



United Healthcare Services, Inc.

Utilization Management Program Description (UMPD)

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**United
Healthcare**



SECTION A – INTRODUCTION, MISSION, OBJECTIVES AND SCOPE

The Utilization Management Program Description (“UMPD” or “Program”) summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review (“UR” or “UM”) responsibilities and functions of United HealthCare Services, Inc. The collective health benefit businesses that are supported are: UnitedHealthcare Employer and Individual (E&I) including Individual and Small Business Health Options Program (SHOP) Exchanges, UnitedHealthcare Medicare and Retirement (M&R) and UnitedHealthcare Community and State (C&S). This UMPD describes the UM Program performed for each C&S plan. Any additional C&S plan UM Program requirements are set forth in an Exhibit to the UMPD.

In addition, the Program provides a structure to monitor the efficiency and quality of these UM services and includes other quality programs to ensure member access to quality care. Legal entity, state, product and client specific addenda and operational policies and procedures detailing processes and staff responsibilities supplement this description and further explain specific Program implementation.

UnitedHealthcare is a registered brand name associated with UHC. UnitedHealthcare uses UR licenses maintained by United HealthCare Services, Inc. Other United entities may also use the Program. The UM Program service delivery model, including inpatient concurrent review staff, is implemented by operational staff in centralized office sites, and remote telecommuters.

I. UTILIZATION REVIEW

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

II. MISSION AND SCOPE

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

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

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

- Post-Service Review
- Pharmacy Management
- Medical Technology Assessment Reviews
- External Review Services
- Physician Consultation
- Medical Claim Review
- Clinical Appeals

III. OBJECTIVES

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

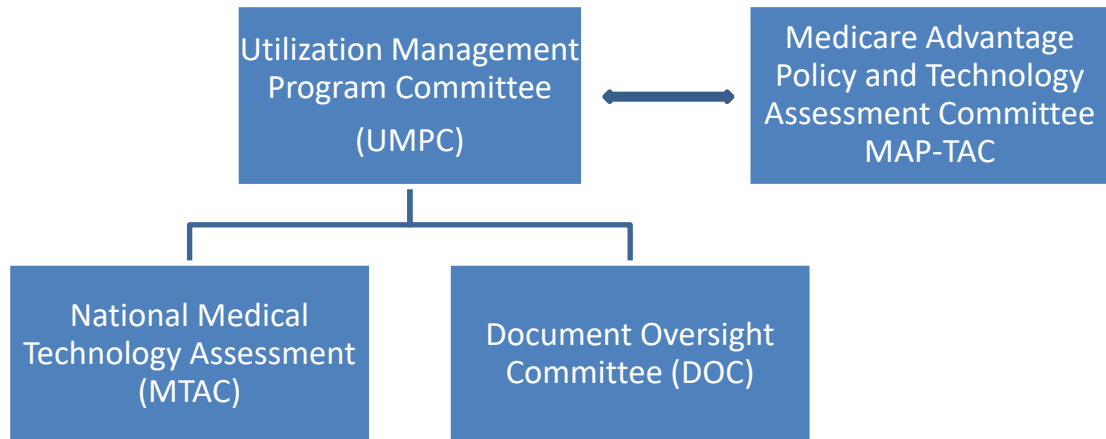
UM Program-focused objectives are to:

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

SECTION B – PROGRAM STRUCTURE OVERSIGHT

IV. UTILIZATION MANAGEMENT OVERSIGHT COMMITTEE STRUCTURE

The UM Program’s development, implementation, oversight, and evaluation involves UnitedHealthcare senior-level medical directors. UM Program activities are monitored and approved through the Utilization Management Program Committee (UMPC).



V. DESCRIPTION OF COMMITTEES

Utilization Management Program Committee (UMPC)

The Utilization Management Program Committee (UMPC) is responsible for oversight of the Utilization Management program and the development and maintenance of the scope and processes of the UnitedHealthcare prior authorization, concurrent review, and post-service review UM program including defining the services that require prior authorization, concurrent review, and post-service review, (collectively, “UM Reviews”) and processes for UM Reviews. In so doing, the UMPC is guided by the UnitedHealthcare Utilization Management Program Description and medical policies of UnitedHealth Group.

Functions of the UMPC include, but are not limited to the following:

- I. Oversight of the UnitedHealthcare Utilization Management Program.
- II. Review and approve of services added to and removed from all UnitedHealthcare prior authorization review lists.
- III. Review and approve of services to be subject to concurrent and retrospective review.
- IV. Refer appropriate matters to the Medicare Advantage Policy and Technology Assessment Committee (“MAP-TAC”).
- V. Oversee development and implementation of UM Review processes to include:

- a. Assign processes to submit and adjudicate UM requests.
 - b. Processes to ensure appropriate clinical review of UM cases; and
 - c. Processes to ensure compliance with UnitedHealthcare Mental Health Parity policies and procedures in UM Reviews.
- VI. Promote compliance with regulatory and accreditation medical management requirements, as applicable.
 - VII. Review and provide feedback on utilization management quality improvement activities, including, but not limited to the annual Utilization Management Evaluation; and
 - VIII. Maintains approved records of all committee meetings.

The composition of the UMPC includes the UnitedHealthcare Chief Medical Officer, the Chief Medical Officers of each UnitedHealthcare business segment, the UnitedHealthcare Senior Vice President for Medical Management, the Senior Vice President for Clinical Advancement, Chief Medical Officers from each line of business, and the Senior Director for Mental Health Parity among others. The UMPC meets at least six times per year or more frequently if needed. A quorum exists when at least 50% of the voting members are present.

National Medical Technology Assessment Committee (MTAC)

The Medical Technology Assessment Committee's (MTAC) reviews the scientifically based clinical evidence used in the development of UnitedHealthcare E&I and C&S medical policies and clinical programs to ensure transparency and consistency and to identify safe and effective health services for UnitedHealthcare members. The MTAC Charter outlines the structure, objectives, responsibilities, and scope of the activities carried out by the committee. Clinical and utilization review guideline recommendations from the MTAC will be reported to the UMPC.

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

The scope of the MTAC includes the functions listed below:

- I. Develop objective, evidence-based position statements on selected medical technologies (i.e., device/service/ technology/medically administered drug).
- II. Assess the evidence supporting new and emerging technologies.
- III. Review and approval of clinical criteria within new or existing medical policies to be utilized when performing a medical necessity review, when applicable.
- IV. Review and maintenance of externally licensed guidelines.
- V. Consider and incorporate nationally accepted consensus statements and expert opinions into the establishment of national standards.
- VI. Promote consistent clinical decisions about the safety and efficacy of medical care across all products and businesses.
- VII. Communicate approved policies internally and externally.
- VIII. Review and approval of utilization review and clinical practice guidelines to align

with internally developed medical policies and the UnitedHealthcare Hierarchy of Clinical Evidence. This includes internally developed guidelines, nationally recognized guidelines, and specialty society guidelines and.

- IX. Review and approval of medical policies and guideline related policies and procedures on an annual basis.
- X. Refer appropriate matters to UMPC.

The MTAC is comprised of Voting Members and Non- Voting Members. Voting Members include UnitedHealth Group, UnitedHealthcare, and Optum Medical Directors with diverse medical and surgical specialties and subspecialties from various business segment representatives. Meetings must have a quorum of Voting Members present to move forward with voting on the policies. A quorum is defined as greater than 50% of individuals designated as Voting Members. The committee chair is not a Voting Member.

Document Oversight Committee (DOC)

The UnitedHealthcare Medical Management (UCSMM) Document Oversight Committee (DOC) is responsible for overseeing the development of operational policies and procedures for UM/UR activities that meet applicable requirements within the UM Program. In doing so, the DOC is guided by the Utilization Management Program Description and the UCSMM Medical Management Policies.

The DOC's responsibilities and functions include:

- I. Oversee project managers, DOC subcommittees, and process/document owners in decision making during the document development phase to ensure the following:
 - a. Procedural compliance with internal policy and applicable requirements;
 - b. Avoidance of content duplication or contradiction of existing document content;
 - c. Appropriate template use, formatting, grammar and composition; and
 - d. Appropriate use of approved terminology compliance.
- II. Review final document versions following director level or above approval to promote regulatory, accreditation and internal policy compliance.
- III. Ensure operational documents are published in a central location for staff access and staff members are made aware of newly created documents or document revisions on a timely basis.
- IV. Identify procedural gaps and recommend procedural standardization.
- V. Ensure maintenance of a master list of documents including document number, title, owner, and approval/effective/revision dates,
- VI. Identify the need for operational policy revisions, development, and oversight of annual policy review/revision; and
- VII. Comply with UCSMM Policy 01.11 - Document Oversight and Adherence and

related Standard Operating Procedures.

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

Medicare Advantage Policy and Technology Assessment Committee (“MAP-TAC”)

The purpose of MAP-TAC is to function as the utilization management committee consistent with 42 CFR §422.137. MAP-TAC is responsible for oversight of the M&R UM program and the development and maintenance of the scope and processes of the M&R prior authorization, concurrent review, and post-service review M&R UM program including defining the services that require prior authorization, concurrent review, and post-service review. MAP-TAC also reviews the scientifically based clinical evidence used in the development of UnitedHealthcare M&R medical policies and clinical programs to ensure transparency and consistency and to identify safe and effective health services for UnitedHealthcare members. The MAP-TAC Charter outlines the structure, objectives, responsibilities, and scope of the activities carried out by the committee.

MAP-TAC includes voting and non-voting members. Voting members include UnitedHealthcare Medical Directors as well as external physicians with diverse medical and surgical specialties and subspecialties, including:

- I. The majority of members will be practicing physicians.
- II. At least one practicing physician who is an expert regarding care of elderly or disabled individuals.
- III. At least one practicing physician who is independent and free of conflict relative to the Medicare Advantage (MA) organization and MA plan.
- IV. The Committee will be led by an MA Plan’s Medical Director.

VI. DESCRIPTION OF PHARMACY COMMITTEES

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

UnitedHealthcare Pharmacy Quality Management Committee

The UnitedHealthcare Pharmacy (UHCP) Quality Management Committee (QMC) directs the QI program.

The functions of the UHCP QMC include:

- I. Define, review, approve and monitor key indicators that monitor access to pharmacy services including, but not limited to, pharmacy networks (both in and out of network services), customer service (call statistics, complaint monitoring), coverage reviews and appeals.
- II. Monitor client and member satisfaction with program services.
- III. Provide oversight for appropriate medication use and patient safety programs including drug utilization review programs.
- IV. Provide oversight for member/consumer directed programs.
- V. Monitor, review, track and trend implementation of prescription drug list (PDL) tier changes.
- VI. Approve national policies and procedures, as applicable, for quality improvement activities.
- VII. Review and approve delegation oversight reports and delegation audit results.
- VIII. Review, approve and monitor corrective action plans for delegates.
- IX. Review and evaluate audit results.
- X. Monitor compliance with both state and federal regulatory requirements.
- XI. Evaluate effectiveness of quality improvement program on an annual basis.
- XII. Communicate QMC initiatives and key findings to appropriate internal staff.

The Committee is chaired by the Chief Pharmacy Officer of UHCP or his/her designee. The membership of the UHCP QMC is composed of an appropriate number of members that is sufficient to represent various departments within the organization to review, support, guide, oversee data, reports and operations. The Committee meets at least quarterly and more often as defined by the Chairperson.

UnitedHealthcare Pharmacy Utilization Management (UM) Committee

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

- I. Oversee development, evaluation, review, and approval of clinical programs criteria. UnitedHealthcare will review drug, medical, and lab submission data as applicable to evaluate current drug use patterns in comparison to published standards of care, FDA approved product dosing, and FDA approved indications.
- II. Maintain a comprehensive program, description of activities and ensure an annual review and evaluation of criteria to ensure clinical programs are achieving desired results; and
- III. Maintain a dotted line relationship with the UnitedHealthcare P&T Committee.

UHCP PDL Management Committee (PDL MC)

Functions of the PDL MC include for E&I:

- I. Assigns approved prescription products to tiers on the PDL,
- II. Enhance the management of the pharmacy benefit by considering clinical, economic/financial and pharmacoeconomic evidence,
- III. Determines benefit exclusion status for drugs/product classified to be therapeutically equivalent to an over-the-counter product or another covered drug product.

This information is provided by UnitedHealthcare Evidence Based Decision Support Committee, including the P&T Committee. Supporting economic/financial/pharmacoeconomic analyses are directed by the Vice President, PDL Management Strategies and Analytics.

UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee

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

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

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

A UnitedHealthcare Medical Director is the chairperson of the Committee. The Committee is composed of internal and external members and may include the following: At least one practicing physician and one pharmacist specializing in the care of older adults and/or persons with disabilities, at least one physician specializing in psychiatry and licensed physicians. The P&T Committee meets in person or virtually where circumstances dictate at least four times per year for an entire day meeting and monthly via teleconference. A quorum is achieved when at least 50% plus one of the Committee's voting members are in attendance. In case of a tie, the Committee Chairperson casts the deciding vote.

SECTION C – PROGRAMS, REVIEWS & SERVICES

VII. DESCRIPTION OF PROGRAMS

Intake

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

Advanced Notification

The Advanced Notification process is designed to:

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

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

Clinical Coverage Review

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

- **Prospective/Pre-Service Review**

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

- **Prior Authorization/Pre-Certification**

Medical necessity determinations may be made for specific entities that require the process within their contract, Certificate of Coverage, Evidence of Coverage, Member Handbook, or Summary Plan Description. Prior authorization/Pre-Certification are reviews for services that are on the UnitedHealthcare Advance Notification and Prior Authorization list that include assessments based on the information provided to determine whether the proposed services meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the provisions of the applicable health benefits plan. The CCR services uses applicable benefit plan documents, objective, evidence-based medical policy, standardized coverage determination guidelines and nationally recognized clinical guidelines and criteria. Notice of all review determinations are communicated in accordance with

applicable state, federal or accreditation requirements.

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

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

Post-Service Review

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

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

Medical Claim Review

The National Medical Claim Review (MCR) supports clinical and/or coding review of claims both prepayment and on reconsiderations to support to claim operations. Selected claims are triggered by payment systems and forwarded for pre-payment review to ensure adherence with UnitedHealthcare and affiliated plans' medical policies, Drug policies, certain Reimbursement policies, InterQual criteria, CMS guidelines, coverage provisions set forth in certificates of coverage and summary plan descriptions as well as specific member commercial health benefit plan provisions that require clinical or medical coding knowledge or input to adjudicate. MCR is staffed with expert registered nurses and board-certified physicians who conduct post service reviews.

Pharmacy Management

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

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

Specific UM processes include:

- Prior Authorization/Notification
- Prior Authorization/Medical Necessity
- Step Therapy; and
- Clinical Appeals Review.

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

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

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

External Review Services – Physician Consultation Services (PCS)

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

Specialties include, but are not limited to:

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

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

SECTION D – DEPARTMENTAL ROLES & RESPONSIBILITIES

VIII. Departmental Resources

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

- Chief Medical Officer, UnitedHealthcare. Provides overall clinical leadership for the Medical Management for UnitedHealthcare.
- Chief Medical Officer (CMO) for each UnitedHealthcare benefit business Employer & Individual, Medicare & Retirement, Individual Exchanges, and Community & State: A licensed physician who is the senior clinical executive within each respective line of business and is a member of the UnitedHealthcare Core Management Team.
- Chief Medical Officer for Medical Policy: Supports the development and review of medical policies, clinical practice guidelines and drug policy guidelines and providing clinical support to the development of Coverage Determination Guidelines.
- Vice President, Clinical Coverage Review Medical Director (CCR): Responsible for the CCR program aligning the clinical coverage review programs based on the established notification list and for UR functions lines of business based on benefits and/or medical necessity where contractually indicated for the geographical area.

Accountabilities include providing prior authorization review for required health care services, and or prospective/pre-service reviews upon member or provider request.

- Senior Vice President, Medical Management: Provides guidance and oversight for the services and benefits within scope of the UnitedHealthcare UM Program.
- Director, Mental Health Parity: Provides guidance to ensure that UM programs fulfill mental health parity requirements.
- Chief Pharmacy Officer (CPO): Provides guidance and oversight and is responsible for all clinical aspects of the UM program for the pharmacy benefits; and has periodic consultations with the clinical pharmacists and staff performing these activities. The Employer & Individual CPO is a member of the UnitedHealthcare P&T Committee and chairs the UnitedHealthcare Utilization Management and Quality Management Committees for pharmacy.
- Sr. National Medical Directors and Regional Chief Medical Officers (RCMOs) are licensed physicians and members of the Market Senior Management Team. They have responsibility for alignment of Market Medical Directors activities. The Regional Chief Medical Officers collaborate with Executive Management and Medical Directors to provide expert consultation to the UM program development when necessary, and implementation. They oversee the implementation of affordability initiatives as well as development of alternative contracting arrangements and oversight of delegation management at the regional level.
- Operations Medical Directors: Licensed, board-certified physicians responsible for the utilization management functions for lines of business based on benefits and/or medical necessity where contractually indicated for geographical or function areas.
- Inpatient Care Management Medical Directors: Accountabilities include support to concurrent review of facility admissions.
- Clinical Coverage Review Medical Directors: Accountabilities include providing prior authorization reviews or prospective/pre-service decisions for requested healthcare services, including reviewing for network gap exceptions; and participating in the concurrent review processes to assist with coverage review of the facility setting.
- Medical Claim Review Medical Directors: Board certified physicians who provide clinical review post service. These decision makers are also distinct from those making initial determinations. Accountabilities include provide coverage review of services that are potentially experimental/investigational and clinical review of retrospective pre-payment coverage reviews in the absence of a notification or authorization.
- Appeals Medical Directors: Medical Directors provide clinical input into the appeal process. Appeal medical directors are different from the medical director who made the initial clinical adverse determinations. Accountabilities include providing clinical review of appealed concurrent and pre-service decisions for requested health care services and clinical review of post-service decisions for appealed payment decisions.

STAFF RESOURCES

Intake/Notification

Intake Coordinators and Pre-Service staff are non-clinical staff members who receive initial review requests and notifications by phone, secure fax or other secure electronic methods from a provider, consumer or authorized representatives. Staff may perform initial screening of certain emergent or scheduled services identified by Summary Plan Descriptions, Evidence of Coverage or Certificates of Coverage prior to health care services being rendered. Providers may enter information into the system to open the case and confirm receipt of the service request in the appropriate medical management system.

Clinical Coverage Review (CCR)

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

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

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

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

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

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

Inpatient Care Managers (ICM): The Inpatient Care Managers (ICM) provide the primary clinical interface with hospital staff and physicians. All ICM staff are health professionals

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

Post-Acute Specialist

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

Clinical Pharmacists (also Clinical Pharmacy Managers, Directors)

Clinical Pharmacists are licensed professionals who work directly with the staff to assist in facilitating delivery of services in the most appropriate and least restrictive manner. The clinical pharmacists supervise and oversee non-clinical staff activities related to the pharmacy processes. Clinical Pharmacists develop the clinical programs to support the pharmacy benefit. These programs may be either utilization management-based programs, or patient safety related programs, or member and physician engagement initiatives. Clinical Pharmacists may also be involved in the clinical coverage reviews and appeal determinations.

SECTION E – SERVICE INITIATIVES/PATIENT SAFETY

IX. CLINICAL REVIEW CRITERIA, DEVELOPMENT AND APPROVAL

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

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

required by law and permitted by the third party. UnitedHealthcare may also develop clinical review criteria with review and input from appropriate providers and based on current clinical principles and processes and evidence-based practices, as outlined in the Hierarchy of Clinical Evidence.

New policies are developed in response to emerging technology or new treatments and are based on scientific evidence, where such evidence exists. Medical Policy updates are communicated to all UM staff through various means of communication: Knowledge Library updates, webcast, online learning modules and other appropriate learning methods.

Pharmacy clinical programs and criteria are developed by UnitedHealthcare clinical pharmacists. Selection of drug products and development of program criteria Utilization Management programs and criteria shall be based on scientifically based clinical evidence including FDA-approved product labeling, clinical guidelines, peer reviewed clinical literature, randomized clinical trials and outcome studies, as applicable.

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

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

X. BEHAVIORAL HEALTH

United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals, and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH uses written clinical criteria consistent with NCQA and URAC requirements, and applicable laws and regulations. UBH selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence, as outlined in the Hierarchy of Clinical Evidence. UBH uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning.

UBH applies objective and evidence-based clinical criteria when making benefit coverage determinations. Consistent with the Clinical Criteria, UBH also considers members' individual needs and circumstances as well as the local delivery system and its ability to meet member's specific needs when determining coverage for behavioral health services. UBH's Clinical Criteria are based on guidance produced by peer-reviewed published research, government sources and professional societies. When applicable peer-reviewed published research is assessed in accordance with the Hierarchy of Clinical Evidence.

For commercial benefits plans that are not governed by ERISA, UBH selects and uses externally developed Clinical Criteria, and creates internally developed Clinical Criteria where appropriate.

UBH involves appropriate stakeholders, including clinical staff and providers in developing/selecting, and reviewing its Clinical Criteria. UBH adopts and disseminates clinical practice guidelines relevant to its enrollees for the provision of behavioral health services.

UBH annual reviews and when appropriate updates the Clinical Criteria and the procedures for applying them.

UBH annually reviews and updates its Medicare Coverage Summaries when the Centers for Medicaid & Medicare (CMS) issues new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health.

UBH monitors CMS's Local and National Coverage Determinations on the CMS website regularly for changes in guidance that may impact benefit coverage. If new or revised guidance is detected, UBH communicates the changes to the applicable areas and updates the Medicare Coverage Summaries accordingly. For behavioral health services, UBH uses its Clinical Criteria (see below) to make coverage determinations.

UBH uses the following Clinical Criteria:

- **Clinical Criteria (Level of Care Utilization System-LOCUS)** – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)**-Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.

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

The clinical practice guidelines offer guidance about evidence-based practices adopted from nationally recognized entities such as those produced by the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, and the U.S. Department of Veteran Affairs.

UBH's Clinical Criteria are available on UBH's internal intranet site. UBH's Clinical Criteria are available to providers and enrollees on UBH's public internet sites. Providers are informed in writing how to obtain UBH's Clinical Criteria. Paper copies are available to providers and enrollees when required and upon request.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A

senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

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

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

XI. MENTAL HEALTH PARITY

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

The Joint Parity Oversight Team (JPOT) supports the operationalization and improvement of the Mental Health Parity Program. JPOT provides oversight and direction related to mental health parity activities, potential issues and risks, and changes in the regulatory landscape. The JPOT meets on a regular basis and approves the mental health parity annual work plan and program description.

JPOT presents the findings of the annual mental health parity program evaluation to the UMPC annually. UMPC reviews and confirms that the UM processes relating non-quantitative treatment limitations are compliant with MHPAEA. Changes to UM processes are evaluated by the UMPC. New policies, and changes to third party criteria, are presented to UMPC for impact to the UM program.

UnitedHealthcare develops and maintains clinical policies that describe the generally accepted standards of medical practice, scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services.

M/S and MH/SUD benefits are administered using evidence-based, nationally recognized medical policies, clinical guidelines and criteria. Clinical criteria are developed using the applicable Hierarchy of Clinical Evidence. These clinical policies are available to members and providers.

XII. APPEALS

The UnitedHealthcare Appeals & Grievances Unit manages appeal requests for UnitedHealthcare E&I, including Individual and SHOP Exchanges, M&R and C&S lines of business. Operational policies and procedures describe the specific appeals processes; for example, required turnaround times, administrative requirements, letter content, and reviewer requirements. When applicable, appeals processes meet Department of Labor (DoL) regulations. State laws are followed if they are more stringent than the DoL regulations.

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

Clinical input into the appeal process is provided by Medical Directors in the UnitedHealthcare Clinical Services Appeals and Grievance functional Unit. Appeal Medical Directors are different from the medical directors who made the initial clinical adverse determinations and will have a same-or-similar specialty as the treating practitioner.

XIII. Other Quality Type Programs

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

Transition of Care or Special Circumstances

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

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

Care Management

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

XIV. QUALITY PROCESS IMPROVEMENT

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

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

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

SECTION F – ACCOUNTABILITY

Measurement and Reporting

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

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

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

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

XV. DELEGATION OF UTILIZATION REVIEW FUNCTIONS

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

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

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

XVI. CONFIDENTIALITY

The UMPD is designed to comply with the applicable policies of UnitedHealth Group, including the Code of Conduct, and those related to Ethics and Integrity. Through

application of the policies related to Privacy, the Program seeks to retain the trust and respect of our customers and the public in handling of private information including health, financial, and other personal information in the conduct of our activities.

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

XVII. CONFLICT OF INTEREST

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

XVIII. FINANCIAL COMPENSATION

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

XIX. ANNUAL EVALUATION

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