Utilization Management (UM) Program & Criteria

Purpose, Goals, and Objectives

Verda Healthcare's Utilization Management (UM) Program ensures that members receive the right care at the right time in a clinically appropriate, cost-effective, and efficient manner. The program provides a structured approach to managing healthcare services, with clearly defined roles for qualified personnel, and applies to all health plan members.

The UM Program promotes optimal health outcomes, responsible resource use, and compliance with regulatory requirements. It uses evidence-based clinical criteria to guide service authorizations, monitors utilization trends, supports care coordination, and collaborates with quality and peer review efforts. Through provider education, performance recognition, and data-driven improvements, the program aligns utilization with medical standards, benefit coverage, and broader health promotion goals.

Utilization Management Policies

1. **Authorization Determinations**
   Authorization decisions by Verda's utilization management reviewers are based solely on the appropriateness of care and services. Verda does not provide financial incentives to any physicians, nurse reviewers, or other parts of the organization—either directly or indirectly—for denying services.

2. **Medical Necessity Criteria**
   All determinations regarding medical necessity are made using established, industry-recognized criteria, applied in the following order of priority:
   - CMS local and national coverage determinations
   - Verda peer-reviewed guidelines (if applicable)
   - InterQual, MCG, or other nationally recognized evidence-based decision support tools
   - Other evidence-based guidelines endorsed by recognized professional societies (e.g., NCCN)

3. **Qualified Reviewers**
   The Utilization Management team including physicians, licensed staff, and unlicensed staff performs responsibilities aligned with their qualifications and scope of practice.

   All preauthorization, concurrent review, and case management decisions are supervised by qualified licensed medical professionals, with specialty physician consultants engaged as needed for specific medical, surgical, or behavioral health cases.

4. **Program Oversight and Annual Review**
   The Utilization Management Program, along with its supporting policies and procedures, is reviewed and approved at least annually by the Utilization Management Committee and the Board of Directors. The appropriate application of medical necessity criteria is overseen by the Verda Chief Medical Officer, a senior physician actively involved in the program's implementation, in collaboration with the Utilization Management Committee. Participating IPA

partners who are not on the committee may also assist with the review or approval of criteria when needed.

5. **Access to Criteria and Oversight of Application**
   Medical necessity criteria are available to all practitioners upon request. Verda has established procedures to ensure proper use and transparency of these criteria, including:
   - A process to verify that both physician and non-physician reviewers apply the criteria accurately and consistently.
   - Clear documentation requirements that show how the criteria support the appropriateness of services, while also considering individual patient needs and the local healthcare delivery environment.
   - A defined and accessible process for practitioners to request copies of the criteria.

6. **Emergency Services**
   Emergency services required to screen and stabilize members will be authorized without prior notification when a prudent layperson would reasonably believe an emergency condition existed.

7. **Information Gathering**
   Verda makes every effort to gather all necessary and pertinent clinical information, including documented communication with the treating physician, to properly review all authorization requests.

8. **Referral/Authorization Timelines**
   The referral and authorization process, including timeframes for decisions, notifications, and confirmations, is implemented and regularly monitored to ensure compliance with applicable regulatory and NCQA standards.
   - Utilization management decisions are made promptly, with careful consideration of clinical urgency.
   - Timeliness is continuously tracked, and corrective actions are taken when performance does not meet required standards.

9. **Denials and Appeals**
   Only the Chief Medical Officer or a designated physician may deny services after a medical review.
   - Denials are clearly documented and communicated to the member and requesting physician.
   - Denial notifications include:
     - The reason for denial
     - Appeal instructions
     - Information about the physician availability for peer-to-peer discussion

10. **Satisfaction Surveys**
    Member and practitioner satisfaction is measured **at least every two years**, focusing on:
    - Ease of obtaining service authorizations
    - Areas of dissatisfaction, which are addressed through corrective actions and re-measurement

11. **Utilization Data Analysis**
    Utilization data is regularly tracked and analyzed to identify trends, including overutilization and underutilization, based on expected benchmarks for the population served.
    - Reports are submitted quarterly to:

- The Utilization Management Committee
- The Board of Directors

The UM Committee reviews the findings, makes recommendations for improvement when needed, and implements a re-measurement process to assess progress or determine if
action is required.

12. Quality Issue Referrals

Any identified quality of care or service concerns are referred to the Quality Management Department and Quality Management Committee for investigation.

- The UM and QM Committees collaborate on any related issues.

13. Scope of Review Services

The UM Program includes prospective, concurrent, and retrospective reviews for the following services:

- Emergency department visits
- Inpatient hospitalizations (acute, rehab, and skilled nursing)
- Outpatient surgeries (performed outside a provider's office)
- Selected outpatient and ancillary services
- Home health services
- Selected physician office services
- Out-of-network services
- Specialist-to-specialist referrals
- Self-referrals by specialists

14. Appeals Processing

Provider and member appeals are processed in accordance with the health plan appeal policies.

15. Case Management Program

The Case Management Program is responsible for clinically and administratively identifying, coordinating, and evaluating services for members who require ongoing or focused care management. Case Management will collaborate with disease management programs approved by the Utilization Management Committee.

16. Health Plan Reporting

The Utilization Management Program and related reports will be submitted to contracted health plans in accordance with the terms of the contractual agreements.

17. Encounter Data Reporting

Timely reporting of encounter data to the health plans is conducted in compliance with contract requirements.