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I. HMO Responsibilities

A. HMO Program Structure

Two health maintenance organizations exist within the managed care structure of Blue Cross and Blue Shield of Illinois (BCBSIL). They are HMO Illinois (HMOI) and BlueAdvantage HMO (BA HMO). Except where distinctions are made, the two programs will be referred to as the HMO.

Independent Practice Association (IPA) physicians and/or IPAs are solely responsible for the provision of all health care services to HMO Members and all decisions regarding Member treatment and care are the sole responsibility of the IPA Physician. Such decisions are not directed or controlled by the HMO. **The HMO's decision about whether any medical service or supply is a covered benefit under the Member's HMO benefit plan are benefit decisions only and are not the provisions of medical care. It is the physician's responsibility to discuss all treatment options with the Member, regardless of whether such treatment is a covered benefit under the Member's benefit plan.** The IPA and IPA physicians shall provide services to Members in the same manner and quality as those services that are provided to other patients that are not HMO Members.

The HMO Utilization Management (UM) Plan incorporates standards related to the monitoring of care and services rendered to HMO Members. The HMO delegates performance of **UM and Case Management (CM)** to the IPAs in the HMO network. With oversight of the delegates, the objective of the HMO UM Program is to monitor the IPA UM decision-making processes and to ensure compliance with the standards as set forth in the HMO UM Plan.

The HMO delegates **behavioral health (bh) UM and CM** to the network IPAs and chemical dependency **UM and CM** to Magellan Behavioral Health (Magellan). IPAs may provide **bh** services through the **Primary Care Physician (PCP)**, a behavioral health **practitioner**, or sub-delegate behavioral health to a specialist vendor. Triage and referral standards are only applicable when an IPA sub-delegates **bh**. The IPA is responsible for the provision of **behavioral** health services. Oversight of the delegated behavioral health aspects of the program is performed by the HMO as described in the HMO UM Plan.

The HMO UM Workgroup performs an important role in the HMO UM Program. The UM Workgroup's responsibilities include, but are not limited to, the following:

- a) Annual review and revision of HMO UM goals and UM Program documents, including the HMO UM Plan and UM sections of the HMO's of BCBSIL Medical Service Agreement (MSA);
- b) Oversight of HMO UM policies and procedures to ensure compliance and annual review and revision of UM policies, if appropriate;
- c) Oversight of IPA UM Plans, UM adherence audits, utilization case files, including components related to behavioral health and selected case management files, and IPA corrective action;
- d) Oversight of IPA complaint, denial/appeal, case management and referral processes;
- e) Review of annual HMO PCP and Member survey results, with specific reference to referrals, and review of interventions for any identified issues;
- f) Review of IPA UM data to identify potential utilization issues;
- g) Annual evaluation of the HMO UM program; and
- h) Review and analysis of UM information collected for QI purposes. (Refer to the HMO QI Plan for all QI components.)

The HMO UM Workgroup is chaired by the BCBSIL Medical Director for Network Management. Other members include Sr. Manager of UM/ HEDIS/ On-site, Sr. Manager of Network Management, Accreditation Coordinator of Quality Administration, QI/ HMO UM/ On-site Project Consultant, an HMO UM Nurse Liaison, and a Nurse Liaison with a behavioral health background. Ad hoc staff representation may include: HMO Nurse Liaison(s), **HMO Provider** Network Consultant(s), other BCBSIL Medical Director(s), a representative from Quality Improvement, and a representative from Health Information Analysis.

B. Physician Involvement

The HMO UM Plan was initially developed in 1995. It has been evaluated and revised annually by the HMO UM Workgroup. The behavioral health components of the HMO UM Plan are reviewed annually by a BCBSIL Medical Director or designated behavioral health practitioner. The Plan is then reviewed and approved by the Managed Care QI Committee.

C. HMO UM Staff

Within the HMO, the following staff are employed to provide oversight of UM functions performed within the contracting IPAs as follows:

- a) Licensed physician(s), including a BCBSIL Medical Director(s), are directly responsible for oversight of the HMO UM Program;
- b) The QI/ HMO UM/ On-site Project Consultant, a licensed Registered Nurse, and the UM/Onsite Senior Manager, are responsible for monitoring the activities of the UM staff, tracking network performance, designing UM interventions, and reporting on IPA UM compliance and UM network activity;
- c) Nurse Liaisons, all of whom are Licensed Registered Nurses, are responsible for monitoring each IPA's UM performance; and
- d) A Behavioral Health Liaison, a licensed Registered Nurse, is responsible for Member and provider assistance with behavioral health issues.

D. Program Scope

The scope of the program includes, but is not limited to, oversight of delegated inpatient and outpatient services as follows:

- a) Referrals
- b) Diagnostic testing
- c) Therapies
- d) Behavioral health
- e) Skilled nursing services
- f) Rehabilitation services
- g) Home health care services
- h) Certifications
- i) Denials and
- j) Appeals
- k) Case management

E. Program Goals

The goals of the HMO UM Program are developed upon review and consideration of the following:

- a) Analysis of the results of HMO UM oversight activities;
- b) Analysis of previous utilization patterns and related cost;
- c) Provider and Member feedback/ communication/ complaints to the HMO; and
- d) Changes in regulatory and accreditation requirements.

The goals of the **2009** HMO UM Program are as follows:

1. To receive UM Plan revisions from all contracting IPAs by **February 15, 2009 (the following Monday if this date is a weekend)**;
2. To ensure all IPAs UM Plans meet the HMO UM Program requirements by **April 30, 2009**;
3. To demonstrate through the onsite adherence audit that the IPAs have UM Programs, **including CM**, that meet or exceed HMO requirements;
4. To verify receipt of timely and accurate IPA submissions including but not limited to: denial/appeal logs and files, sample denial letter(s), referral logs, sample referral forms, UM logs, certification forms, referral inquiry log (if no denials), CM logs, and any additional requests from all IPAs;
5. To maintain effective educational programs related to perceived and documented needs of the IPAs;
6. To improve Member and PCP satisfaction with the referral process;
7. To evaluate utilization through IPA monitoring of avoidable inpatient days;
8. To ensure compliance with behavioral health triage and referral requirements;
9. To meet NCQA accreditation standards, URAC UM accreditation standards, and pertinent legislative **and regulatory** requirements; and
10. To ensure IPA denial files meet HMO, legislative, **regulatory** and accreditation requirements.

F. Clinical Criteria for UM Decisions

The HMO delegates selection of nationally recognized clinical criteria to the IPA and specifies procedures for selection, annual review, application, and dissemination of the criteria. Clinical (medical and behavioral health) criteria must be a current version of the selected criteria. Clinical practice guidelines are designed to assist IPA Physicians. **The guidelines are not a substitute for the sound medical judgment of the physician. The physician must make the final determination about what treatment or service is appropriate for the Member based upon the medical condition of the Member.**

G. Requirements for UM Decision Making

The IPAs shall meet the following UM decision-making requirements, including those related to behavioral health UM decisions:

- a) UM decisions are made within the time frames established by the HMO using clinical information;
- b) A process is identified for UM reviews performed on-site at facilities, such as hospitals and skilled nursing facilities (SNF); and
- c) Transition of care is provided when benefits end, **when appropriate**.

The IPAs shall meet the following denial decision requirements, including those denials related to behavioral health:

- a) Denial decisions are made by appropriately licensed practitioners and/or specialists (Behavioral Health Practitioner for behavioral health denials);
- b) Denial decisions are clearly communicated to the Member and practitioner (understandable to the member with an alternative provided);
- c) Practitioners are provided a practitioner contact for discussion of any denial;
- d) Written notification to the practitioner/ Member includes reference to the benefit provision, guideline, protocol or other criterion utilized to make the decision, as well as information on how to obtain a copy; and
- e) Written denial notification includes an explanation of the HMO's appeal process.

The HMO does not delegate Member appeals to the IPAs; however, the IPA may have a voluntary appeal process for the Member.

The IPA voluntary appeal process must meet HMO requirements. Members may appeal to the IPA or directly to the HMO. The appeal process must meet the time frame requirements for all types of appeals (pre-service, concurrent, post-service). If the Member appeals to the IPA and the original denial is upheld, the Member may appeal to the HMO. The HMO will facilitate the appeal process according to NCQA, URAC, and legislative **and regulatory** requirements.

1. Pre- and Post-Service Appeals

The HMO has written policies and procedures regarding appeals that address the following: documentation of the substance of the appeal and action taken;

- a) Full investigation of the appeal;
- b) The opportunity for the Member to submit written comments, documents or other information relating to the appeal;
- c) Appointment of a new person for review of the appeal who was not involved in, or a subordinate to anyone involved in the previous review;
- d) For medical necessity appeals, the case must be reviewed by a practitioner of the same or similar specialty as the managing practitioner;
- e) The decision and notification to the Member must be made within **15** calendar days of the receipt of the request **for first level appeal (clinical/ non-clinical) and 30 calendar days of the receipt of the request for second level at the HMO (clinical/ non-clinical)**;
- f) There must be notification about further appeal rights including the appeal process;
- g) There must be procedures for providing the Member access and copies of all documents relevant to the appeal, upon request; and
- h) An authorized representative must be able to act on the Member's behalf.

a. Expedited Appeal

An expedited appeal may occur if proposed or continued services pertain to a medical condition that may seriously jeopardize the life or health of a Member; or if the Member has received emergency services and remains hospitalized.

If the Member is hospitalized, the Member may continue to receive services with no financial liability until notified of the decision.

The HMO has procedures for registering and responding to expedited appeals which include:

- a) Allowance of oral or written initiation of an expedited appeal by the Member or practitioner acting on behalf of the Member;
- b) Decision and notification to the Member and practitioner as quickly as the medical condition requires, but no later than 72 hours after the request is made; and
- c) Electronic or written confirmation of the decision must be made within this timeframe.

The HMO letter that includes instructions about appeal rights and resources must be used for all denials and for all appeals for which the denial was maintained.

b. External Appeal

Requests from the Practitioner(s) and/or Member for an external appeal should be directed to the Customer Assistance Unit of HMO.

H. New and Existing Medical Technology

Medical Policies represent guidelines in making health care benefit coverage determinations on particular clinical issues, including new treatment approaches and medical technologies. HMO evaluates emerging medical technologies as well as new applications of existing technologies through BSBCIL's corporate medical policy development process. The evaluation process is applied to new technologies, products, drugs, medical and surgical procedures, behavioral health procedures, medical devices and any other such services as may come under policy and claims review. The Managed Care New and Existing Medical Technology Policy outlines the process for evaluation of technology. IPAs are required to contact the HMO with any questions regarding medical technologies.

I. Satisfaction with the UM Process

The BCBSIL QI Department performs annual surveys for measuring member and PCP satisfaction with the UM process. In addition, the HEDIS[®] CAHPS[®] survey results, member complaints, and appeals data are reviewed. Satisfaction with the referral process is analyzed to identify opportunities for improvement at the network and IPA levels. Interventions are implemented where appropriate. Annually, evaluation of the outcomes of the interventions is performed.

J. Emergency Services

The HMO contractually requires IPAs to follow the "prudent layperson" standard set forth in the MSA in making UM decisions related to emergency services.

K. Pharmaceutical Management

Pharmacy benefits are administered by Prime Therapeutics, BCBSIL's Pharmacy Benefit Manager.

L. Ensuring Appropriate Utilization

1. The HMO reviews and evaluates the following data, **and such other information as the HMO deems appropriate** in order to identify any patterns of potentially inappropriate utilization:
 - a) Inpatient admissions/1000;
 - b) Inpatient days/1000;
 - c) Average length of stay (LOS);
 - d) Outpatient surgery/1000;
 - e) Behavioral health days/1000; and
 - f) Member and PCP referral satisfaction data from annual surveys.

Data is collected at the network and IPA level. Thresholds for intensified review by the HMO UM Workgroup are established based on a statistical analysis of a IPA's performance in relation to overall network performance. The HMO QI Plan contains utilization goal benchmarks that are set based on all BCBSIL products. In addition, Milliman benchmark performance data (for moderately managed health plans) are used as a guide. The variance between Milliman and the IPA's average length of stay, days/1000, and behavioral health days/1000 are utilized to determine the mean and standard deviation as compared to the network. IPAs are targeted for annual focus visits based on the **various factors considered by the HMO including the following**: avoidable days/ 1000; days/ 1000; average length of stay; hospitalist program; date of last visit;

or any other identified potential issue. In addition, member survey and PCP survey data are reviewed for each identified IPA. The HMO UM Workgroup reviews reports and identifies potential issues. Also, claims payment data, denial files, customer service issues, quality of care issues, diagnosis, referrals, case detail, member satisfaction and appeals are utilized to identify potential problems. When deemed appropriate, a corrective action plan is requested from the IPA. It may include any of the following components: further data collection, written requests for action, meeting with the network consultant and the IPA, and/ or meeting with the identified IPA.

2. All IPAs, as well as the HMO, are required to distribute an affirmation statement to all staff involved in UM decisions making affirming that:
 - a) UM decisions are based on medical necessity, which includes appropriateness of care and services, and the existence of available benefits;
 - b) The organization does not specifically reward health plan staff, providers or other individuals for issuing denials of coverage, care or service; and
 - c) Incentive programs are not utilized to encourage decisions that result in under-utilization.
3. A statement regarding conflict of interest must be included with the affirmation statement.

M. Triage and Referral for Behavioral Health Care

The HMO delegates behavioral health care to the IPAs and chemical dependency care to Magellan. Triage and referral is applicable to any IPA delegating behavioral health to a vendor/ contract management firm (CMF). IPAs that delegate must meet the triage and referral requirements as defined by the HMO. Quarterly telephone data is collected and analyzed annually by the HMO.

N. Delegation of UM

The HMO delegates the UM **and CM** function(s) to its contracting network IPAs. The MSA and the HMO UM Plan delineate the responsibilities of the IPAs, as well as the HMO's responsibility and mechanisms for UM oversight.

1. **The HMO adheres to the Health Insurance Portability and Accountability (HIPPA) provisions for the use of Protected Health Information (PHI) and requires the IPA, in turn, to follow these provisions:**
 - a) Use PHI (any Member identifiers that can be linked to a Member) only to provide or arrange for the provision of medical and behavioral health benefits administration and services;
 - b) Provide a description of appropriate safeguards to protect the information from inappropriate use or further disclosure;
 - c) Ensure that sub-delegates have similar safeguards;
 - d) Provide individuals with access to their PHI;
 - e) Inform the HMO if inappropriate uses of the PHI occur; and
 - f) Ensure that PHI is returned, destroyed or protected if the contract ends.

2. Approval of the IPA Um Plan and Process

Annually, each IPA must submit a UM Plan defining their UM processes. The HMO reviews and approves each UM Plan **for compliance with** the HMO UM requirements.

In addition, annual on-site audits and monthly denial file reviews are performed by the HMO.

Non-compliance of an IPA or its' delegates will result in corrective action until resolution of the identified deficiencies or termination of the contract. This process is outlined in the MSA and the delegation agreement.

3. Appointment of New IPAs to the Network

Appointment of a new IPA to the network or appointment of an existing IPA into new HMO products within BCBSIL is contingent upon **a number of factors, including IPA adherence to** the following HMO UM criteria:

- a) Demonstration of ability to effectively manage utilization within the other HMO products in which it participates.
- b) Demonstration of successful implementation of the IPA UM Plan while maintaining Member and practitioner satisfaction, as demonstrated in the HMO PCP and Member surveys, with identified sources of dissatisfaction addressed by the IPA.
- c) Demonstration of satisfactory performance on Quality and UM site visit audits.
- d) Demonstration of compliance with all other HMO UM requirements.
- e) **Demonstration of an effective CM process.**

II. IPA Responsibilities

A. Delegation to the IPAs

The HMO delegates performance of UM **and CM** to IPAs as is formally set forth in the MSA.

The IPA is required to have a UM Committee, with specialist representation, to review the use of ambulatory and inpatient services provided to HMO Members. Within this structure, the IPA has the opportunity to design a UM **and CM** Program that is suited to its unique practice environment. Delegated UM **and CM** must be consistently performed within **the** parameters set forth in the MSA and HMO UM Plan.

B. IPA UM Plan

Each IPA must have a formal, written UM Plan that meets, **at a minimum**, the HMO requirements and to which the IPA will be held accountable. The IPA must review and update its UM Plan on an annual basis, and assure that all aspects are consistently applied.

The IPA UM Plan must contain the following **elements**:

1. A written description of the UM program structure, which includes a clear statement of the scope, goals, objectives and purpose of the IPA UM program, **including CM**. The IPA UM Plan must identify the UM Committee chairperson, its membership, the committee structure and meeting schedule. The UM Committee must include broad physician representation, including the following: Medical Director or his/her physician designee, actively practicing PCPs, and specialists. A listing of the committee membership must include each member's professional degree and specialty (submitted to the HMO). The UM Plan must include a description of the process for its development (i.e. which persons or Committees are responsible for the UM Plan review, revision, and the final approval).
2. The IPA must identify staff responsible for specific activities. The IPA must have a Medical Director, Physician Advisor (PA), (the Medical Director may also be the PA), UR Coordinator, Board Certified specialists or consultants, behavioral health consultant, and UM Committee. A description of the UM staff accountability should be detailed in the IPA UM Plan. For example, the plan should indicate which level of staff (MD, RN, LPN, Non-clinical) are responsible for case management, inpatient review, outpatient review, discharge planning, behavioral health, denials, etc.
3. If an IPA chooses to sub-delegate or outsource any UM function to another entity (e.g. (CMF), hospital UR department, behavioral health facility or group) that entity must be named and specific contact information documented in the IPA UM Plan. The sub-delegated entity is responsible for all IPA UM activity for which it is contracted with the IPA. Sub-delegates must meet the HMO UM standards set forth in the HMO UM Plan. The IPA is responsible for oversight of any sub-delegates.
4. Any IPA delegating behavioral health to a CMF or similar organization must document that delegation in its UM Plan. The IPA must incorporate all pertinent HMO UM standards in its UM Plan or the IPA must submit a UM Plan from the delegate that meets HMO standards. Behavioral health organizations must meet the HMO UM standards set forth in the HMO UM Plan. The IPA is responsible for the review, approval, and submission to the HMO of the behavioral health organization's UM Plan.
5. The IPA UM Plan must describe the behavioral health aspects of its UM Program.
6. The IPA UM Plan must include the program scope, which includes, but is not limited to a description of the process for accomplishing the following:
 - a) Pre-certification or initial review
 - b) Concurrent Review
 - c) Retrospective Review
 - d) Referrals

- e) Denials/Appeals, including expedited appeals (if the IPA does not submit denials, include the process for referral inquiry between PCP and the IPA);
 - f) Complaints
 - g) Corrective Action
 - h) Discharge Planning
 - i) Case Management
 - j) Triage and screening for behavioral health cases, if applicable
 - k) Diagnoses/ procedures/ services/ physicians that do not require review based on historical UM data
7. The UM Plan must identify the nationally recognized medical criteria selected by the IPA, the process for its selection, approval, application, dissemination, and the annual process for criteria update and review.
 8. The UM Plan must describe the process of making medical necessity (including out-of-network determinations) and benefit determinations and the information utilized in making determinations.
 9. The IPA UM Plan must identify annual UM goals for the program.
 10. The IPA UM Plan must describe the process for UM reviews that are performed on-site at any facility. If the IPA UM Coordinator performs on-site review at facilities, the IPA must have a documented process that includes the following **elements**:
 - a) Guidelines for identification of IPA staff at the facility (in accordance with facility policy);
 - b) A process for scheduling the on-site review in advance (unless otherwise agreed upon); and
 - c) A process for ensuring that IPA staff follow facility rules.**If no on-site review is performed, this must be documented.**

The IPA UM Plan, including the UM Plan of any delegate(s), if applicable must be submitted to the HMO by the required date. The HMO Nurse Liaison reviewing the Plan will notify the IPA of the need for any revisions with an assigned due date for submission of revision(s). Failure to meet the revision due date may result in an HMO Administered Complaint.

Any incidence of non-compliance with the HMO UM Plan requirements may result in the assignment of an HMO Administered Complaint.

Hospitalist Program (If Applicable)

The Hospitalist Program process must be documented in the UM Plan, if applicable. At all hospitals where the IPA has developed its provider network, an IPA must:

- a) Ensure that a Physician (PCP and/or hospitalist) sees the patients a minimum of twice daily (AM and PM)
Note: Specialist visits do not meet this requirement;
- b) Ensure that all inpatient cases (excluding routine OB) are seen twice daily (AM and PM);
- c) Provide onsite physician coverage of Members who present in the Emergency Department.

The IPA hospitalist program will be audited on an annual basis. Thirty cases will be randomly selected from the IPA admission logs two to six months prior to the date of the scheduled audit. The hospital medical records will be reviewed for the twice daily PCP or hospitalist coverage required. 90% of the cases reviewed must meet the hospitalist program criteria. **Hospitalist/ PCP signatures must be provided prior to the audit.**

C. IPA Physician and UM Staff

IPAs must have appropriate staff to perform UM functions with the minimum staffing requirements as follows:

The Medical Director is a licensed physician who:

- a) Supervises all UM decision-making **and CM activities**
- b) Is responsible for approving the final IPA UM Plan
- c) Monitors the implementation of IPA UM Plan

- d) Is the team leader responsible for educating and encouraging involved staff
- e) Makes the final decision for utilization issues
- f) Oversees the analysis of trends, profiling, and long term IPA planning
- g) Is responsible for satellite and CMF oversight, if applicable
- h) Is responsible for the proper functioning of the IPA UM Committee
- i) Is responsible for oversight of the behavioral health care for the IPA members.

The Physician Advisor (P.A.) is the licensed physician most directly involved with individual case review. The Medical Director may act as the Physician Advisor. This physician reviews all cases that do not meet the medical necessity guidelines or are long stay cases (defined as greater than **seven** days). The physician review must be documented.

Board certified specialists, including a behavioral health practitioner, must be available as needed to assist in making determinations of medical necessity. The IPA must maintain and annually update a list of available board-certified specialists used for this purpose. This list of specialists must be submitted to the HMO with the annual submission of the UM Plan. In addition, there must be a board-certified psychiatrist or licensed clinical psychologist available as needed for behavioral health.

The UM Coordinator, who is a health professional and possesses an active professional license, is responsible for the day-to-day utilization review activities. Utilization case review and application of criteria to approve initial and continued inpatient services must be performed by a licensed professional nurse or supervised by a licensed professional nurse or physician. Professional staff licensure **will be verified annually by the HMO. Registered Nurse license numbers must be submitted to the HMO annually.** The UM Coordinator is proficient in the use of medical terminology and nationally recognized medical criteria and is able to communicate accurately with the Medical Director, PA and/or PCPs. There must be sufficient UM Coordinator staffing to perform necessary reviews and to discuss cases with the appropriate physician(s). The UM Coordinator usually serves as the primary UM contact for the HMO.

All physicians practicing/participating within a IPA must be currently licensed to practice medicine in the state of practice and must be currently credentialed by BCBSIL. The IPA Medical Director and PA must be currently licensed in the state in which the IPA operates. Annually, a listing of the Medical Director and all PAs must be submitted with the IPA UM Plan. The HMO will verify physician licenses through the HMO credentialing department.

The IPA must have written job descriptions with practitioner qualifications for practitioners who review denials. Qualifications should include education, training or professional experience in medical or clinical practice. **The job description must include the responsibilities for that position.** The job description(s) must be submitted with the UM Plan. A behavioral health practitioner job description must be included.

The IPA must have written procedures for training, orientation, and ongoing performance monitoring of clinical and non-clinical utilization review staff. The procedures must be submitted to the HMO annually, at the time of submission of the UM Plan.

D. IPA Clinical Criteria For UM Decisions

Annually the IPA, through its UM Committee, must select, review, update, and approve nationally recognized medical criteria used in medical necessity review and LOS determinations. The clinical (medical and behavioral health) criteria must be the current version of the selected criteria. The UM Committee selecting and approving nationally recognized medical criteria must include credentialed or licensed actively practicing physicians including input from at least one specialist from each of the IPA high volume specialty areas. The IPA staff must use the most current criteria set; that encompasses all medical services including, but not limited to, the following:

- a) Medical;
- b) Surgical;
- c) Outpatient surgery;
- d) Behavioral health;
- e) Rehabilitation;

- f) Home health care (HHC); and
- g) Skilled nursing facility (SNF).

For situations where nationally recognized criteria is not available, the IPA may utilize additional guidelines created by the IPA, provided that the guidelines are reviewed and approved annually, including any procedures for their use, through the IPA UM Committee. The development process of the criteria must include appropriate specialists. Every year, the criteria and procedure(s) must be submitted to the HMO with the IPA UM Plan. Documentation of review and approval must be in the UM Committee minutes. The IPA may adopt additional objective criteria, clinical pathways, and/ or guidelines. They must be reviewed by the UM Committee and chosen based on scientific medical evidence. Discussion of how the additional criteria, clinical pathways, and/ or guidelines were chosen must be identified in the UM Plan as part of the criteria approval process.

To support UM decision-making, the UR Coordinator and/or Physician Advisor must gather and document relevant clinical information including information from the attending physician. The review sheet should include documentation of the source of the clinical information used in the review, i.e. PCP, lab, medical record. Relevant clinical information may include, but is not limited to, lab tests, physician's progress notes, x-ray reports, and individual patient circumstances as listed below:

- a) Age
- b) Comorbidities
- c) Complications
- d) Progress of treatment
- e) Psychosocial situation
- f) Home environment assessment upon admission, for discharge planning purposes

The UM decision-maker must also consider characteristics of the local delivery system that are available for the particular patient, including:

- a) The availability of skilled nursing facilities or home care in the IPA's service area to support the patient after hospital discharge;
- b) The coverage of benefits for skilled nursing facilities or home care when needed; and
- c) The ability of local hospital(s) to provide all recommended services within the estimated length of stay.

On an annual basis, a written statement must be distributed to all IPA practitioners notifying them of the availability of the IPA's nationally recognized criteria and any additional guidelines, the method for requesting the criteria, and the format in which the criteria will be provided. A sample of this annual written statement is to be attached to the annual UM Plan for submission to the HMO.

For cases that do not meet the nationally recognized medical criteria, the IPA Medical Director and/or P.A. must make a determination taking into account the individual patient's circumstances including age, co-morbidities and psychosocial considerations. For all diagnoses and procedures that are not listed in the IPA's nationally recognized medical criteria set, the case must be reviewed by Medical Director and/or P.A. for determination of medical necessity. For long stay cases (greater than **seven** days), the cases must be reviewed weekly by the Medical Director and/or PA for continued medical necessity and appropriateness of setting. The physician review must be documented.

Semi-annually: the UM Committee must assess inter-rater reliability (consistency in the application of nationally recognized medical criteria) and document its findings in the UM Committee minutes. Physician Advisors, Medical Directors and UM staff must be included in this assessment. Inter-rater reliability testing must be performed by a licensed professional peer of the individual being reviewed. **Every physician and UM staff member involved in UM decision-making must be included in the testing.**

E. Access to IPA UM Staff

The IPA must provide the following communications services for practitioners and Members:

- a) At least eight hours a day, during normal business hours, staff must be available for inbound calls regarding UM issues;
- b) UM staff must have the ability to receive inbound after business hours communication regarding UM issues (i.e. voice mail or answering service);
- c) There must be outbound communication from staff regarding UM inquiries during normal business hours;
- d) Calls must be returned within one business day of receipt of communication;
- e) Staff must identify themselves by name, title and organization name when initiating or returning calls;
- f) There must be a toll free number or staff that accepts collect call regarding UM issues; and
- g) Callers must have access to UM staff for questions.

The IPA must document their inbound and outbound communication process in the annual UM Plan. The method for receiving after hours communication must be included. Practitioners and Members must be notified of access to UM staff for questions and the acceptance of collect calls or the availability of a toll free number. Practitioners and Members may be notified by welcome letter, newsletter, or memo in the PCP office.

F. Requirements for UM Decision-Making

NON-BEHAVIORAL AND BEHAVIORAL HEALTH DECISIONS

1. Prospective/Precertification/Pre-Service Process includes determination of medical necessity and appropriateness of service and site for inpatient and outpatient services. It is performed by the UR Coordinator and/or the PA using the nationally recognized medical criteria selected by the IPA. IPAs may develop written policy and procedures related to services not requiring pre-certification. The policy may include diagnoses, procedures, and/or physicians that do not require prior authorization and/ or concurrent review.

Pre-certification/Pre-Service includes documentation of the following:

- a) Sources of relevant clinical information utilized (medical record, physician information, labs/test results/x-rays, other)
- b) Estimated length of stay (LOS) (admission)
- c) Medical criteria met including criteria code (admission)
- d) Non-urgent pre-service determination (approval and denial) within five calendar days of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information)
- e) Non-urgent pre-service member notified within five calendar days of the receipt of request
- f) Non-urgent pre-service practitioner notified within five calendar days of the receipt of request
- g) Urgent pre-service determination (approval and denial) within 72 hours of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information)
- h) **For urgent cases**, member notified within 72 hours of receipt of request (IPA policy may include statement that PCP notifies member of approved certification)
- i) **For urgent cases**, practitioner notified within 72 hours of receipt of request

For practitioner notification, if initial notification is made by telephone, IPA must: record time and date of call, and document name of IPA employee who made the call.

For all denials, confirmation of the decision must be provided by mail, fax, or e-mail.

2. Certification/Initial Review Process for emergent/urgent admissions is to be completed within 24 hours of admission or notification of admission and includes documentation of the following:
 - a) UM decision (approval or denial) made within 24 hours of receipt of the request
 - b) Nationally recognized medical criteria being met (code documented) in justification of medical necessity issues
 - c) Assigned length of stay (LOS)
 - d) Notification of member within 24 hours of receipt of request (IPA policy may include statement that PCP notifies member of approved certification)

- e) Notification of practitioner(s) within 24 hours of the receipt of request
- f) Discharge planning/case management needs addressed

For practitioner notification, if initial notification is made by telephone, IPA must: record time and date of call, and document name of IPA employee who made the call.

For all denials, confirmation of the decision must be provided by mail, fax, or e-mail.

Initial Review for precertified/ pre-service non-urgent (elective) admissions may be deferred until assigned length of stay for that approved admission has reached its limit.

The completed certification form for admissions (excluding those identified by the IPA as not requiring review) must include the following:

- a) Name of patient and patient identifier
- b) Date of review, Admit Date
- c) Name of Physician – PCP (or admitting physician) and/or Specialists
- d) Diagnosis and Procedure – date of procedure
- e) Facility /Agency Name
- f) Relevant clinical Information – supporting the admission and clinical information source
- g) Medical Criteria (nationally recognized) Met and Code
- h) Anticipated Length of Stay (LOS)
- i) Physician Notification Date
- j) Member Notification Date (IPA policy may include statement that PCP notifies member of approved certification)
- k) Social, family, home assessment for discharge planning
- l) Potential Discharge Plan, discharge needs
- m) Case Management Referral, if applicable

Admissions must be included on the admission log with the patient name, facility, date of admit, diagnosis/ procedures performed, PCP or admitting physician and discharge date. The same log may be used for all admissions (including Hospital, SNF, HHC, Rehabilitation). A sample admission log must be submitted annually.

- 3. Concurrent Review Process – the established process provides for review of all continued stay situations (excluding those identified by the IPA as not requiring review) and includes the following documentation:
 - a) UM decision (approval or denial) made within 24 hours of receipt of request
 - b) Sources of relevant clinical information utilized (medical record, physician information, labs/test results/x-rays, other)
 - c) Nationally recognized medical criteria being met (code documented)
 - d) Additional criteria used in decision-making
 - e) Additional assigned length of stay that is consistent with criteria
 - f) Notification of practitioner(s) within 24 hour time frame (If the IPA states in their UM Plan that the practitioner assumes approval of continued stay, then the practitioner does not need to be notified of continued stay approval.)
 - g) Discharge planning/case management needs addressed
 - h) Case review one day prior to the expiration of the current certification, or one day prior to the anticipated discharge date (if only one certification is performed), to determine need for continued stay or change in discharge plan. (Example: 3 days certified from 5/18 to 5/21 (21-18=3), case should be reviewed on 5/20.)

For concurrent review of behavioral health services, the IPA makes decisions regarding: inpatient program, partial hospitalization program, intensive outpatient program, and residential behavioral care program within 24 hours of the receipt of the request.

- 4. If the requested service (pre-service, initial review, concurrent stay) does not meet nationally recognized

medical criteria, the following must also be documented:

- Date sent to Physician Advisor
- Documentation of PA reason for continued stay approval or denial
- Date additional clinical information requested, date received
- Determination (approval, denial)
- Physician Advisor (name)
- Member Notification and date (IPA policy may include statement that PCP notifies member of approved certification)
- Physician Notification and date

The IPA must provide the number of PA referrals per month in aggregate, and the number of PA referrals resulting in denial in aggregate.

IPAs must have a written policy and procedure for closure of a case due to insufficient information for UM decision-making. The closure of the case must meet the time frames identified for the type of review decision.

The IPA cannot reverse a certification decision unless it receives new information not available at the time of the initial determination. An approval decision cannot be reversed.

5. The UM Committee must, on a semi-annual basis, review UM staff adherence to all time frames established for making UM decisions including urgent and non-urgent pre-service review, initial review, concurrent review, Member complaints, denials and appeals, post-service reviews, and referral case review. Every UM staff member must be included in the testing.
6. Case Management/ Discharge Planning/ Complex Case Management

A. A designated individual at the IPA is responsible for assisting with identifying the Member needs and implementing discharge plans/case management.

Each IPA must have written guidelines or protocols showing effective and timely discharge planning/case management with documentation as part of the concurrent review process and that include the following:

- a) Assessment of Member's needs including psychosocial needs;
- b) Development of discharge treatment plan; and
- c) Documentation of Skilled Nursing Facility transfer, Home Health Care service, and treatment plan.

Potential case management/ discharge needs should be evaluated on admission, and continuously as part of the concurrent review process.

For behavioral health follow up, the date of appointment with a specific behavioral health practitioner/ provider is to be scheduled prior to discharge and documented on the discharge instruction sheet. All appointments should be scheduled within seven days of discharge.

B. Complex Case Management is the coordination of care and services provided to Members with multiple or complex conditions. Through the case management process, these Members are helped to access care and services and their care is coordinated with the assistance of the IPA. The goal is to help these Members regain optimal health or improved functional capability.

The IPA must demonstrate use of the following to identify potential complex cases:

- a) Claims data;
- b) Hospital discharge data;
- c) Pharmacy data; and
- d) Data collected from the UM process (i.e. initial and concurrent review).

Other sources for complex case identification may include:

- a) Health information line referral, if applicable;
- b) Disease management program referral;

- c) Discharge planner referral;
- d) PCP, Participating Specialist Provider (PSP), or UM referral; or
- e) Member self-referral.

Members and PCPs should be made aware of the ability to refer to complex case management through communication of the program and the contact information at the IPA. The IPA may use printed materials such as; the Welcome Letter, PCP newsletters, or a web site for this notification.

D2 Hawkeye may be used to identify potential complex cases for management.

A log of Members **assisted through the IPA's complex case management process** must be maintained and provided to the HMO upon request.

Complex case management should be supported by a system or systematic process that includes, at a minimum, the following elements:

- a) **The use of evidence-based guidelines (these may include guidelines available from medical or behavioral health specialty societies, the National Guideline Clearinghouse or guidelines/ algorithms developed by the IPA based on researched clinical evidence);**
- b) **Documentation of any Member or Member related contact (includes staff member, date and time of action on the case or interaction with the Member)**
- c) **Prompt or date documented for follow-up with the Member.**

A CM file needs to be maintained for the patient in complex case management. **Verbal or written consent must be obtained and included in the file.** The complex CM file must contain documentation of the following, **at a minimum**, for each complex case managed member:

- a) Initial assessment (include health status, condition, mental status, ADL's, clinical history, medications, co-morbidities);
- b) **Life planning activities (living will, advance directives, power of attorney);**
- c) Evaluation of member's cultural and linguistic needs;
- d) Evaluation of available benefits;
- e) Evaluation of caregiver resources (family involvement);
- f) Individualized CM plan (long and short term measurable goals);
- g) **Barriers to Member meeting goals or following CM plan;**
- h) **A schedule for follow-up with the Member;**
- i) **Communication of member self-management plan (example, test blood sugar daily, change dressing daily, take meds, follow diet);**
- j) **Assessment of Members progress toward goals and overcoming barriers; and**
- k) **Estimated inpatient days saved, if applicable.**

The IPA must have a documented policy and procedure which address the following:

- a) Identification of potential complex cases,
- b) How Members and PCPs are notified of the ability to refer to complex CM,
- c) The method or system of documentation for complex cases,
- d) The elements required for documentation for the complex cases (must include all the elements required in the complex CM file),
- e) How a Member consents, declines, or disenrolls from complex CM,
- f) Minimum allowed contact with Member in complex CM, and
- g) The inclusion of a Member survey for all closed cases.

The IPA must provide an HMO CM survey to participants in complex CM when the case is closed. The survey will be provided by the HMO. The IPA can ask the questions telephonically or provide the survey to the Member to mail to the HMO. All surveys should be returned to the HMO Nurse Liaison.

Oversight of the IPA complex CM process will be performed on an annual basis and scored as a part of the case file review portion of the UM Adherence Audit.

7. RETROSPECTIVE REVIEW PROCESS/POST-SERVICE PROCESS

A retrospective review requires a decision within 30 (thirty) calendar days of receipt of the request. If the decision results in a denial, the Member and practitioner(s) must be notified in writing by mail, fax, or e-mail within 30 calendar days of the receipt of request. The Member should not be sent a denial letter when services have already been delivered in an inpatient setting.

8. ILLINOIS DEPARTMENT OF INSURANCE REQUIREMENT – URO REGISTRATION

UM, including but not limited to prospective, initial, concurrent and retrospective review, CM, referrals, and/ or discharge planning, must be performed by a Utilization Review Organization (URO) that is registered every two years with the Illinois Department of Insurance. The IPA may not delegate URO registration. Any delegated CMF must be registered with the state as a URO. Proof of registration/ renewal must be submitted to the HMO with the IPA UM Plan.

9. IPA REFERRAL PROCESS

Initiation of the Referral Process requires a written request for all services (as required by the IPA) referred by the PCP, including, but not limited to:

- a) Diagnostic testing
- b) Therapies
- c) Specialist evaluation or other consultation services

The HMO requires a referral decision for specialist referrals to be rendered, and the Member and Practitioner(s) notified of the decision, within five calendar days of receipt of the request, including any requests for additional information. If the referral is denied, the Member and Practitioner(s) must be notified in writing or electronically within the five calendar days.

All written referrals must include the following elements:

- a) Documentation of the date received by IPA;
- b) Documentation of the Member name and patient identifier;
- c) Documentation of the reason for referral;
- d) Documentation of the number of visits or extent of treatment;
- e) Referral form must be signed and dated by PCP/PCP office; and
- f) Referral must include a statement that referral does not authorize benefits for non-covered services.

Additional requirements related to referrals include:

- a) Maintenance of a referral log by the IPA;
- b) Maintenance of at least one month of referral inquiries if IPA reports no denials;
- c) Providing the Member with a copy of the referral (The IPA or PCP must
- d) Mail or fax copy to Member, if requested by the Member.);
- e) Documentation of communication with PCP if referral is denied (including member requested referrals). It must be documented that the PCP agrees with the denial decision.

Referrals, including but not limited to, therapies, diagnostics, durable medical equipment (DME), and specialists, must be monitored by the IPA for quality of care, appropriate utilization, and compliance with UM decision-making timeframes.

10. STANDING REFERRALS

Members having a disease or condition requiring an ongoing course of treatment from a specialist or other health care provider may request a standing referral from his/her PCP. This is a single referral, provided at the discretion of the PCP, specifying duration, type and frequency of specialist services to complete an ongoing course of treatment. The IPA must provide the HMO with a written policy and procedure addressing processes related to standing referrals.

G. Transition of Care

Transition of care is applicable when a Member is new to the HMO, is displaced by physician de-participation, or is displaced by termination of an IPA contract. New Members must request transitional services within 15 days of eligibility and existing Members within 30 business days after receiving notification of displacement. Members in one of these situations who are receiving frequent or ongoing care for a medical condition or pregnancy beyond the first trimester may request assistance to continue with established specialists for a defined time. Such Members should be directed to the HMO Customer Assistance Unit (CAU) at (312) 653-6600 for help in this matter.

H. Exhaustion of A Limited Benefit

There are limited benefits for outpatient rehabilitation therapies, infertility services, and outpatient behavioral health services. Once a Member has exhausted a limited benefit, the IPA must document this in writing to the Member within two business days. A copy of the communication must be submitted to the HMO. The written communication must include:

1. The fact that benefits are exhausted;
2. PCP name;
3. Appeal rights and procedure;
4. Reminder that the charges incurred beyond the contract limits are the Member's financial responsibility; and
5. An offer to educate Member about alternatives to continuation of care and ways to obtain further care as appropriate.

In the event, the Member exhausts the number of inpatient mental health days allowed by their benefit plan; the IPA must implement the following process:

1. The IPA's Utilization Review (UR) Coordinator must report the case to the HMO by speaking directly to the HMO Behavioral Health Liaison or designee when the Member is approaching the inpatient mental health benefit limit. If there is no HMO behavioral health staff available, the IPA UR Coordinator should call the designated HMO Nurse Liaison.
2. The IPA UR Coordinator will fax the Member notification of exhaustion of benefits letter to the Behavioral Health Liaison.

3. The exhaustion of benefits letter will be reviewed by the Behavioral Health Liaison. **The letter must be reviewed and approved by the HMO Behavioral Health Liaison or Nurse Liaison before being mailed to the Member.**
4. The Behavioral Health Liaison will call the IPA after the letter has been reviewed and approved for delivery to the Member.
5. The IPA must notify the Member, per letter sent via express mail or fax, that he/she is approaching the inpatient mental health benefit maximum. The letter should be sent 24-36 hours prior to exhaustion of the benefit.
6. The IPA will fax a copy of the letter to the business office of the provider, the PCP, the IPA Medical Director, and the HMO Behavioral Health Liaison. The Behavioral Health Liaison will distribute copies to the HMO Nurse Liaison, **HMO Provider** Network Consultant, and BCBSIL Medical Director. Upon receipt of the letter, the HMO Behavioral Health Liaison will send a letter to the Member documenting denial of benefits for any days exceeding the inpatient mental health benefit limit.
7. The HMO Behavioral Health Liaison will send a copy of this letter to the business office of the provider, the PCP, the IPA Medical Director and administrator, the psychiatrist, the BCBSIL Medical Director, Nurse Liaison, **HMO Provider** Network Consultant, and the HMO Claims Department.

I. IPA Denials

The IPA must have a clear plan that describes the method for processing behavioral health and non-behavioral health denials and subsequent appeals. This process applies to all services included in the UM Plan and must meet the following requirements:

- a) All cases that do not meet nationally recognized medical criteria must be reviewed by the Medical Director and/or PA with the decision rendered and documented within the appropriate UM time frame (non-urgent pre-service - within five calendar days of the receipt of request, urgent pre-service - within 72 hours of the receipt of request, and concurrent - within 24 hours of the receipt of request). The Medical Director or PA must determine whether the care should be approved or denied in medical, non-behavioral health care situations. A psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist must be responsible for denial of behavioral health care that is based on lack of medical necessity.
- b) For all denied cases, including concurrent review, practitioner(s) and Member must be informed of the expedited appeals process and this must be noted by IPA staff member making the call if initial notification was made by telephone. The Member and practitioner(s) must be sent confirmation by mail, fax, or e-mail of the original notification within the appropriate time frame with inclusion of information on the expedited appeal process.
- c) The denial must include documentation of the relevant clinical information supporting the decision and its source(s) (e.g. medical record, lab results, information from the PCP). Communication with the PCP regarding the decision must be documented (including member requested referrals). It must be documented that the PCP agrees with the denial decision.
- d) If more clinical information is requested in order to make a denial decision, document the dates information was requested and received.
- e) Medical Director/PA/Behavioral Health Practitioner(s) denial documentation must include one of the following: physician's handwritten signature, e-mail documentation from the physician, or unique electronic identifier on the letter or a signed or initialed note from a UM staff person, co-signed by the specific physician/behavioral health practitioner.

- f) A PA must be available by telephone for the Practitioner(s) to discuss denial decisions (behavioral health and non-behavioral health denials). The IPA must notify practitioners of its policy for making a reviewer available to discuss any UM denial decisions in a newsletter, direct mailing, or orientation.
- g) A denial/appeal log must be maintained monthly. All denials must be included in the log with the reason for denial identified. All denials must be clearly identified by type on the log by the IPA, i.e medical necessity, benefit, out-of-network, etc. NOTE: Referrals written by the PCP to an out-of-network provider (clinical in nature), then redirected to an in-plan provider, are considered clinical denials and must be documented on the denial log. The HMO denial/appeal process must be followed for these out-of-network denied referrals.
- h) If no denials have been logged for the **specified** month, this must be documented on the log. If no denials are documented for the calendar year **(2009)**, a one month referral inquiry log must be submitted by January 10th, **2010**.
- i) Denial/ appeal logs (and medical necessity denial files) must be submitted to the HMO Nurse Liaison by the 10th day of the month following the end of the quarter. Failure to meet this deadline will result in an HMO Administered Complaint. The HMO will review the denial/ appeal logs/ files and contact the IPA with the results. Additional files may be requested for review. The additional files must be submitted to the HMO within 10 business days of the request. The HMO will send quarterly results to each IPA.
- j) If the IPA uses a behavioral health organization or CMF, a denial/ appeal log from the organization must be maintained and submitted to the HMO. Behavioral health medical necessity denial files (including out-of-network) must be submitted to the HMO with the denial/ appeal logs. The HMO will review the denial/ appeal logs and contact the IPA with the additional behavioral health denial files needed for review. The additional files must be submitted to the HMO within 10 business days of the request.

WRITTEN DENIAL NOTIFICATION

Behavioral health and non-behavioral health denial decisions must be communicated to the member and practitioner in writing, and within the appropriate time frames. The HMO sample letters must be used for denials and must include:

- a) Reason for denial, including an understandable summary of the UM criteria upon which denial was based (i.e. a statement in laymen's terms as to why the service was denied);
- b) Reason includes a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based;
- c) Appropriate alternative care recommendations;
- d) The means by which the PCP may contact the PA to discuss denial decisions (behavioral health and non-behavioral health denials);
- e) Notification that the Member may obtain a copy of the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request;
- f) Description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal;
- g) Explanation of the appeal process, including the right to member representation and time frames for deciding appeals;
- h) If the denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process must be included.

J. IPA Appeal Process

The HMO does not delegate Member appeals to the IPAs; however, the IPA may have a voluntary appeal process for the Member.

The IPA voluntary appeal process must meet HMO requirements. Members may appeal to the IPA or directly to the HMO. The appeal process must meet the time frame requirements for all types of appeals (pre-service, concurrent, post-service). If the Member appeals to the IPA and the original denial is upheld, the Member may

appeal to the HMO. The HMO will facilitate the appeal process according to NCQA, URAC, and legislative requirements. The IPA is responsible for explaining all levels of appeal (pre-service, post-service, expedited and external) and the appeal process to the HMO Member. IPA procedures for initiating an appeal must be listed within the new Member welcome letter.

All levels of appeal may be initiated by either the Member, the practitioner(s) acting on behalf of the Member, or other Member representatives.

In addition, the HMO requires that the IPA provide practitioner(s) with an appeals process in addition to a Member appeals process for all denied services. The HMO will facilitate a separate appeal process according to NCQA, URAC, and legislative requirements for any Member whose issues are not resolved at the IPA level.

When a final determination is made, a written response must be sent to the practitioner(s) and Member which describes the decision of the appeal body and options for a second level of appeal to the HMO.

Retrospective (post-service) member appeals are allowed.

The HMO reserves the right to modify or amend the policies or procedures in order to meet any legislative or regulatory requirements as determined by the HMO.

PRE- AND POST-SERVICE APPEALS

The HMO has written policies and procedures regarding appeals that address the following:

- a) Documentation of the substance of the appeal and action taken;
- b) Full investigation of the appeal;
- c) The opportunity for the Member to submit written comments, documents or other information relating to the appeal;
- d) Appointment of a new person for review of the appeal who was not involved in, or a subordinate to anyone involved in the previous review;
- e) For medical necessity appeals, the case must be reviewed by a practitioner of the same or similar specialty as the managing practitioner;
- f) The decision and notification to the Member must be made within **15** calendar days of the receipt of the request (**this timeframe includes both clinical/ non-clinical appeals if first level is performed at the IPA**);
- g) There must be notification about further appeal rights including the appeal process;
- h) There must be procedures for providing the Member access and copies of all documents relevant to the appeal, upon request; and
- i) An authorized representative must be able to act on the Member's behalf.

1. EXPEDITED APPEAL

An expedited appeal may occur if proposed or continued services pertain to a medical condition that may seriously jeopardize the life or health of a Member; or the Member has received emergency services and remains hospitalized.

If the Member is hospitalized, the member may continue to receive services with no financial liability until notified of the decision.

There must be procedures for registering and responding to expedited pre-service appeals which include:

- a) Allowance of oral or written initiation of an expedited appeal by the Member or practitioner acting on behalf of the Member;
- b) Decision and notification to the Member and practitioner as quickly as the medical condition requires, but no later than 72 hours after the request is made; and
- c) Electronic or written confirmation of the decision must be made within this time frame.

The HMO letter that includes instructions about appeal rights and resources must be used for all denials and for all appeals for which the denial was maintained.

2. EXTERNAL APPEAL

Requests from the Practitioner(s) and/or Member for an external appeal should be directed to the CAU of HMO at (312) 653-6600.

K. New and Existing Medical Technology

IPAs are required to contact the HMO with any questions regarding new and existing medical technologies.

L. Satisfaction with the UM Process

The BCBSIL QI Department performs annual surveys for evaluating Member and PCP satisfaction with the UM process. The IPAs are not required to perform their own survey. The IPAs are required to discuss the survey results, perform interventions, and evaluate the results of the intervention, especially specific to PCP referral satisfaction.

M. Emergency Services

The HMO contractually requires IPAs to follow the “prudent layperson” standard set forth in the MSA in making UM decisions related to emergency services.

N. Pharmaceutical Management

Pharmacy benefits are administered by Prime Therapeutics, BCBSIL’s Pharmacy Benefit Manager.

O. Ensuring Appropriate Utilization

The IPAs are required to track and trend utilization data at least semi-annually during the year. Utilization data is analyzed and discussed as part of the IPA UM Committee meeting, and minutes documenting this discussion are reviewed by the HMO during the on-site review process. The IPAs are required to track specialty referrals in aggregate, behavioral health referrals in aggregate and all out-of-network referrals (in detail). In addition, the IPAs are required to track at least four of the following, including one for behavioral health: inpatient days/1000, admits or discharges/1000, behavioral health days/1000, average length of stay, rates for types of procedures.

IPAs are required to develop a methodology to identify and track avoidable inpatient days. A policy must be in place to obtain corrective action from IPA Physicians with identified avoidable days.

P. UM Affirmation Statement

All IPAs, as well as the HMO, are required to distribute an affirmation statement to all Members and practitioners, providers and employees who make UM decisions affirming that:

- a) UM decisions are based on medical necessity, which includes appropriateness of care and services, and the existence of available benefits;
- b) The organization does not specifically reward health plan staff, providers or other individuals for issuing denials of coverage, care or service; and
- c) Incentive programs are not utilized to encourage decisions that result in under-utilization.

This statement can be made via the welcome letter, newsletters, memos to practitioners, providers, and employees or on the IPA internet site.

A statement regarding conflict of interest must be included with the affirmation statement.

Q. Triage and Referral for Behavioral Health

IPAs must describe their Member process for obtaining behavioral health services, including written standards for ensuring appropriate behavioral health triage and referral decisions. IPAs may coordinate behavioral health services through the PCP, a behavioral health **practitioner**, or the IPA may sub-delegate behavioral health to a specialist vendor. Any delegation of behavioral health must be described in the IPA UM Plan. Triage and referral standards are only applicable when a IPA sub-delegates behavioral health to a Contract Management Firm (CMF, vendor or behavioral health specialty group). Any IPA that delegates behavioral health must ensure these standards are followed in the delegate's processes. They must include the following:

- a) Triage and referral protocols address the level of urgency and the appropriate setting;
- b) Triage and referral protocols are based on sound clinical evidence and currently accepted practices, and are reviewed or revised annually;
- c) Triage and referral decisions are made by staff with appropriate professional experience;
- d) Triage and referral decisions are made by licensed behavioral health care practitioners with appropriate experience;
- e) Triage and referral staff are supervised by a licensed behavioral health care practitioner with a minimum of a master's degree and five years of post-master's clinical experience; and
- f) Triage and referral decisions are overseen by a licensed psychiatrist or an appropriately licensed doctoral-level clinical psychologist.

Behavioral health services must be provided in accordance with the following access standards with written documentation provided to the HMO as requested:

- a) Access to care for non-life threatening emergency within 6 hours;
- b) Access to urgent care within **24** hours;
- c) Access to an appointment for a routine office visit within 10 business days or two weeks, whichever is less.

In addition, the following are additional requirements when triage and referral are applicable:

- a) Telephone answered by nonrecorded voice within 30 seconds;
- b) Abandonment rate (the percentage of phone calls where member disconnected before the call was answered) less than 5%.

Any Behavioral Health Organization or IPA providing behavioral health services must submit telephone reports quarterly to the HMO **QI Department**. The reports must include the average speed of answer and the call abandonment rate. For IPAs that are unable to separate behavioral health telephone statistics from medical, combined telephone statistics are acceptable. IPAs with telephone systems that cannot report telephone statistics must notify the HMO in writing about system limitations.

R. Protected Health Information

The IPA must follow the HIPAA provisions for the use of PHI and the provisions identified below and also require any sub-delegates to follow those same provisions:

- a) Use PHI (any Member identifiers that can be linked to a member) only to provide or arrange for the provision of medical and behavioral health benefits administration and services;
- b) Provide a description of appropriate safeguards to protect the information from inappropriate use or further disclosure;
- c) Ensure that sub-delegates have similar safeguards;
- d) Provide individuals with access to their PHI;
- e) Inform the IPA if inappropriate uses of the PHI occur; and
- f) Ensure that PHI is returned, destroyed or protected if the contract ends.

S. IPA Delegation of UM

The IPA UM Plan must describe any delegation of UM. If UM is delegated to another entity, all HMO UM Plan requirements must be met by the sub-delegate. There must be a contract that identifies accountability of the IPA and the sub-delegate, as well as the mechanisms for oversight. The IPA is responsible for review and approval of the sub-delegate UM Plan through their UM Committee. The sub-delegate UM Plan and a completed HMO Compliance tool must be submitted by the HMO required date.

If an IPA changes contract management firms, or initiates sub-delegation mid-year, the HMO (both the Nurse Liaison and **HMO Provider** Network Consultant) must be notified **at least 30 days in advance of the date the new firm will assume the delegation**. The HMO may request a new UM Plan from the IPA and/or sub-delegate.

Mechanisms for oversight must include, but are not limited to:

- a) Annual approval of the sub-delegate UM Plan;
- b) Annual evaluation of sub-delegate against HMO and IPA requirements;
- c) Review of quarterly submissions and any reports; and
- d) Identification of any deficiencies with corrective action.

A pre-delegation evaluation of the proposed delegate must be performed prior to delegation to ensure compliance with HMO and IPA requirements.

III. HMO Oversight of IPA

The HMO Staff will review required IPA submissions quarterly, semi-annually, and annually as outlined in the MSA and HMO UM Plan.

The HMO provides regular feedback to the IPAs with monthly paid claims and quarterly utilization reports. HMO Staff review specific utilization trends including medical, surgical, outpatient surgery, home health, and mental health with IPA Staff. Individual IPA performance is compared to its previous performance and to the performance of other IPAs within the network.

For selected IPAs, the HMO will implement educational interventions to assist their progress. These interventions may include comprehensive and detailed UM or CM in-services, focused educational activities targeted to specific problem areas, document review and/or on-site UM or CM assessment.

The HMO provides an opportunity for discussion of important utilization issues through practitioner conferences. In this forum, best practices are discussed and IPA input is obtained. The HMO may conduct focus groups with the IPAs.

Through selected QI indicators and studies, the HMO has the opportunity to monitor the network for issues relating to over-utilization and/or under-utilization of services. This review, discussion and monitoring includes utilization data across practices and practitioner sites. This monitoring information is used to evaluate effectiveness of the processes used to achieve appropriate utilization. Where specific outcomes are relevant to a single IPA, this is communicated to the IPA Medical Director and considered in the re-credentialing and reappointment process.

By contract, the HMO reserves the right to have HMO staff attend the IPA's UM/QR Committee meetings in order to observe and assess the IPA's internal processes and activities, and then to provide feedback to the IPA about these processes and activities. **The HMO reserves the right to monitor and assess whether the delegated UM activity is performed according to the HMO's Plan requirements and the MSA, however, such oversight shall not relieve the IPA of its obligations to perform the UM functions in accordance with all applicable HMO policies, procedures, and agreements.**

Under the supervision of the BCBSIL Medical Director, a Nurse Liaison will review and approve each IPA UM Plan, conduct an annual audit of the IPA UM and case management activities, review and analyze UM statistical reports, and oversee specialty networks and programs. The contracting entity is responsible for UM and CM activities at all of its IPA sites.

Any significant substandard performance from the HMO requirements will be reported to HMO management. The IPA is required to create an action plan that includes more detailed review and appropriate educational interventions. The HMO then monitors this plan. The HMO will assess the effectiveness of the interventions. Continued non-compliance may result in the assignment of an HMO Administered Complaint and possible default of the MSA.

A. Annual IPA UM Audit Performed by the HMO

The annual adherence audit assists in determining IPA compliance with HMO requirements. A Nurse Liaison performs the audit of IPA UM activities. The UM Adherence Site Visit Report Tool is used to measure compliance with HMO UM requirements. Audit scoring methods are reviewed with the IPA at the time of the audit. The IPAs receive a written report on the day of the audit.

Any IPA that receives a failing score on this audit is required to submit a corrective action plan within **60** days of the date on the audit results letter. The corrective action plan must meet guidelines established by the HMO. The Nurse Liaison monitors receipt of the corrective action plan and reviews it for completeness once it is approved and implemented. A re-audit is performed to re-measure compliance with HMO UM Guidelines. IPAs that do not meet corrective action requirements or fail the re-audit may be placed in default of the MSA. Should this occur, specific default provisions of the MSA are enforced.

The annual audit consists of UM Committee Activity review and Case File review. UM Committee review is performed through review of monthly IPA UM Committee meeting minutes. This Committee is required to meet at least monthly to review and discuss UM activities. The minutes of the committee meeting are to show documentation of the following:

- a) Date of the meeting;
- b) Chairman and members present, including at least one specialist; and
- c) Minutes signed by the Medical Director/Chair within five weeks of the date of the last meeting.

The following must be presented in IPA UM Committee meetings:

ANNUALLY:

Review and approval of the IPA UM Plan, including Behavioral Health.

Review and approval of delegated Behavioral Health UM Plan, if applicable.

Review and acceptance of medical criteria (including behavioral health and any additional criteria).

Evaluation of the UM program and progress in meeting determined goals. All goals identified for the year must be discussed. Interventions implemented, results of intervention (outcomes), further opportunities for improvement must be discussed.

Review and revision of all UM related policies and procedures. Policies must include, at a minimum: **IPA** name, name of policy, effective date, review date and most current revision date, signature of reviewing and approving authority. Policies should include, but are not limited to the following:

- 1) UM staff onsite review at facility, (if applicable);
- 2) Staff orientation/ training/ performance review;
- 3) Diagnoses, procedures, physicians not requiring pre-certification and/or concurrent review, if applicable;
- 4) Additional criteria, clinical pathways, guidelines used for UM decision-making and the process for development and approval, if applicable;
- 5) Case closure due to insufficient information;
- 6) Standing referrals;
- 7) Appeals;
- 8) Protected Health Information;
- 9) Confidentiality;
- 10) Information systems, security, integrity, storage, disaster recovery;
- 11) Tracking avoidable days for IPA physicians and method for corrective action and non-compliance;
- 12) Hospitalist, Practitioner program, if applicable;
- 13) PCP notification to member of approved certification, if applicable.
- 14) **Complex case management.**

Policies must be listed in the minutes or a list brought to the committee, with review, revision and approval discussed. If using a separate listing, this list must be attached and included with the minutes. **A listing of policies may be submitted to the HMO for the annual submissions requirement. The list must include all required policies, the date of review or revision, and the Medical Director signature. If a policy does not have any revisions, it does not have to be submitted to the HMO. If the policy is new and has never been reviewed by the HMO, the policy must be submitted. The HMO may request review of any policy during the calendar year.**

Review and discussion of the HMO PCP Survey and Member Survey **by IPA** reports. **The referral score must be documented for both surveys with interventions, if the referral question score is <83%**

SEMI-ANNUALLY:

Identification, analysis and development of interventions for improvement relating to the utilization statistics, studies on trends, patterns and/or physician practice patterns. If no interventions are needed, this must be documented. IPAs are required to track at least four of the following, including one for behavioral health: inpatient days/1000, admits or discharges/1000, behavioral health days/1000, average length of stay, rates for types of procedures. Analysis must include comparison of past quarters (at least six months of data must be arrayed or graphed and included in the minutes). **Monthly data for six months or quarterly data for two quarters meets this requirement.**

Summary/ discussion of six months of avoidable inpatient days and reasons for delayed discharge. IPA Physicians identified with avoidable day practice pattern trends must be identified in UM Committee with documentation of corrective action according to IPA policy.

Discussion of referral statistics (including behavioral health) with a two quarter referral comparison, trending, analysis, and discussion documented in the minutes (at least six months of data must be arrayed or graphed and included in the minutes). **Monthly data for six months or quarterly data for two quarters meets this requirement.** Interventions must be documented for any trends noted. If there are no referrals for the month, that is to be documented in both minutes and on log. Out-of-network referrals are to be maintained monthly and submitted to HMO upon request. Mental Health referral logs are to be maintained monthly, regardless of whether the IPA or a CMF manages behavioral health care, and submitted to HMO upon request.

Inter-rater reliability testing for criteria utilization (Medical Director, PA(s) and UM staff) and decision making timeframes (UM staff). Inter-rater reliability testing must be performed by a licensed professional peer of the individual being reviewed. A summary of the results and number of cases reviewed per each physician/staff reviewed must be included in the minutes. Include any corrective action. **Every physician and UM staff member involved in UM decision-making must be included in the testing.**

QUARTERLY:

Quarterly, the UM Committee must discuss all complaints (including BH) received by the group related to HMO Members including: complaints received at the IPA, Quality of Care complaints received at the IPA and/or forwarded from the HMO, and HMO Administered complaints. These may be discussed in summary format using categories of complaints; such as: access, PCP issues, etc. A monthly log of these complaints must be maintained. The complaints must be resolved within 30 days. Resolution of the complaints and the timeframe must be documented on the log or in the minutes. If there are no complaints for the month, that is to be documented in both minutes and on the log.

Quarterly review and discussion of any sub-delegate, CMF, behavioral health delegate including review of any submissions, reports from the sub-delegates, if applicable. CMF quarterly reporting must include reference to telephone statistics and compliance with HMO standards.

Quarterly discussion of HMO review of IPA denial files, any non-compliance and corrective action, if required.

MONTHLY:

The committee must review and discuss all denied/appealed services to insure denials have been appropriately managed according to IPA's established procedures and HMO policies. Denial discussion must include a summary of the category of denials (BH and non-BH: medical necessity, out-of-network, and benefit), number in each category, timeframes compliance, and resolution, number of PA referrals and number resulting in a denial.

NOTE: Denial files (medical and behavioral health) are reviewed as requested (monthly) after submission to the HMO with the denial logs.

Case File Review

The HMO Nurse Liaison performs case file review by randomly choosing 20 case files from the IPA admission logs at the time of the audit. The cases are reviewed against HMO standards for medical criteria, time frames, documentation of clinical source, etc. Additional file reviews may include case review for the hospitalist program criteria, potential issues in utilization, and neonate cases (neonates that remain inpatient after the mother's discharge). Note: If a hospitalist program is utilized, the IPA must still perform utilization management review for inpatient cases not reviewed by a hospitalist. SNF and home health cases must continue to be reviewed by utilization management.

In addition, five CM files will be chosen for review. For 2009, CM requirements and cases will be reviewed **and scored as a part of the 2009 UM Adherence Audit**.

IV. Additional UM Requirements/Activities

According to the MSA, the IPA is required to distribute the following to all their PCPs: reports, surveys, UM criteria, the IPA UM Plan, UM statistical reports specific to the IPA and other materials.

- A) A written confidentiality policy and procedure must be provided to the HMO outlining the protection of patient and provider specific information collected during the utilization review process.
- B) If an IPA maintains an information system, the system must provide for data security, integrity, storage and the IPA must have a written disaster recovery plan.
- C) Chemical Dependency (CD) and Mental Health are separate entities with regard to IPA responsibilities and Member benefits. Chemical Dependency care is managed by the HMO CD network. A PCP referral is not required for these services. Referrals are made through the HMO CD network number (800-346-3986) which can be reached 24 hours per day and seven days per week.

In all instances of CD care, the IPA must direct and manage the care when notified that a Member has concomitant medical or psychiatric problems prior to or during hospitalization for treatment of CD.

- D) The HMO requires that each IPA develop and adhere to a maternity discharge program to help manage utilization. This program should be included within the Utilization Review process. The following elements are required for an acceptable HMO OB Discharge Plan:

Documentation of pre-natal education with the mother and information about the OB Discharge Program during the first and second trimester

Documentation of eligibility criteria related to the OB Discharge Program

Arrangements for an infant examination either by a Practitioner or by a Nurse visit to the home within 48 hours after discharge from the hospital must be offered if the infant is discharged less than 48 hours after vaginal delivery or less than 96 hours after Cesarean delivery.

- E) Either the PCP or the Woman's Principal Health Care Provider (WPHCP) may establish a diagnosis of infertility. Once this diagnosis has been made, either the PCP or the WPHCP may refer the Member for infertility services. Such a referral is required for these services to be in benefit. Reference may be made to the MSA.
- F) IPAs are responsible for monitoring all aspects of clinical care including referral, pre-certification, and concurrent review related to organ transplants. The IPA should notify the HMO Transplant Coordinator prior to the Member's evaluation at a BCBS transplant network facility. The HMO Transplant Coordinator will confirm that the facility is currently in the HMO transplant network for the relevant organ. If the Member is accepted as a transplant candidate, the IPA should forward certain documents to the HMO Transplant Coordinator for a HMO medical review. These documents include the Member's history, the reason for transplant, a letter from the PCP indicating his/her approval, and a letter from the transplant facility confirming the Member's transplant candidate status. After the HMO review, the HMO Transplant Coordinator will provide a letter of authorization or a written denial to the IPA.
- G) The HMO is financially responsible for out-of-area admissions where Members are admitted for an emergency condition or a life-threatening situation more than 30 miles away from **the IPA or IPA affiliated hospital in which the Member is enrolled**. The IPA retains responsibility for monitoring clinical aspects of care and for arranging the transfer of the Member back into plan once clinically appropriate. When the treating physician determines that the Member is medically stable for transfer, the IPA notifies the PCP that the Member can be brought back into plan within one business day of IPA notification. Refer to Termination of Benefits (TOB) section for protocol of issuing TOB if member refuses to transfer in-plan.

- H) Out-of-Network admissions are urgent or emergent admissions that are within 30 miles of the contracting IPA **or IPA affiliated hospital in which the Member is enrolled** and occur without prior IPA approval. IPA's responsibilities include: As soon as the IPA becomes aware of the admission, the UR Coordinator will obtain an initial review and patient information including the following:

Monitoring of care to determine when the Member is stable.

When stable, facilitates the transfer of the Member to an in-plan or in-network facility

Contact the Member concerning the decision to transfer

- I) "Individual Benefits Management Program" (IBMP) - for requests for an alternative treatment plan providing alternative benefits for services in certain situations in which the Member's condition would otherwise require continued care in a Hospital or other health care facility, the IPA must contact their HMO Nurse Liaison for the IBMP policy and procedure."

The PCP must be notified of the admission within one business day of IPA notification. If the local attending physician and PCP agree that the Member is medically stable for transfer, an attempt must be made to bring the Member into plan. The TOB process may be utilized if the Member refuses to transfer.

- J) Termination of Benefits (Applies to Medical as well as **Behavioral Health** Admissions)

An IPA may not terminate inpatient benefits of any type without the concurrent authorization of the HMO.

1. TERMINATION OF BENEFITS FOR SERVICES NOT MEDICALLY NECESSARY AT GROUP APPROVED FACILITY

When a IPA PCP is notified of a member's admission to a group approved facility, the PCP must contact the attending physician within one business day of the notification of the admission to determine medical necessity. If it is determined that services are no longer medically necessary and the Member refuses to be discharged, the following process is begun:

- a) The PCP communicates the Member's refusal to the IPA UR Coordinator and/or Medical Director. A written statement from the PCP must indicate that continued services for the Member are no longer medically necessary.
- b) The IPA UR Coordinator must report the case to the HMO through its HMO Liaison or HMO UM Manager.
- c) The HMO Liaison must receive the PCP written statement, **a diagnosis, clinical summary and patient status**, and the IPA TOB letter prior to acting on the IPA request to terminate benefits.
- d) HMO UM Manager and/or the BCBSIL Medical Director will review the submitted documentation and respond to the IPA within one business day.
- e) The Member must receive written notification from the IPA stating that the PCP has determined that continued services are no longer medically necessary and are not group approved after a stated date. This date must reflect that the Member may remain inpatient until 11 AM the next calendar day following the Member's receipt of the determination.
- f) The IPA submits a copy of the letter to the business office of the facility, the PCP, the IPA Medical Director and the HMO Liaison.
- g) The HMO Liaison distributes copies of the letter to the HMO **Provider** Network Consultant, HMO UM Manager, and the BCBSIL Medical Director.
- h) Upon receipt of the letter, the HMO Liaison notifies the Member of the denial of benefits for the Non-Group Approved Service(s).

- i) The HMO Nurse Liaison will send a copy of this letter to the business office of the facility, the PCP, IPA Medical Director, IPA UR Coordinator, HMO UM Manager, HMO **Provider** Network Consultant, BCBSIL Medical Director, and HMO Claims Department.

2. TERMINATION OF BENEFITS FOR MEDICALLY NECESSARY CONTINUED SERVICES AT A NON-GROUP APPROVED FACILITY

When a IPA/PCP is notified of a Member's medically necessary admission to a non-group approved facility, the PCP contacts the attending physician within **one** business day of the notification of the admission to the facility. In the event the Member is determined by the attending physician and the PCP to be medically stable for transfer but the Member refuses to transfer to an in-plan hospital, the following process is begun:

- a) The PCP must communicate this determination and situation in a written statement to the IPA UR Coordinator and/or IPA Medical Director.
- b) The IPA UR Coordinator must report the case to the HMO through their HMO Nurse Liaison or HMO UM Manager.
- c) The HMO Liaison must receive the PCP's written statement, **a diagnosis, clinical summary and patient status**, and the IPA TOB letter prior to acting on the IPA request to terminate benefits.
- d) The HMO UM Manager and/or the BCBSIL Medical Director will review the submitted documentation and respond within one business day.
- e) The Member must receive notification from the IPA stating that the PCP has determined continued services are only covered in plan and are not group approved in the current facility after a stated date. This date must reflect that the Member may remain inpatient until 11 AM the next calendar day following the Member's receipt of the determination.
- f) The IPA submits a copy of the letter to the business office of the facility, the PCP, the IPA Medical Director and the HMO Nurse Liaison.
- g) The HMO Nurse Liaison distributes copies of the letter to the HMO **Provider** Network Consultant, HMO UM Manager and the BCBSIL Medical Director.
- h) Upon receipt of the letter, the HMO Nurse Liaison notifies the Member of the denial of benefits for the Non-Group Approved Service(s).
- i) The HMO Nurse Liaison will send a copy of this letter to the business office of the facility, PCP, IPA Medical Director, IPA UR Coordinator, HMO UM Manager, HMO **Provider** Network Consultant, BCBSIL Medical Director, and HMO Claims Department.