Samaritan Health Plans

InterCommunity Health Network CCO

Utilization Management and Service Authorization

Prepared by Clinical Services Division

2025

References:

- *Centers for Medicare and Medicaid Services (CMS).*
- *Code of Federal Regulations (CFR).*
- *Oregon Health Authority (OHA).*
- *National Committee for Quality Assurance (NCQA).*
- *MCG Health CareWebQI.*
- *Samaritan Health Plans Utilization Management Department approved policies.*
- *Samaritan Advantage Health Plan HMO Approved Special Needs Plan Model of Care.*
- *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.*

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Program Overview

The Utilization Management Department, also known as UM, is integrated within the Clinical Services Division. The medical director, associate vice president for the Clinical Services Division, UM Committee, a subcommittee of the Quality Management Council, and UM director oversee the program operations. Utilization review is conducted according to department policies, procedures and clinical criteria. Benefits and clinical criteria are reviewed. Decisions and notifications must adhere to time frames, policies and plan documents. Prospective (pre-service), concurrent and retrospective post-service reviews are performed to provide a basis for decision-making. UM decisions are made by qualified, licensed health care professionals who have the knowledge and skills to assess clinical information and to evaluate working diagnoses and proposed treatment plans including:

- Registered Nurse (RN).
- Licensed Practical Nurse (LPN).
- Certified Durable Medical Equipment (CDME) personnel.
- Assistive Technology Personnel (ATP).
- Licensed Clinical Social Worker (LCSW).
- Licensed Professional Counselor (LPC).

Utilization management is supported by board-certified UM physician reviewers and behavioral health physicians and doctoral-level practitioners who hold a current license to practice without restrictions including Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) or Pharmacist and doctoral level clinician (PhD, PsyD). These licensed providers oversee UM decisions to ensure consistent and appropriate medical- necessity determinations. Inter-rater reliability reviews are conducted to ensure consistent application of the utilization criteria. The Utilization Management Department utilizes the Cognizant software program, Facets and Clinical CareAdvance. Health plan activities related to members and providers, including authorizations, claims, customer service, appeals, quality and case management are documented in the systems. Clinical and supporting documentation submitted to Samaritan Health Plans is electronically stored within the Clinical CareAdvance system.

Monitoring for over-utilization and underutilization occurs through utilization, medical management and case management reports as well as clinical performance measures, including the Healthcare Effectiveness Data and Information Set, also known as HEDIS. Race, ethnic, cultural and linguistic disparities are used to identify actions for improvement. All sources of member satisfaction surveys, complaints, appeals and grievances are reviewed to identify potential areas of concern. Appeals data is reviewed in the Quality Improvement Committee and the Quality Management Council meetings for review, tracking and trending. Appeals and grievances are reviewed for quality of care concerns and may be reported to the Clinical Quality of Care Committee for further review.

Education and support

Samaritan Health Plans/InterCommunity Health Network Coordinated Care Organization, also known as SHP/IHN-CCO, provides a Health Insurance Portability and Accountability Act compliant, internet-based portal, called Provider Connect. This is accessible via OneHealthPort and allows providers easy access to real-time authorization information, submission, eligibility and claims.

Provider education is accomplished through Provider Connect, special trainings, the Provider manual, annual

updates and webinars or through news bulletins or clinical education provided by the chief medical officer, Network Strategy and Contracting Department and/or Quality and Health Outcomes Department.

Members may receive education about benefits, UM and care management through welcome letters, periodic newsletters, quality initiatives or projects or individual communication through the efforts of Clinical Services Division staff.

Prior authorization requirements

Decisions regarding what services should require prior authorization are made to focus on services that are high risk (of complications or side effects), frequently overused and high cost. Services that are low risk, low cost and not typically overused, generally, do not require prior authorization.

The availability of a nationally recognized, evidence-based guideline (from organizations like MCG Health or the Center for Medicare and Medicaid Services) that can be used to review a service for medical necessity/medical appropriateness also contributes to decisions about what services may require prior authorization.

For the InterCommunity Health Network Coordinated Care Organization line of business, also known as IHN-CCO, information contained within the Oregon Prioritized List, including Guideline Notes published by the Oregon Health Authority, also contribute to decisions about what services should require prior authorization. Early and Periodic Screening, Diagnostic & Treatment (EPSDT) is a comprehensive child and youth health care benefit for Oregon Health Plan members ages birth to 21. Medically necessary and medically appropriate physical, dental, behavioral health, and pharmacy benefits are covered through EPSDT, regardless of placement on the Prioritized List of Health Services. This includes screenings, checkups, tests and follow-up care, including for vision, hearing and oral/dental health. All services which do not "pair" with diagnoses will automatically be sent for medical review following an initial review by UM managers.

Prior authorization list

Prior authorization lists are managed by the UM Department. They are updated annually with input from multiple departments within Samaritan Health Plans, also known as SHP, including the Clinical Services Division, and require external regulatory review. Prior authorization lists are reviewed and approved by the UM Committee.

The **prior authorization list** includes services and procedures requiring review prior to the member receiving care. The list is plan-specific and published on the SHP website and in the member benefit materials. UM policies, procedures and criteria outline utilization requirements for most procedures, diagnostic treatments, provider specialties and code or item-specific detailed requirements prior to authorizing. Authorization request determinations are made using evidence-based, established local, state or nationally accepted criteria adhering to regulatory and plan-specific requirements.

Minimum health record requirements for hospitals and behavioral health hospitals

Each member's record must include information needed to perform prior authorization. This information must include, at least, the following:

- Identification of the member (name, date of birth, ID number) — minimum of two.

- The name of the member's health care provider.
- Date of admission and dates of application for and authorization of Medicaid benefits, if applicationis made after admission.
- Assessment and diagnosis.
- Medication changes.
- Place of service.
- The plan of care.
- Initial and subsequent continued stay review dates.
- Date of operating room reservation, if applicable.
- Justification of emergency admission, if applicable.
- Reasons and plan for continued stay, if the attending provider believes continued stay is necessary.
- Other supporting material that the committee believes appropriate to be included in the record.

For more specific information, please reference the SHP **medical record standards**.

Authorization specialist review

The authorization specialist's role is to verify eligibility, benefits, and provider status. They perform data entry and process determination letters, as well as request and track medical and health records. With training and supervision, the authorization specialist may process certain authorizations following written guidelines for the auto-authorization process. The authorization specialist will refer all requests that do not meet criteria for auto-authorization to clinical review for organizational determination.

Clinical review

All authorization requests that require clinical review must be assessed by a clinical Utilization Management staff member with credentials and training appropriate to the request, i.e., Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Durable Medical Equipment (CDME) personnel, Assistive Technology Personnel (ATP), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC). All clinical reviewers have knowledge of Medicare coverage criteria and Clinical Practice Guidelines. Authorization requests requiring clinical review have the appropriate criteria applied as part of the review process. Criteria source examples may include but are not limited to:

- Oregon Health Authority Prioritized List of Health Services.
- Guideline Notes.
- Oregon Administrative Rules.
- Oregon Revised Statutes.
- National and local Medicare coverage determinations.
- SHP medical coverage policies.
- MCG guidelines.

Medical review

All authorization requests that do not meet established criteria will be forwarded to medical review for a determination by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) who has knowledge of Medicare coverage criteria and Clinical Practice Guidelines. Behavioral Health requests may also be reviewed

by a doctoral level clinician (PhD, PsyD). Medical Review is the only level of review able to make adverse benefit determinations.

Service types

- **Alcohol and drug treatment:** outpatient chemical dependency services or substance use disorder services includes inpatient hospitalization for medical detoxification, residential treatment, partial hospitalization treatment, intensive outpatient and outpatient substance use treatment. SHP currently contracts with multiple substance use providers across several counties to meet the needs of members seeking substance use treatment. Coordinating resources is a collaborative effort between UM, Care Coordination, providers, hospitals, community programs and resources.
- **Ambulance/medical transport:** medically necessary transportation of a member to hospital, facility or medical service. Methods of transportation include land, water or air.
- **Dental services:** aspects of oral health delivery for members in a comprehensive, continuously accessible, coordinated and person-centered process. Services provided by a qualified dental professional in an office or inpatient setting.
- **Diagnostic studies:** examination to identify diagnosis. Services include all testing and imaging to determine a condition, disease or illness provided in an outpatient facility or inpatient setting. This includes CT scans, PET scans and other diagnostic tests excluding MRI/MRA.
- **Durable medical equipment:** Durable medical equipment, prosthetics, orthotic devices or supplies are authorized by certified DME coordinators and appropriately trained RNs within the department. Authorization requirements may be plan-specific.
- **Emergency services:** services furnished in an emergency department and ancillary services routinely available to an emergency department that may be needed to stabilize a patient do not require referrals or prior authorization. The definition of an emergency is based on a prudent layperson's judgement. An emergent condition requires stabilization and may require ongoing care coordination and case management.
- **Hospital:** inpatient/facility services where the UM nurse and/or behavioral health care manager team members telephonically coordinate care, review documentation for quality and care and facilitate transitions for members at contracted and out-of-network facilities.
- **Inpatient mental health:** mental health treatment provided at the Samaritan Health Services Mental Health Unit and through the SHP/IHN-CCO network of contracted mental health facility providers. Members are triaged from the emergency room, home, community or from another facility for care. This setting offers the highest level of physical security and most intensive level of intervention. Concurrent review for inpatient mental health is provided by the UM Department using MCG guidelines for reviewing medical necessity and length of stay.
- **Mental health:** includes outpatient services in the treatment of conditions of psychological and emotional well-being.
- **Magnetic resonance imaging:** diagnostic services that use magnetic fields and radio waves to produce a detailed image of the body's soft tissue and bones. This service type also includes magnetic resonance angiogram to provide pictures of blood vessels inside the body.
- **Non-emergency medical transport:** transportation to and from medical appointments for members with no other means of transportation.
- **Occupational, physical and speech therapy:** services provided in an inpatient facility or outpatient setting by a qualified provider. Therapies for members recuperating from medical procedures, surgical

conditions or mental illness that encourage rehabilitation through the performance of activities required for daily life.

- **Outpatient services:** certain outpatient services, including diagnostic, procedural, limited specialist visits, speech therapy, occupational and physical therapy, transplants and other procedures or services requiring prior authorization, are published in the member benefit guide.
- **Out-of-network services:** nonparticipating or non-contracted providers will have their requests processed in the same manner as contracted providers. Service and treatment will be approved on a case-by-case basis and depend on the plan and/or individual case considerations. For IHN-CCO members, if the provider network is unable to provide necessary covered services to a particular member in-network, IHN-CCO covers the out-of-network services for as long as IHN-CCO's provider network is unable to accommodate them.
- **Pain management:** medical approach that draws on disciplines in science and alternative healing to study the prevention, diagnosis and treatment of pain. Pain management services provided in an outpatient setting by a qualified provider.
- **Primary care provider:** services provided in an outpatient setting by member's primary care provider, who is a credentialed and qualified billing provider.
- **Psychiatric day treatment/ Partial hospitalization:** comprehensive, interdisciplinary, non-residential, community-based program consisting of psychiatric treatment, family treatment and therapeutic activities integrated with an accredited education program.
- **Psychiatric subacute:** a short-term residential program in a 24/7 inpatient setting that is more intensive than residential rehabilitation, but less intensive than treatment provided at a hospital. The program focuses on stabilization of symptoms during a person's mental health crisis.
- **Residential rehabilitation:** treatment received at a residential substance abuse facility or psychiatric residential treatment center. This 24/7 setting is an alternative to more intensive inpatient treatment and authorized when the benefit allows to treat psychiatric illness and substance use disorder as clinically appropriate.
- **Skilled nursing facility:** SNF services provided in a medical rehab facility. This covers a continuum of medical and social services designed to support the needs of members recovering from conditions that affect their ability to perform everyday activities.
- **Specialty care:** surgical or medical specialty care provided in an outpatient or inpatient setting by a qualified provider.

Review types

- **Pre-service review:** A review of services/treatments prior to the service date is considered pre-service or prior authorization. Prior authorization requests account for the highest volume of requests reviewed in the department. These include planned inpatient hospitalizations or procedures, outpatient services (for non-contracted outpatient providers) and home health items, services and/or equipment.
- **Concurrent review:** a review to determine extending a previously approved, ongoing course of treatment or services. Concurrent reviews are typically associated with inpatient care, skilled nursing facility, residential behavioral health care, intensive outpatient behavioral health care and ongoing ambulatory care.
- **Post-service review:** The process of reviewing services or treatment after the date of service occurs is considered a post-service review. Post-service review of services that require prior authorization is limited by exception reasons. If an exception is granted the same criteria and plan benefits and

guidelines are applied to the request or case as would be applied for pre-service requests.

Utilization management criteria

The plan's evidence of coverage, or plan document, uses federal and state guidelines to determine benefits. Nationally recognized criteria, federal (CMS), state, internal practice guidelines and internally developed clinical standards are used to determine clinical and medical appropriateness of services.

All utilization management criteria is reviewed and approved by the Utilization Management Committee. The UM Committee and SHP leadership team work closely with Clinical Services Division leadership to ensure clinical consistency and appropriateness of all criteria utilized by the UM Department.

Complete criteria sets are maintained electronically and are available for reference to authorized entities, providers and members upon request.

Evidence-based criteria

Utilization management is performed using nationally recognized evidence-based guidelines from MCG Health. MCG Health's Care Guidelines offer best practices and care plan tools across the continuum of treatment, providing clinical decision support and documentation which enables efficient transitions between care settings. Some of the largest United States health plans and hospitals use MCG Health's evidence-based guidelines and software. MCG Health's informed care strategies affect over 208 million covered lives.

Criteria examples

- American Society of Addiction Medicine.
- MCG CareWebQI MCG Health.
- For Samaritan's Medicare Advantage Health Plans, applicable content from:
  - CMS Medicare National Coverage Determinations.
  - CMS Medicare Local Coverage Determinations.
  - Medicare Benefit Policy Manual.
- InterCommunity Health Network CCO follows coverage guidelines and funding limitations that govern the Oregon Health Plan (Oregon Medicaid) established by the Oregon legislature and Oregon Health Authority:
  - Oregon Medicaid Prioritized List (which includes above the line and below the line information as well as guideline notes developed by the state Health Evidence Review Commission).
  - Oregon Administrative Rules.

On the rare occasion that no appropriate guideline exists from the sources above, SHP/IHN-CCO uses a small number of internally developed Samaritan Health Plans medical coverage policies, found at **samhealthplans.org/MedicalCoveragePolicies**.

It should be noted that the conclusion that a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by SHP/IHN-CCO) for a member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits.

Clinical reviewers consider the individual characteristics of the member, i.e., age, comorbidity,

complications, progress of treatment, psychosocial situation, care supports and home environment when applying criteria.

Request types

Requests for services or items and decision notification time frames are consistent with applicable state and federal laws and regulations and accreditation standards. Detailed explanations and timelines are outlined in decision support tools and department policies and procedures.

- **Expedited:** When a service request is expedited, a provider is documenting that the member's health condition cannot wait the standard authorization time frame to receive a response (see table below).
- **Standard:** Each line of business has a regulatory time frame to process a standard request. When a request is incomplete or requires a more extensive review, additional time may be necessary to process the request. It is the responsibility of the plan to reach out a minimum of three times within the standard timeframe to request additional documentation and then refer to the plan medical director for follow-up (see timelines below).
- **Retroactive:** A post-service or retroactive request may be reviewed up to 30 or 90 days past the date of service depending on the line of business. If exception criteria are met, retroactive requests are processed within 14 days of receipt for all lines of business except Samaritan Employer Group Plans which are processed within two business days.

Notification process

Members may receive written notification of the authorization determination by mail. Each plan requirement is documented in Clinical Services Division policies and procedures. In addition, phone calls, faxes, letters and e-mails are documented and maintained per regulatory requirements. Prior authorization request processing timeline requirements:

Line of business	Expedited time frame	Standard time frame
Samaritan Advantage Health Plans	72 hours	14 days
Samaritan Advantage Health Plans Part B drugs	24 hours	72 hours
IHN-CCO	72 hours	14 days
IHN-CCO provider administered drugs	72 hours	72 hours
Samaritan Choice Plans	72 hours	14 days
Samaritan Employer Group Plans	72hours	Two business days

Denials/Appeals

A denial is a decision to limit or deny authorization of a requested service or item that is published as requiring authorization from UM. This is defined by Centers for Medicaid and Medicare as an adverse organizational determination.

Whenever issuance of a denial is warranted, the member will receive notice in writing which is copied to the

provider. The written notification of a denial of coverage is based upon medical appropriateness or benefit limitation and will include, but is not limited to:

- Reason for the adverse determination in terms specific to the member's condition.
- Description of the member's treatment interventions requested.
- Specific criteria deemed to be appropriate to apply to the specific request indicating (when appropriate and applicable) which portion of the criteria was not found to be met.
- Description of the member's appeal rights and how to initiate an appeal.

The chief medical officer or medical director is available to discuss the decision with the provider regarding an adverse determination. This is called a "peer-to-peer" consultation. The intent is to provide an opportunity to discuss the details of a specific case for better understanding as to why the request may not have met the required criteria. A "peer-to-peer" is carried out after an adverse determination (denial) and prior to appeal.

Any request that is denied can be appealed by a member or their authorized representative. All lines of business have individual appeal processes including internal and external review. An impartial provider, who was not involved in the initial denial, makes the redetermination of medical necessity.

Confidentiality

Clinical Services Division staff follow all Samaritan Health System and Samaritan Health Plans HIPAA policies as they relate to procedures, access, safeguards and security of protected health information. SHP/IHN-CCO ensures that, through the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent they are applicable. The policies are reviewed with all staff upon hire and annually.

Financial incentives

SHP does not use financial or other incentives to encourage over or underutilization. Decision-making is based only on member eligibility and appropriateness of care and service. Physicians and staff make decisions about which care, and services are provided based on the member's clinical needs, the appropriateness of care and service and the member's coverage. SHP does not make decisions regarding hiring, promoting, or terminating its physicians or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. SHP does not specifically reward, hire, promote or terminate practitioners, or other individuals for issuing denials of coverage or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care or services. To maintain and improve the health of our members, all physicians and health care professionals should be especially diligent in identifying any potential underutilization of care or services.

Quality and performance improvement

Utilization Management takes a systematic and data-driven approach to evaluating, maintaining and improving the quality and safety of services delivered to our members. The department is focused on training and continuous improvement and uses the Agency for Healthcare Research and Quality **PDSA model of improvement**.

Inter-rater reliability

The purpose of inter-rater reliability testing is to monitor and evaluate consistency of internal utilization review decision-making according to established standards. These standards address specifications for conducting effective and efficient utilization management services. The results are evaluated for opportunities to improve consistency in decision-making. IRR testing is completed on an annual basis by all clinical and medical reviewers making determinations, SHP Medical Reviewers (MD/DO), Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Durable Medical Equipment (CDME) personnel, Assistive Technology Personnel (ATP), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC) and Clinical Pharmacists (PharmD, RPh).

Case study examples are compiled of typical authorizations encountered within the department that require clinical and/or medical review. The testing for these cases uses the criteria for the specific plan represented. This includes MCG evidence-based software, CMS standards, Medicare Benefit Policy Manual, Medical Coverage Guidelines (National Coverage Determinations and Local Coverage Determinations), SHP approved medical coverage policies, American Society of Addiction Medicine and Oregon Administrative Rules including Guideline Notes and the Prioritized List. Documented determinations of the case studies are compared for percentage of agreement of the reviewers. An overall percentage of 80% or higher is the acceptable standard. If an individual SHP Medical Reviewer, Clinical Reviewer or Clinical Pharmacist does not achieve an 80% score, focused reviews, training and/or coaching will follow, and may include retesting. A score of 79% or below on re-test requires management follow-up. Management follow-up may involve retraining, coaching and observation and/or corrective action.

IRR review is completed each calendar year. The most current annual IRR percentage rate is 94%.

Utilization Management policies

The policies referenced in this handbook are available upon request by calling Customer Service at **541-768-5207** or toll free **800-435-2396**.

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