assignment of level of care, and benefit review. These criteria are not absolute and are used in conjunction with an assessment of the needs of the member and the availability of local health care resources
- Obtaining a request from the appropriate facility staff, practitioners or providers for authorization of services
- Reviewing relevant clinical information to support the medical necessity
- Determining benefit coverage for authorization of service
- Communication with the health care team involved in the member's care, the member, and/or his or her representative and the provider
- Notifying facility staff, practitioners, and providers of coverage determinations in the appropriate manner and time frame
- Identifying discharge planning needs and facilitating timely discharge planning
- Identifying and referring potential quality of care concerns, Never Events/Serious Reportable Events, and Hospital Acquired Conditions for additional review
- Identifying members for referral to AllWays Health Partners' Care Management specialty programs

All existing services will be continued without liability to the member until the member has been notified of an adverse determination. However, denial of payment to the facility and/or attending physician may be made when days of care or visits do not support medically necessary care.

Retrospective Review

As part of AllWays Health Partners' UM program in assessing overutilization and underutilization of services, focused retrospective review activity may be performed as cost drivers, HEDIS scores, changes in medical and pharmacy utilization trends, provider profiling and financial audits suggest.

Retrospective review is also performed on a case-by-case basis and is routinely applied to hi-tech radiology cases.

In the event that the utilization management registered nurse is unable to perform concurrent review, cases may be reviewed retrospectively. A copy of the medical record will be requested in accordance with applicable confidentiality requirements.

UM Time Frame for Decision-Making and Notification

Authorizations are made as expeditiously as possible, but no later than within the designated time frames.

Commercial and Qualified Health Plans

UM Subset	Decision Time Frame	Verbal Notification Provider	Written Approval Notification Provider and Member	Written Denial Notification
Pre-service/Initial Determination *Non-urgent*	Within two business days of obtaining all necessary information. Decision and notification must occur no later than 14 calendar days after receipt of the request, independent of receipt of necessary information	Approval and Denial: Within 24 hours of decision, but must not exceed the overall decision time frame of 14 calendar days after receipt of the request	Within two business days following verbal notification	Within one business day following verbal notification, but no later than 14 calendar days after receipt of the request
Pre-service/Initial Determination *Urgent care*	Up to 72 hours/three calendar days of receipt of the request	Approval and Denial: Within 24 hours of decision, but must not exceed the overall decision time frame of 72 hours/three calendar days from receipt of the request	Within two business days following verbal notification	Within one business day of verbal notification or three calendar days of verbal notification (always using the lesser time frame)
Concurrent Review *Urgent* Inpatient stays are always considered Urgent/Expedited	Within 24 hours/one calendar day of receipt of the request	Approval and Denial: Within 24 hours/one calendar day of receipt of the request	Within one business day following verbal notification	Within one business day of verbal notification or three calendar days of verbal notification (always using the lesser time frame)

UM Subset	Decision Time Frame	Verbal Notification Provider	Written Approval Notification Provider and Member	Written Denial Notification
Concurrent *Non-urgent*	Within 1 business day of obtaining all necessary information. Decision and notification must occur no later than 14 calendar days after receipt of the request. independent of receipt of necessary information	**Approval:** Within one business day of decision. Must not exceed the overall decision time frame of 14 calendar days. **Denial:** Within 24 hours of decision. Must not exceed the overall decision time frame of 14 calendar days.	Within one business day following verbal notification	Within one business day following verbal notification or three calendar days following verbal notification (always using the lesser time frame)
Retrospective *Review*	Within 2 business days of obtaining all necessary information. Decision and notification must occur no later than 14 calendar days after receipt of the request, independent of receipt of necessary information	N/A	Within 14 calendar days after receipt of the request	Within 14 calendar days after receipt of the request
Reconsideration of Adverse Determination (Initial and concurrent medical necessity review determinations)	Within one business day of receipt of request for reconsideration	Within one business day of receipt of request for reconsideration	According to type of request as described above	According to type of request as described above

Notification

Notification to AllWays Health Partners of provided services assists utilization management registered nurse in identifying those members who might benefit from care management intervention. Notification also allows AllWays Health Partners to monitor utilization statistics and to initiate improvements to AllWays Health Partners' service network in conjunction with primary care sites. AllWays Health Partners collaborates with its contracted provider community and appreciates the coordination of communication between provider and AllWays Health Partners.

Depending on the service type, notification is either "requested" or "required." "Required" notification is a condition for payment. Please refer to the Prior Authorization and Notification Grid for further clarification and the most current information on services subject to prior authorization or notification requirements.

Requested Notification

Requested notification is not a condition for payment. Claims will adjudicate as long as all other claims processing rules have been met, the provider rendering the service is in the AllWays Health Partners network and the member has active eligibility.

Emergency care providers should contact a member's primary care provider to coordinate care once the member is screened and stabilized.

Required Notification

"*Required* notification" applies to services that often would require prior authorization but due to the emergent nature of the service, AllWays Health Partners allows notification within one business day. To ensure payment, a provider must submit the required notification. Failure to provide required notification within one business day could result in an administrative denial of services to the provider. Please refer to the Prior Authorization and Notification Grid for further clarification and the most current information on services subject to prior authorization or notification requirements.

AllWays Health Partners network providers are contractually prohibited from holding any AllWays Health Partners member financially liable for any service administratively denied by AllWays Health Partners for the failure of the provider to provide timely notification of provided services.

Most notifications for network providers are submitted through allwaysprovider.org. Information that normally would accompany a prior authorization request should be submitted at the time of the notification. Failure to submit supporting documentation could result in an administrative denial of services to the provider.

Examples of services that require notification are:

- Emergency admissions and sick newborn admissions (inpatient and transfers); concurrent authorization is required for days of care following notification. All admissions are reviewed for medical necessity
- For Skilled home nursing care, providers are required to notify AllWays Health Partners of any service initiated during non-business days/hours; subsequent services require authorization
- Medical supplies (DME) associated with the home care plan for services initiated during non-business days/hours
- Observation

Contracted Provider Network

Contracted providers have agreed to provide covered services to AllWays Health Partners members. Contracted providers are not employees, agents or representatives of AllWays Health Partners.

AllWays Health Partners Provider Directory is available by visiting our website at allwaysprovider.org. Provider Service Professionals are also available to help PCP offices locate a contracted provider.

Information about AllWays Health Partners Providers

More information about a Massachusetts licensed provider's education, hospital affiliations, board certification status, and so on is available from the Board of Registration in Medicine at www.massmedboard.org.

The following websites also provide useful information in selecting quality health care providers:

- Leapfrog: www.leapfroggroup.org (For information on the quality of a hospital)
- Massachusetts Health Quality Partners: www.mhqp.org (For learning how different medical groups treat the same type of illness)
- Joint Commission for the Accreditation of Healthcare Organizations: www.qualitycheck.org

(For comparing quality of care at many hospitals, home care agencies, laboratories, nursing homes, and behavioral health programs)

- MA Health Care Quality and Cost Council: www.mass.gov/myhealthcareoptions (For comparing quality and cost at Massachusetts Hospitals)

Out-of-Network Authorization Request Exceptions

PCPs should always refer members to in-network providers. Should the PCP refer a member to a non-contracted provider, the PCP must obtain an approved prior authorization from AllWays Health Partners to confirm coverage. Members should be advised to speak with AllWays Health Partners regarding their options prior to seeking out-of-network care.

Authorization is required for all non-emergent out-of-network service requests.

AllWays Health Partners' contracted Provider Directory is available at allwayprovider.org.

AllWays Health Partners works with members, and providers to provide continuity of care and to ensure uninterrupted access to medically necessary covered services, whether current members or newly enrolled.

In most cases, a pre-existing relationship with a non-contracted provider is not reason alone to justify the need for an out-of-network provider. There are some circumstances when AllWays Health Partners will provide coverage for services to be rendered by an out-of-network provider as listed below.

Authorization requests for out-of-network specialists are submitted by fax or mail and are subject to medical necessity review.

Conditions for Accessing Out-of-Network Providers

- A member chooses to continue with his or her PCP for up to 30 days after the provider's termination
- A member undergoing active treatment for a chronic or acute medical condition chooses to continue with the provider for up to 90 days after provider's termination
- A member in her second or third trimester of pregnancy chooses to continue with her provider for treatment through the first post-partum visit
- A member is receiving care directly related to a terminal illness may continue treatment with the provider treating the terminal illness through the time of death

Transition of Care for Newly Enrolled Members

- The provider is giving the insured an ongoing course of treatment or is the insured's primary care practitioner for up to 30 days
- A member in her second or third trimester of pregnancy chooses to continue with her provider for treatment through the first post-partum visit
- A member receiving care directly related to a terminal illness may continue treatment with the provider treating the terminal illness through the time of death

Other Coverage Conditions

- A participating in-network provider is unavailable because of distance and travel
- To minimize disruption of care when delays in accessing a participating in-network provider for medically necessary covered services, other than those attributed to the member, would result in interrupted access to medically necessary services
- In the absence of a participating in-network provider with the qualifications and expertise matching the health care needs of the member for medically necessary covered services. Provisions are made to authorize an out-of-network provider for as long as AllWays Health Partners is unable to provide the medically necessary covered services in-network
- When the member's PCP determines that the member needs a service and would be subjected to unnecessary risk if the member received those services separately and not all related services are available in-network

All Members

- AllWays Health Partners will assist the member, as needed, in choosing an in-network provider that is located within the shortest travel time from the member's residence, considering the availability of public transportation. AllWays Health Partners does its best to ensure that, if a member accesses an out-of-network provider, the provider will be clinically appropriate and qualified to provide the services by checking the physician's profile with the Massachusetts Board of Registration in Medicine
- AllWays Health Partners requires out-of-network

providers to coordinate with AllWays Health Partners' Contracting department for payment of services so that any cost to the member is not greater than the cost would be if provided by an in-network provider. AllWays Health Partners informs the out-of-network provider of his or her obligations under state and federal law to communicate with the member in his or her primary language, either directly or through a skilled medical interpreter

- If the provider is the only available provider in the network, to the extent possible, AllWays Health Partners shall ensure that such provider does not, because of moral or religious objections, decline covered services to the member
- All non-emergent, out-of-network services are subject to prior authorization
- All behavioral health requests for out-of-network providers are reviewed by AllWays Health Partners' behavioral health delegate, Optum, an NCQA-accredited managed behavioral health care organization

A letter of agreement is required for each unique authorization including agreed upon terms for rendering services.

Discharge Planning

Discharge planning occurs through the entire continuum of care for members engaged in medical as well as behavioral health treatments since members are discharged from home care and outpatient service, as well as inpatient stays more commonly associated with discharge planning.

Discharge planning for AllWays Health Partners members is initiated as expeditiously as possible on admission to the inpatient facility and with the initiation of home and outpatient services, and is addressed throughout the continuum of care to facilitate timely and appropriate discharge and post-discharge services.

Utilization management registered nurse ensure that treating providers have up-to-date benefit information, understand the member's benefit plan, possible barriers with authorizing transition services, and know how to access covered services.

Utilization management registered nurses assist with transition of care when requested by the facility for in-network services and out-of-network authorizations when the network of providers cannot meet the member's after care needs. In addition to assisting the provider with traditional authorization/benefit information, the utilization management registered nurse collaborates and coordinates services with the provider and works with other appropriate members of the health care team, including but not limited to, AllWays Health Partners care management programs, behavioral health care management programs, community and agency resources, and the member's designee on their unique discharge planning needs in order to coordinate services and facilitate a smooth transfer of the patient to the appropriate level of care and/or into clinical care management programs that will continue to support the member's recovery.

Care Management

AllWays Health Partners believes that care management services are best provided by those clinicians closest to the member. As such, the AllWays Health Partners Care Management Programs are designed to supplement those care management services that are available at the primary care site or the treating facility. The care management process is directed at coordinating care and creating appropriate cost effective alternatives for catastrophic, chronically ill, acutely ill or injured members on a case-by-case basis to facilitate the achievement of realistic care management goals.

For more information, please refer to the "Clinical Programs" section of this manual. To refer a member to one of AllWays Health Partners' Care Management Programs call 855-444-4647.

Medical Necessity Decision-Making

AllWays Health Partners recognizes that underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, AllWays Health Partners promotes appropriate utilization of services. AllWays Health Partners' utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage. AllWays Health Partners does not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the diagnosis, type of illness, or condition of the Member or make authorization determinations solely on diagnosis, type of illness or the condition of the Member.

All medical necessity decisions are made only after careful consideration of the applicable written medical

criteria, interpreted considering the individual needs of the member and the unique characteristics of the situation.

AllWays Health Partners does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does AllWays Health Partners provide financial incentives to UM decision-makers to encourage decisions that result in underutilization.

In all instances of medical necessity denials, it is AllWays Health Partners policy to provide the treating/referring practitioner with an opportunity to discuss a potential denial decision with the appropriate practitioner.

Collection of Clinical Information for UM Decision-making

The AllWays Health Partners Clinical Operations staff requests only that clinical information which is relevant and necessary for decision-making. AllWays Health Partners uses relevant clinical information and consults with appropriate health care providers when making a medical necessity decision.

When the provided clinical information does not support an authorization for medical necessity coverage, the utilization management registered nurse and/or physician reviewer outreaches to the treating provider for case discussion. A decision will be made based on the available information if the treating provider does not respond within the time frame specified.

All clinical information is collected in accordance with applicable federal and state regulations regarding the confidentiality of medical information.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), AllWays Health Partners is entitled to request and receive protected health information for purposes of treatment, payment, and health care operations without the authorization of the member.

Clinical Criteria

AllWays Health Partners internally develops and uses medical necessity guidelines and criteria to review medical appropriateness of targeted services based on its member population and service utilization. Utilization management criteria and procedures for their application are reviewed at least annually and guidelines and criteria are updated when appropriate.

AllWays Health Partners uses McKesson's InterQual criteria tools or the AllWays Health Partners Medical Necessity Guidelines on allwaysprovider.org to make decisions for authorization or requested services or treatment.

Medical necessity guidelines and criteria are based on sound clinical evidence of safety and efficacy and developed and amended using various professional and government agencies and local health care delivery plans. These include, but are not limited to:

- Centers for Medicare and Medicaid Services
- Commonwealth of Massachusetts Division of Medical Assistance
- National therapy associations
- The Massachusetts Department of Public Health
- The Massachusetts Health Quality Partnership
- The Centers for Disease Control
- Professionally recognized Clinical Practice Guidelines
- AllWays Health Partners reinsurer
- Formal literature review using Hayes Inc., an independent health technology assessment organization providing assessment of the safety and efficacy of technologies,
- Cochrane Peer reviewed journals, Epsco; UpToDate.com and Ovid
- Regional and national managed care organizations
- The Massachusetts Division of Insurance, Managed Care Consumer Protection and Accreditation of Carriers
- Expert review by board-certified practicing specialists

The utilization management registered nurse and/or physician reviewer evaluates all relevant information before making a determination of medical necessity. Clinical guidelines and criteria are used to facilitate fair and consistent medical necessity decisions. At a minimum, the utilization management registered nurse considers the following factors when applying criteria to a given member: age, comorbidities, complications, progress of treatment, psychosocial situation, and home and family environment, when applicable. Medical necessity criteria are applied in context with individual member's unique circumstances and the capacity of the local provider delivery system. When criteria do not appropriately address the individual

member's needs or unique circumstances, the utilization management registered nurse and/or physician reviewer may override the criteria for an approval of services.

Providers can obtain a copy of internally developed criteria used for a specific determination of medical necessity by accessing allwaysprovider.org. Proprietary criteria are made available to providers and members on request and only to the extent it is relevant to the treatment or service.

Division of Insurance Definition of Medical Necessity

Medically Necessary health care services are those that are consistent with generally accepted principles of professional medical practice as determined by whether:

(a) The service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
(b) Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
(c) For services and interventions not in widespread use, is based on scientific evidence

Information Request

PROVIDER SERVICE
Phone 855-444-4647
Monday–Friday, 8 AM to 6 PM

MEMBER SERVICE
Phone 800-462-5449
TTY 711
Monday–Friday, 8 AM to 6 PM
Thursday, 8 AM to 8 PM

For after-hour requests and utilization management issues, these lines are available 24 hours a day, seven days a week. All requests and messages will be retrieved on the next business day. Language assistance is available to all members.

Medical Necessity Denials

A medical necessity denial is a decision made by AllWays Health Partners to deny, terminate, modify or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care.

Only an AllWays Health Partners physician reviewer or physician designee may make medical necessity determinations for denial of service. Appropriate AllWays Health Partners network specialists and external review specialists are used for complex specialty reviews and to review new procedures or technology. Reconsideration (clinical peer review) may be requested for services that are denied prospectively or concurrently based on medical necessity. Reconsideration is an informal process offered to providers. It is not an appeal nor is it a precondition for filing a formal appeal. A physician reviewer conducts the reconsideration within one business day of the request.

Written notifications of medical necessity denials contain the following information:

- The specific information upon which the denial was made
- The member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical necessity review criteria
- Specification of any alternative treatment option that is available through AllWays Health Partners or the community, if any
- A summary of the applicable medical necessity review criteria and applicable clinical practice guidelines
- How the provider may contact a physician reviewer to discuss the denial
- A description of AllWays Health Partners' formal appeals process, the mechanism for instituting the appeals process, and the procedures for obtaining an external review of the decision

Administrative Denials

Administrative denials for authorization of requested services or payment for services rendered may be made when:

Member issued

- A service is explicitly excluded as a covered benefit under the member's benefit plan
- The requested benefit has been exhausted

Provider only issued

- A service was provided without obtaining the required prior authorization
- Required notification was not made in a timely manner

- Failure to submit clinical documentation necessary to make a medical necessity determination with the requested service

AllWays Health Partners network providers are contractually prohibited from holding any AllWays Health Partners member financially liable for any service administratively denied by AllWays Health Partners for failure of the provider to adhere to established utilization processes.

Delegation of Utilization Management

AllWays Health Partners delegates some utilization management activities to external entities and provides oversight of those entities. UM delegation arrangements are made in accordance with the requirements of the National Committee on Quality Assurance (NCQA), the Massachusetts Division of Insurance, the Executive Office of Health and Human Services (EOHHS), and other regulatory requirements. AllWays Health Partners has entered delegated arrangements with:

- Optum for the utilization and care management of behavioral health services on behalf of AllWays Health Partners members. Optum is a fully NCQA accredited Managed Behavioral Health Organization.
- CVS Caremark has been delegated certain utilization management functions for a select group of pharmaceuticals. AllWays Health Partners' Pharmacy and Therapeutics Committee approves all pharmaceuticals to be included in CVS Caremark's prior authorization process. The responsibility for making denials based on medical necessity remains with AllWays Health Partners.
- eviCore has been delegated certain utilization management functions for elective, non-emergent outpatient high tech radiology services (including MRI, MRA, CT, and PET imaging studies), selected cardiac imaging and diagnostic services, selected molecular and genetic testing, and radiation therapy.
- Focus Health provides AllWays Health Partners with consultative reviews of prior authorization requests for spinal surgery. Focus Health is a medical management services organization specializing in the evaluation of pain management services, including spinal surgery.
- Sleep Management Solutions has been delegated sleep diagnostic and therapy management services.
- Medical Review Institute of America—AllWays Health Partners partnered with Medical Review Institute of America (MRIoA) to supplement the prior authorization review process. MRIoA is an external review organization that is staffed with board-certified physicians with a wide variety of specialties. In the rare instance when AllWays Health Partners physician reviewers are unavailable, MRIoA will provide support for the UM reviews. In these instances, MRIoA representatives may reach out to the requesting provider to obtain additional clinical information or conduct a physician-to-physician review.

AllWays Health Partners maintains close communications with its delegated partners to ensure seamless operations and positive member and provider experiences.

Technology Assessment

AllWays Health Partners reviews and evaluates new and emerging technologies, including diagnostics, surgical procedures, medical therapies, equipment and pharmaceuticals to determine their safety and effectiveness. In its evaluation efforts, AllWays Health Partners uses numerous sources of information including, but not limited to, the Hayes Medical Technology Directory, the Cochrane Library, peer reviewed scientific literature, policy statements from professional medical organizations, national consensus guidelines, FDA reviews, and internal and external expert consultants. Additionally, AllWays Health Partners may analyze market trends and legal and ethical issues in its evaluations as appropriate.

Medical Directors are responsible for making medical necessity decisions on urgent requests for new technologies that have not been evaluated and approved by AllWays Health Partners. The Clinical Policy and Quality Committee is responsible for approving new and emerging technologies based upon recommendations submitted by the Technology Assessment Team.

Online Clinical Reports on allwaysprovider.org

AllWays Health Partners provides its primary care network with a wealth of clinical resources to help effectively manage their patients via provider portal, allwaysprovider.org. This provision of timely, actionable site- and patient-level data allows PCPs to download electronic versions of a variety of reports

and analyze the data based on the specific needs of their practice.

Available reports include both quality and utilization information. This includes both quality measures and utilization for members with asthma and diabetes as well as ER utilization. For a detailed list of allwaysprovider.org reports and available transactions, please visit the Member and Provider Management sections of this manual.

Access to the data is entirely at the discretion of the provider office. To protect the confidentiality of our members and due to the sensitive contents of these reports, providers are strongly encouraged to grant role-based access only and review user permissions regularly.