IPA Medical Management Audit Tool 2010
Utilization Management

IPA: ______________________ **Review Date:** ______________

Reviewed by: ______________________

NCQA UM 1: Utilization Management Structure
The IPA clearly defines its structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals. The IPA has a well structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.

Element A: Written Program Description (Desk Review)	0	1	2	N/A
The IPA's UM program description includes the following factors: The UM program may be contained in a separate document or within UM/Case Management policies and procedures. Behavioral health aspects of UM may be included in the program description or in a separate document referenced in the description.				
1. Program structure must describe:				
a. Staff members responsible for specific activities, including those members with the authority to deny coverage				
b. The extent of involvement of a designated senior physician in the UM Program implementation, supervision, oversight, and evaluation.				
c. How the IPA evaluates, approves, and revises the UM program, the frequency of evaluations and who is responsible for the evaluation				
d. The UM program's role in the QI program, including how the IPA collects UM information and uses it for QI activities				
e. Procedures by which a member or practitioner can appeal a determination				
2. Scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity. The scope of the UM program must describe:				
a. The IPA's UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including:				
(2) The method by which the IPA develops and chooses criteria				
(3) The method by which the IPA reviews, updates and modifies criteria				
b. The processes by which the IPA makes determinations of medical necessity and benefit coverage for inpatient and outpatient services				
c. Data and information the IPA uses in making determinations (e.g., patient records, conversations with appropriate physicians)				
COMMENTS:				

Element B: Physician Involvement (Desk Review)	0	1	2	N/A
A senior physician is actively involved in implementing the IPA's UM program. The UM program description must clearly define the involvement of a senior physician in the implementation and supervision of the UM program. In addition to defining the role, there must be evidence of the senior physician involvement in key aspects of the UM program, such as setting policies, reviewing				

cases and participating in UM committee meetings. A senior physician is a Medical Director or Associate Medical Director or equivalent.				
COMMENTS:				

Element D: Annual Evaluation (Desk Review)	0	1	2	N/A
The IPA annually evaluates and updates the UM program as necessary				
COMMENTS:				

NCQA UM 2: Clinical Criteria for Utilization Management Decisions

To make utilization decisions, the IPA uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria. The IPA applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

Element A: Utilization Management Criteria (Desk and Onsite Review)	0	1	2	N/A
1. The IPA has written UM decision-making criteria that are objective and based on medical evidence. The IPA must have clearly written criteria to evaluate the necessity of medical services. There must be written criteria for all UM activities that the IPA conducts, including review of specialist referrals when a PCP's referral is subject to IPA approval. These criteria can be widely applicable principles or more diagnosis or procedure-specific detailed protocols. The IPA must use criteria based on medical evidence.				
2. The IPA has written policies for applying UM criteria based on individual needs: Nationally developed procedures for applying criteria, particularly those for lengths of hospital stay, are often designed for "uncomplicated" patients and for a complete delivery system. The criteria may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to inpatient care. The IPA may include the factors listed as part of the UM criteria or as separate overriding instructions to the staff. The written UM procedures must direct decision makers to alternatives when the factors listed indicate that UM guidelines are not appropriate. Possible alternatives in these instances include use of a secondary set of UM criteria and individual case discussions.				
a. The IPA must consider at least the following factors when applying criteria to a given individual:				
(1) Age				
(2) Co-morbidity				
(3) Complications				
(4) Progress of treatment				
(5) Psychosocial situation				

(6) Home environment, when applicable				
3. The IPA has written policies for applying the criteria based on an assessment of the local delivery system:				
a. Availability of skilled nursing facilities, sub acute care facilities or home care in the IPA's service area to support the patient after hospital discharge				
b. Coverage of benefits for skilled nursing facilities, sub acute care facilities or home care where needed				
c. Local hospitals' ability to provide all recommended services within the estimated length of stay				
4. The IPA involves appropriate practitioners in developing, adopting and reviewing criteria applicability. The IPA documents that practitioners with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on development or adoption of UM criteria and on instructions for applying the criteria. The IPA can solicit opinions through practitioner participation on a committee or by considering comments from practitioners to whom it has circulated the criteria.				
5. The IPA has a process to annually review UM criteria and the procedures for applying them and to update them as appropriate. The IPA may either adopt national criteria or develop its own. The IPA and its practitioners must review national criteria for local use annually.				
COMMENTS:				

Element B: Availability of Criteria (Desk Review)	**0**	**1**	**2**	**N/A**
The IPA states in writing: The IPA may: • Copy criteria • Read them over the phone • Make them available for review at its offices • Distribute them via the Internet. The IPA will provide a paper copy upon request.				
1. How members and practitioners can obtain the UM criteria				
2. Makes the criteria available to its practitioners and Members upon request.				
COMMENTS:				

Element C: Consistency in Applying Criteria (Desk and Onsite Review)	**0**	**1**	**2**	**N/A**
The IPA annually evaluates the consistency with which health care professionals involved in UM apply criteria in decision-making and acts on opportunities for improvement, if applicable. The IPA must use an appropriate mechanism to assess the consistency with which physician and non-physician reviewers apply UM criteria. The assessment of inter-rater reliability applies only to determinations made as part of a UM process. Any referral that requires prior approval is considered a UM determination.				

Element C: Consistency in Applying Criteria (Desk and Onsite Review)	0	1	2	N/A
The assessment mechanism can include any of the following: • A supervisor's periodic review of determinations (which include side-by-side comparisons of how different UM staff members manage the same case) • Weekly UM "rounds" attended by UM staff members and physicians to evaluate determinations and problem cases • Periodic audits of determination against criteria				
COMMENTS:				

NCQA UM 3: Communication Services

The IPA provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

Element A: Access to Staff (Desk Review)	0	1	2	N/A
The IPA provides the following communication services for practitioners and members: Inbound and outbound communications may include directly speaking with practitioners and members or fax, electronic or telephone communications, e.g., sending e-mail, messages, or leaving voicemail messages.				
1. Availability of staff at least eight hours a day during normal business hours for inbound calls regarding UM issues.				
2. Ability of staff to receive inbound communication after normal business hours regarding UM issues. The IPA must describe its method of receiving after-hours communication.				
3. Outbound communication from staff regarding inquiries about UM during normal business hours, unless agreed upon otherwise.				
4. Staff identifies themselves by name, title and IPA name when initiating or returning calls regarding UM issues.				
5. A toll-free number or staff that accept collect calls regarding UM issues.				
6. Access to staff for callers with questions about the UM process. IPAs may refer general UM inquiries to its customer service staff. However, inquiries regarding specific UM cases must be triaged to and handled by UM staff, e.g., inquiries about decisions beyond the confirmation of approval or denial of care.				
COMMENTS:				

NCQA UM 4: Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions. UM decisions are made by qualified health professionals.

Element A: Licensed Health Professionals	0	1	2	N/A
The IPA has written procedures:				
1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. People who are not qualified health professionals may, under the supervision of appropriately licensed health professionals, collect data for pre-authorization and concurrent review. They may also have the authority to approve (but not to				

Element A: Licensed Health Professionals	**0**	**1**	**2**	**N/A**
deny) services for which there are explicit criteria.				
2. Specifying the type of personnel responsible for each level of UM decision-making.				
COMMENTS:				

Element B: Use of Practitioners for UM Decisions (Desk Review)	**0**	**1**	**2**	**N/A**
The IPA has a written job description with qualifications for practitioners who review denials of care based on medical necessity that requires:				
1. Education, training or professional experience in medical or clinical practice.				
2. Current license to practice without restriction.				
COMMENTS:				

Element C: Non-Behavioral Health Practitioner Review of Denials (FILE REVIEW)
The IPA ensures that a physician reviews any denial of care based on medical necessity. The evaluation of this element is assessed during the monthly retrospective review of the IPA's monthly UM denials based on medical necessity, or decisions on services that are, or that could be considered, covered benefits. Documentation may consist of a handwritten signature, handwritten initials, or unique electronic identifier on the letter of denial or on the notation of the denial in the file. For electronic signatures, the IPA must be able to demonstrate appropriate controls to ensure that the signature can be entered into the system only by the individual indicated.
COMMENTS:

Element E: Use of Board-Certified Consultants Desk and Onsite Review)	**0**	**1**	**2**	**N/A**
1. The IPA has written procedures for using board-certified consultants and evidence that it uses these procedures to assist in making medical necessity determinations. The IPA must have written procedures for using board-certified consultants that include a list of available consultants that are used in appropriate circumstances.				
2. The IPA demonstrates the use of appropriate board-certified specialists. The IPA must have available for review at least two cases demonstrating that consultants are board certified and that the IPA uses them in appropriate circumstances.				
COMMENTS:				

Element F: Affirmative Statement About Incentives (Desk and Onsite Review)	**0**	**1**	**2**	**N/A**
The organization distributes a statement to all members and to all practitioners, providers and				

Element F: Affirmative Statement About Incentives (Desk and Onsite Review)	0	1	2	N/A
employees who make UM decisions affirming that (IEHP distributes the Affirmative Statement to members via the member's handbook): The IPA must distribute an affirmative statement to all of its practitioners, providers, and staff regarding its incentives to encourage appropriate utilization and discourage underutilization. In addition, the organization must clearly indicate that it does not use incentives to encourage barriers to care and service. The statement must have been distributed at least once since the last survey. Distribution via the Internet is permitted. Written information about the availability of the information on the Web must be mailed to all participating practitioners, providers, and employees. A paper copy of the affirmative statement posted on the Web must be made available upon request. Element F does not preclude the use of appropriate incentives for fostering efficient, appropriate care.				
1. UM decision-making is based only on appropriateness of care and service and existence of coverage.				
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage of care.				
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.				
COMMENTS:				

NCQA UM 5: Timeliness of Utilization Management Decisions

The IPA makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The IPA makes utilization decisions in a timely manner to minimize any disruption in the provision of health care.

Element A: Timeliness of Non-Behavioral Health UM Decision Making (FILE REVIEW)

The IPA adheres to the following standards for timeliness of UM decision making:

This applies to all UM decisions, whether they are made on the basis of benefits or on medical necessity and whether they are approvals or denials. Documentation in the UM files must include the date of receipt of each request and the date of the resolution.

1. **For non-urgent pre-service decisions, the IPA makes decisions within 5 working days from receipt of the request.**

   Pre-service decision is any case or service that the IPA must approve, in whole or part, in advance of the member obtaining medical care or services. Preauthorization and pre-certification are pre-service decisions.

2. **For urgent pre-service decisions, the IPA makes decisions immediately or within 72-hours from receipt of request.**

   Urgent care is any request for medical care or treatment with respect to which application of time periods for making non-urgent care determinations:
   - Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment or
   - In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request

3. **For urgent concurrent review, the IPA makes decisions within 24-hours from receipt of the request.**

   Concurrent review decision is any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments, typically associated with inpatient or ongoing ambulatory care. If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the IPA does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate to the type of decision.

Element A: Timeliness of Non-Behavioral Health UM Decision Making **(FILE REVIEW)**
4. For post-service decisions, the IPA makes decisions within 30 calendar days from receipt of the request.   **Post-service decision** is any review for care or services that have already been received, e.g., retrospective review.
COMMENTS:

Element B: Notification of Non-Behavioral Health Decisions **(FILE REVIEW)**
The IPA adheres to the following standards for notification of UM decision-making: The date of the electronic or written notification is evaluated for timeliness of notification. For oral notifications, the IPA must record the time and date that the notification occurred, as well as who spoke with the practitioner or member. Members must be notified of a UM denial except, when a denial is either concurrent or post service and the member is not a financial risk.
1. For non-urgent pre-service decisions, the practitioner must be initially notified within 24 hours of the decision either by telephone or fax. (SB59)
2. For non-urgent pre-service denial decisions, the IPA gives electronic or written notification of the decision to practitioners and members within 2 working days of the decision.
3. For urgent pre-service decisions, the practitioner must be initially notified within 24 hours of the decision either by telephone or fax. (SB59)
4. For urgent pre-service denial decisions, the IPA gives electronic or written notification of the decision to practitioners and members within 72 hours from receipt of the request.
5. For urgent concurrent decisions, the IPA gives oral, electronic or written notification of the decision to practitioners and members within 24 hours of the request.
6. For urgent concurrent denial decisions, the IPA gives electronic or written notification of the decision to practitioners and members within 24 hours of the request or no later than 3 calendar days after the verbal notification.
7. For post –service denial decisions, the IPA makes the decision and gives electronic or written notification of the decision to practitioners and members within 30 calendar days from receipt of the request.
COMMENTS:

NCQA UM 6: Clinical Information
When making a determination of coverage based on medical necessity, the IPA obtains relevant clinical information and consults with the treating practitioner. The IPA uses all information relevant to an individual member's care when making UM decisions.

Element A: Information for UM Decision Making (Desk Review)	0	1	2	N/A
The IPA has a written description that identifies the information that is needed to support the UM decision-making. The UM process must ensure that the information needed to make a determination of medical necessity has been collected. A written policy must guide this process, which must not be overly burdensome for the member, the practitioner or the health delivery IPA's staff.				
COMMENTS:				

Element C: Non-Behavioral Health Documentation of Relevant Information (FILE REVIEW)
There is documentation that relevant clinical information is gathered consistently to support UM decision-making. This element is based on a review of a random selection of medical necessity denials. There must be evidence that the IPA has followed its own policies and procedures. Denial files must contain clinical information appropriate to each case.
COMMENTS:

NCQA UM 7: Denial Notices
The IPA clearly documents and communicates the reasons for each denial. Practitioners and members receive information sufficient to understand and decide about appealing a decision to deny care or coverage.

Element A: Notification of Reviewer Availability (Desk and Onsite Review)	0	1	2	N/A
The IPA notifies practitioners of: The IPA's policies and procedures must explain how it informs treating practitioners that they may contact a physician reviewer to discuss denial decisions. The IPA must notify the practitioners in writing of its policy, e.g., practitioner direct mailing, manual, orientation materials, newsletter, and internet if the IPA also sends written notification to all participating practitioners of the availability of the information on the website and provides a written copy upon request. A **physician reviewer** is an IPA physician representative who makes UM decisions. The physician reviewer may be someone other than the IPA's medical director.				
1. Its policy for making an appropriate practitioner reviewer available to discuss any UM denial decision.				
2. Evidence that the IPA notified the practitioners of this policy in writing.				
COMMENTS:				

Element B: Discussing a Denial with a Reviewer (FILE REVIEW)
The IPA provides practitioners with the opportunity to discuss any UM denial decision with a physician reviewer. This element is based on review of a random sample of the IPA's medical necessity denial files. There is evidence that the IPA notified each treating practitioner how to contact an IPA physician reviewer to discuss a denial.
COMMENTS:

Element C: Reason for Non-Behavioral Health Denial (FILE REVIEW)
The IPA provides written notification that contains the following: This element applies to all denials, whether they are made on the basis of benefits or on the basis of medical necessity. The evaluation is based on a review of a random sample of medical necessity denials. Documentation must show that the decision was communicated in writing to the practitioner and the member involved. Members

Element C: Reason for Non-Behavioral Health Denial (FILE REVIEW)
do not need to be notified when a denial is either concurrent or retrospective and the member is not at financial risk. The practitioner must be notified of all denials that pertain to the patients they are treating.
1. The specific reason(s) for the denial, in easily understandable language. The reasons for UM denials must be clearly documented in a permanent case record, which can be either manual or automated. A copy of the specific denial notification can demonstrate compliance. Samples of denial notifications or examples of form letters do not meet the intent of the standard.
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. The IPA must provide the reason for denial and include an easy-to-understand summary of UM criteria. The reason is to give the practitioner and member sufficient information to make a decision about appealing the denial.
3. Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.
COMMENTS:

Element D: Non-Behavioral Health Notification of Appeal Rights and Appeal Process (FILE REVIEW)
The IPA provides written notification that contains the following: This element applies to all denials, whether they are made on the basis of benefits or on the basis of medical necessity. The evaluation is based on a review of a random sample of medical necessity denials.
1. Description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
2. Explanation of the appeal process, including the right to member representation and timeframes for deciding appeals.
3. If a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process is included.
COMMENTS:

NCQA UM 12: Emergency Services
The IPA provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs. Members can obtain needed emergency services.

Element A: Emergency services Policies and Procedures (Desk Review)	0	1	2	N/A
The IPA's emergency services policies and procedures require: The IPA must have policies and procedures for handling emergency room claims, to ensure that retrospective denials or billing adjustment of payment include consideration of presenting symptoms and are not based solely on discharge diagnoses.				
1. Coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. A **prudent layperson** is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of the observation of the medical symptoms at hand, that emergency medical treatment was necessary.				
2. Coverage of emergency services if an authorized representative, acting				

Element A: Emergency services Policies and Procedures (Desk Review)	0	1	2	N/A
for the IPA, has authorized the provision of emergency services. The IPA's policies and procedures must clearly state that the IPA covers emergency services when authorized by a practitioner participating within the IPA's network or other authorized representative. **Authorized representative** may be any employee or contractor of the IPA who directs the member to seek services, e.g., advice nurse, network physician, physician assistant, and customer service representative. The ER practitioner is not considered an authorized representative unless they are participating within the IPA's practitioner network.				
COMMENTS:				

MC/UM 1: California Assembly and Senate Bills - 2002
The following criteria apply to California audits only; and are applicable as the contract between the health plan and IPA dictate.

Element A: California Senate Bills Desk and Onsite Review)	0	1	2	N/A
a. Written process to obtain second opinion from PCPs and specialists **H & S 1383.15** & **AB 12 (Davis):** Members are allowed to obtain a second opinion from a specialist outside the IPA, but within the health plan network. Members must stay within the IPA if requesting a second opinion from their PCP.				
b. Written description of Independent External Review (IER) (FILE REVIEW) **H & S 1274.30, 1274.31, 1274.32, 1274.33** & **AB 55 (Migden):** Member may request an independent, external review for any referral that is denied, modified or delayed because of lack of medical necessity. Must be in place by January 1, 2001. **DMHC:** Denial letter must have the DMHC required Independent Medical Review language when treatment or service has been denied as not medically necessary or experimental.				
COMMENTS:				

MC/UM 2: Denial and Modification of Prior Authorizations

Element A: Policy and Procedure (Desk Review)	0	1	2	N/A
Policies and procedures for notification to members of denials and modification of prior authorization requests The IPA has a written policy regarding the notification to members of denial or modification of prior authorization requests.				
COMMENTS:				

Element B: Notice of Action Letters (FILE REVIEW)
The notice of action letters must be a Health Plan/DHCS approved denial letter and include: The notice of action letters include instructions regarding how to file an appeal that is in compliance with all regulatory requirements (DHCS, DMHC, etc.) **1. Ombudsman contacts – DHCS Ombudsman 1(888) 452-8609**

2. **State Fair Hearing information for Medi-Cal**
3. **DMHC information with TTY and Internet website information included**
4. **Health Plan address and member services telephone number**
5. **Health Plan approved denial letter**
6. **Non-covered benefit denials must specify the provision in the contract that excludes the benefit**
7. **"Your Rights" attachments for Medi-Cal, Healthy Families and Healthy Kids**

COMMENTS:

MC/UM 3: Approved Referrals

Element A: Approved Referral Audit (FILE REVIEW)

1. **Approved referral turn-around time**

   IEHP Guidelines

   Referral turn-around time
   - 5 working days from receipt of the request
   - Urgent requests must be adjudicated immediately or within 72 hours from receipt of the request
   - Emergency services will not require prior authorization

   Scoring
   - 100% – 80% = Pass
   - Less than 79% = Focused Audit

2. **Proof service was delivered or member notified**

   IEHP Guidelines

   There must be documented evidence that the member was notified of the approved authorization or that the member received the requested service.

COMMENTS:

MC/UM 4: Denied Referrals

Element A: Denied Referral Audit (FILE REVIEW)

1. **Denied referral overall score**

   Scoring
   - 100% – 80% = Pass
   - Less than 79% = Focused Audit

The final MMA score is determined based on the total points achieved during the MMA period. The IPA must achieve a passing score of 80% or > in each of these major categories (Overall audit, TAT compliance, and the use of the correct denial letter template and required "your rights" attachments for each LOB.

2. **The following components are reviewed as part of the denied referral audit:**
   a. **Evidence that a physician conducts a review on every denial decision for medical appropriateness and benefit coverage**

      Qualified licensed health professionals assess the clinical information used to support UM decisions.

   b. **Evidence that the member was given alternative direction for follow-up care when a service is denied**
   c. **Timeliness of UM decisions**

      The IPA makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

Element A: Denied Referral Audit (FILE REVIEW)
Referral turn-around time • 5 working days from receipt of the request • Urgent request must be adjudicated immediately or within 72 hours from receipt of the request • Emergency services will not require prior authorization (1) The IPA notifies the practitioner of the decision of non-emergent requests within the appropriate time frame. Initial notification of the provider • Routine and urgent referrals within 24 hours of the decision • Urgent requests notification includes information on how to file expedited appeal within 2 working days of the decision, but not to exceed 72 hours from receipt of the request for urgent referrals. • Member may be initially notifie*d within 24 hours of the decision by telephone for urgent referrals.* (2) The IPA provides written notification regarding denial decisions of non-emergent requests within appropriate timeframes to the following: Timeliness of written notification to the Member and Practitioner with appeals information to the member and provider of denial determinations: • Within 2 working days of the decision for routine referrals • Within 72 hours from receipt of the request for urgent referrals. **d. There is evidence that the IPA consistently gathers relevant clinical information to support UM decision making prior to making determination.** **e. The IPA notifies the practitioner that a physician will be available to discuss determinations based on medical appropriateness.** Evidence that the IPA notifies the practitioner how to contact the physician reviewer to discuss determinations based on medical appropriateness. **f. The IPA clearly documents the reason for the denial in the written notification to the Member and Practitioner. The notification includes specific utilization review criteria or benefit provisions used in the determination.** **g. The IPA includes information about the appeal process in denial notifications to the Member and Practitioner.**
OVERALL SCORE: **2010 MMA (July 1, 2009 through June 30, 2010) Denial File Review Audit Total Points Earned:** • **Overall score =** • **TAT compliance score =** • **Use of correct templates and all required “Your Rights” attachments score =**
COMMENTS: {insert detail regarding corrective action taken during the MMA period in regards to score < 80%}