

POLICY AND PROCEDURE

RELATING TO
HEALTH UTILIZATION
MANAGEMENT STANDARDS

Prepared by

The Kansas Insurance Department

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**POLICY AND PROCEDURE RELATING TO
HEALTH UTILIZATION MANAGEMENT STANDARDS**

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This Policy and Procedure is an adaptation of URAC Health Utilization Management Accreditation, Version 5.0, which provides Core Standards, Version 2.0, and Health Utilization Management Standards for Utilization Review Organizations. Deletions in these standards have been stricken through and additions are underlined.

~~URAC, an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation and certification programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.~~

~~Important:—To achieve URAC Health Utilization Management Accreditation, an organization must comply with both URAC's Core Standards and Health Utilization Management Standards. Both sets of standards are included in this document. Certification by URAC is prima facie evidence of that these standards are currently being met.~~

~~Except as provided in K.S.A. 40-22a06(b) and amendments thereto, each organization offering utilization review services that is required to apply for a certificate pursuant to K.S.A. 40-22a01 et seq., and amendments thereto, shall comply with these regulations. The utilization review services subject to these regulations shall include the following:~~

- ~~(a) Prospective, concurrent, and retrospective utilization review for inpatient and outpatient care conducted by a health care provider; and~~
- ~~(b) utilization review activity conducted by a health care provider in connection with health benefit plans.~~

Notwithstanding adherence to the standards prescribed by these regulations, the decision as to what treatment to prescribe for an individual patient shall remain that of the health care provider, and either the patient or the patient's representative. The final decision as to whether the prescribed treatment constitutes a covered benefit shall be the responsibility of the claims administrator or health benefit plan.

If specified in the health benefit plan which imposes the utilization review requirements:

- (a) The insured individual seeking the health care services shall be responsible for notifying the utilization review organization in a timely manner and initiating the request for certification of health care services; and
- (b) any health care provider or responsible patient representative, including a family member, may assist in fulfilling the responsibility of initiating the request for certification.

~~Important: This document is intended to provide a basic understanding of the accreditation standards. It does not include interpretive information, scoring information, or other guidance necessary for a detailed understanding of the standards and the accreditation process. This information is contained in the Program Guide for this accreditation program, which may be purchased on URAC's Web site at www.uraac.org, or by calling (202) 216-9010.~~

~~Note: Defined terms appear in italics throughout this document. A definitions section follows the standards.~~

Core Standards

Version 2.0

Organizational Structure

Core 1 – Organizational Structure

The organization has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the organization.

Core 2 – Organization Documents

Organization's documents address:

- (a) Mission statement;
- (b) Organizational framework for program;
- (c) A description of the services delivered by the organization and how those services are delivered;
- (d) The population served; and
- (e) Organizational oversight and reporting requirements of the program.

Policies and Procedures

Core 3 – Policy and Procedure Maintenance, Review, and Approval

The organization:

- (a) Maintains and complies with written policies and procedures that govern all aspects of its operations;
- (b) Maintains a master list of all such policies and procedures;
- (c) Reviews policies and procedures no less than annually and revises as necessary; and
- (d) Includes the following on all policies and procedures:
 - (i) Effective dates, review dates, including the date of the most recent revision; and
 - (ii) Identification of approval authority.

Staff Qualifications

Core 4 – Job Descriptions

The organization has written job descriptions for staff that address:

- (a) Required education, training, and/or professional experience;
- (b) Expected professional competencies;
- (c) Appropriate licensure/certification requirements; and
- (d) Scope of role and responsibilities.

Core 5 – Staff Qualifications

Staff meets qualifications as outlined in written job descriptions.

Core 6 - Credentialing

The organization implements a policy to:

- (a) Verify the current licensure and credentials of licensed or certified personnel/consultants upon hire, and thereafter no less than every 3 years;
- (b) Require staff to notify organization in a timely manner of an adverse change in licensure or certification status; and
- (c) Implement corrective action in response to adverse changes in licensure or certification status.

Staff Management

Core 7 – Staff Training Program

The organization has a training program that includes:

- (a) Initial orientation and/or training for all staff before assuming assigned roles and responsibilities;
- (b) Ongoing training, at a minimum annually, to maintain professional competency;
- (c) Training in ~~URAG~~ utilization management standards as appropriate to job functions;
- (d) Training in state and regulatory requirements as related to job functions;
- (e) Conflict of interest;
- (f) Confidentiality;
- (g) Delegation oversight, if necessary; and
- (h) Documentation of all training provided for staff.

Core 8 – Staff Operational Tools and Support

The organization provides staff with:

- (a) Written operational policies and procedures appropriate to their jobs; and
- (b) Clinical decision support tools as appropriate.

Core 9 – Staff Assessment Program

The organization maintains a formal assessment program for individual staff members that includes an annual performance appraisal and a review of relevant documentation produced by that individual staff member.

Clinical Oversight

Core 10 – Senior Clinical Staff Requirements

The organization designates at least one senior clinical staff person who has:

- (a) Current, unrestricted clinical license(s) (or if the license is restricted, the organization has a process to ensure job functions do not violate the restrictions imposed by the State Board);
- (b) Qualifications to perform clinical oversight for the services provided; and
- (c) Post-graduate experience in direct patient care; and
- (d) Board certification (if the senior clinical staff person is an M.D. or D.O.).

Core 11 – Senior Clinical Staff Responsibilities

The senior clinical staff person:

- (a) Provides guidance for all clinical aspects of program;
- (b) Is responsible for clinical aspects of program; and
- (c) Has periodic consultation with practitioners in the field.

Inter-Departmental Coordination

Core 12 – Inter-departmental Coordination

The organization establishes and implements mechanisms to promote collaboration, coordination, and communication across disciplines and departments within the organization, with emphasis on integrating administrative activities, quality improvement, and where present, clinical operations.

Information Management

Core 13 - Information Management

The organization implements information system(s) (electronic, paper or both) to collect, maintain, and analyze information necessary for organizational management that:

- (a) Provides for data integrity;
- (b) Provides for data confidentiality and security;
- (c) Includes a disaster recovery plan that;
 - (i) Is tested at least every two years; and
 - (ii) Addresses identified areas for improvement; and
- (d) Includes a plan for storage, maintenance, and destruction.

Business Relationships

Core 14 – Business Relationships

The organization maintains signed written agreements with all clients describing the scope of the business arrangement.

Oversight of Delegated Functions

Core 15 – Delegation Review Criteria

The organization establishes and implements criteria and processes for an assessment prior to the delegation of functions.

Core 16 – Delegation Review

Prior to delegating functions to another entity, the organization:

- (a) Conducts a review of the potential contractor's policies and procedures and capacity to perform delegated functions; and
- (b) Outlines and follows criteria and processes for approving contractors.

Core 17 – Delegation Contracts

The organization enters into written agreements with contractors that:

- (a) Specify those responsibilities delegated to the contractor and those retained by the organization;
- (b) Require that services be performed in accordance with the organization's requirements and URAC utilization management standards;
- (c) Require notification to the organization of any material change in the contractor's performance of delegated functions;
- (d) Specify that the organization may conduct surveys of the contractor, as needed;
- (e) Require that the contractor submit periodic reports to the organization regarding the performance of its delegated responsibilities;
- (f) Specify recourse and/or sanctions if the contractor does not make corrections to identified problems within a specified period;
- (g) Specify the circumstances under which activities may be further delegated by the contractor, including any requirements for obtaining permission from the organization before any further delegation; and
- (h) Specify that, if the contractor further delegates organizational functions, those functions shall be subject to the terms of the written agreement between the contractor and the organization and in accordance with URAC utilization management standards.

Core 18 – Delegation Oversight

The organization implements an oversight mechanism for delegated functions that includes:

- (a) A periodic review (no less than annually) of the contractor's policies and procedures and documentation of quality activities for related delegated functions;
- (b) A process to verify (no less than annually) the contractor's compliance with contractual requirements and policies and procedures; and
- (c) A mechanism to monitor financial incentives to ensure that quality of care or service is not compromised.

Regulatory Compliance

Core 19 – Regulatory Compliance

The organization implements a regulatory compliance program that:

- (a) Tracks applicable laws and regulations in the jurisdictions where the organization conducts business; and
- (b) Ensures the organization's compliance with applicable laws and regulations.

Financial Incentives

Core 20 – Financial Incentive Policy

~~If the organization has a system for reimbursement, bonuses, or incentives to staff or health care providers based directly on consumer utilization of health care services, then the organization implements mechanisms addressing how the organization will ensure that consumer health care is not compromised.~~

Communications

Core 21 – Communication Practices

The organization follows marketing and communication practices that include:

- (a) Mechanisms to clearly and accurately communicate information about services to consumer and clients;
- (b) Safeguards against misrepresentations about the organization's services;
- (c) A formal process of inter-departmental review of marketing materials before dissemination; and
- (d) Monitoring of existing materials for accuracy.

Core 22 – Consumer Communication Plan

The organization documents and has a mechanism for informing consumers and clients of their rights and responsibilities, including:

- (a) How to obtain services; and
- (b) How to submit a complaint or appeal.

Consumer Protection

Core 23 – Consumer Safety Mechanism

The organization has a mechanism to respond on an urgent basis to situations that pose an immediate threat to the health and safety of consumers.

Core 24 – Confidentiality of Individually-Identifiable Health Information

The organization establishes and implements a policy and procedure to protect the confidentiality of individually-identifiable health information that:

- (a) Identifies how individually-identifiable health information will be used;
- (b) Specifies that individually-identifiable health information is used only for purposes necessary for conducting the business of the organization, including evaluation activities;
- (c) Addresses who will have access to individually-identifiable health information collected by the organization;
- (d) Addresses oral, written, or electronic communication and records that are transmitted or stored;
- (e) Address the responsibility of organization employees, committee members, and board members to preserve the confidentiality of individually-identifiable health information; and
- (f) Requires employees, committee members, and board members of the organization to sign a statement that they understand their responsibility to preserve confidentiality.

Consumer Satisfaction

Core 25 – Consumer Satisfaction

The organization implements a mechanism to collect or obtain information about consumer satisfaction with services provided by the organization.

Access to Services

Core 26 – Access to and Monitoring of Services

The organization:

- (a) Establishes standards to assure that consumers or clients have access to services: and
- (b) Defines and monitors its performance with respect to the access standards.

Complaints and Appeals

Core 27 – Complaint and Appeal System

The organization maintains a system to receive and respond in a timely manner to complaints and, when appropriate, inform consumers of their rights to submit an appeal.

Core 28 – Appeal Process

The organization maintains a formal appeal resolution process that includes:

- (a) Written notice of final determination with an explanation of the reason for the determination;
- (b) Notification of the process for seeking further review, if available; and
- (c) A reasonable, specified time frame for resolution and response.

Core 29 – Complaint and Appeal Reporting

The organization reports analysis of the complaints and appeals to the quality management committee (see Core 33).

Quality Improvement/Management

Core 30 – Quality Management Program

The organization maintains a quality management program that promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the findings.

Core 31 – Quality Management Program Resources

The organization employs staff and provides resources necessary to support the day-to-day operations of the quality management program.

Core 32 – Quality Management Program Requirements

The organization has a written description for its quality management program that:

- (a) Is approved by the organization's governing body;
- (b) Defines the scope, objectives, activities, and structure of the quality management program;
- (c) Is reviewed and updated by the quality management committee at least annually;
- (d) Defines the roles and responsibilities of the quality management committee; and
- (e) Designates a member of senior management with the authority and responsibility for the overall operation of the quality management program and who serves on the quality management committee.

Core 33 – Quality Management Committee

The organization has a quality management committee that:

- (a) Is granted authority for quality management by the organization's governing body;
- (b) Provides on-going reporting to the organization's governing body;
- (c) Meets at least quarterly;
- (d) Maintains approved minutes of all committee meetings;
- (e) If applicable, includes at least one participating provider or receives input from a participating provider committee (such as a Physician Advisory Group);
- (f) Provides guidance to staff on quality management priorities and projects;
- (g) Approves the quality improvement projects to undertake;
- (h) Monitors progress in meeting quality improvement goals; and

- (i) Evaluates the effectiveness of the quality management program at least annually.

Core 34 – Quality Management Documentation

The organization, as part of its quality management program, provides written documentation of:

- (a) Ongoing monitoring for compliance with ~~URAC~~ utilization management standards;
- (b) Objectives and approaches utilized in the monitoring and evaluation of activities;
- (c) Identification and tracking and trending of key indicators relevant to the scope of the entire organization and related to:
 - (i) Consumer and health care services; or
 - (ii) For organizations who do not interact with consumers, client services;
- (d) The implementation of action plans to improve or correct identified problems;
- (e) The mechanisms to communicate the results of such activities to staff; and
- (f) The mechanisms to communicate the results of such activities to the quality management committee.

Core 35 – Quality Improvement Project Requirements

For each quality improvement project, the organization utilizes valid techniques comparable over time to:

- (a) Develop quantifiable measures;
- (b) Measure baseline level of performance; and re-measure level of performance at least annually; and
- (c) Establish measurable goals for quality improvement.

Core 36 – Quality Improvement Project Goals and Measurement

For each quality improvement project, the organization:

- (a) Designs and implements strategies to improve performance;
- (b) Establishes projected time frames for meeting goals for quality improvement;
- (c) Documents changes or improvements relative to the baseline measurement;
- (d) Conducts at least one remeasurement prior to re-accreditation; and
- (e) Conducts a barrier analysis, if the performance goals are not met.

Core 37 – Clinical, Error Reduction, and Consumer Safety Requirements

At any given time, the organization maintains no less than two quality improvement projects.

- (a) At least one quality improvement project that:
 - (i) Focuses on consumers; or for organizations who do not interact with consumers, client services;
 - (ii) Relates to key indicators of quality as described in 34(c); and
 - (iii) Involves a senior clinical staff person in judgments about clinical aspects of performance, if the quality improvement project is clinical in nature; and
- (b) At least one quality improvement project focuses on error reduction and/or consumer safety.
 - (i) ~~Consumer safety QIPs (Quality Improvement Procedures) are required of the following programs: HUM (“Health Utilization Management”), WCUM, HCC, HP, DM, IRO, and CM.~~
 - (ii) ~~Error reduction QIPs are required of all accreditation programs that do not conduct consumer safety QIPs.~~

Health Utilization Management Standards

Version 5.0

Review Criteria

UM 1 – Review Criteria Requirements

The organization utilizes explicit clinical review criteria or scripts that are:

- (a) Developed with involvement from appropriate providers with current knowledge relevant to the criteria or scripts under review;
- (b) Based on current clinical principles and processes;
- (c) Evaluated at least annually and updated if necessary by:
 - (i) the organization itself; and
 - (ii) appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts under review, and;
- (d) Approved by the medical director (or equivalent designate) or clinical director (or equivalent designate).

Accessibility of Review Services

UM 2 – Access to Review Staff

The organization provides access to its review staff by a toll free or collect telephone line at a minimum from 9:00 a.m. to 4:00 p.m. of each normal ~~business~~ working day in each the central time zone ~~where the organization conducts at least two percent of its review activities.~~

UM 3 – Review Service Communication and Timeframes

The organization maintains processes to:

- (a) Receive communications from providers and patients during the business day and after business hours;
- (b) Respond to communications within one business day; and
- (c) Conduct its outgoing communications related to utilization management during providers' reasonable and normal business hours, unless otherwise mutually agreed.

UM 4 – Review Service Disclosures

The organization:

- (a) Requires utilization management staff to identify themselves by name, title, and organization name; and
- (b) Upon request, verbally informs patients; facility personnel; the attending physician and other ordering providers; and health professionals of specific utilization management requirements and procedures.

UM 5 – Onsite Review Requirements

For on-site review services, the organization:

- (a) Requires on-site reviewers to carry a picture ID with full name and the name of the organization;
- (b) Schedules reviews at least one business day in advance, unless otherwise agreed; and
- (c) Requires the on-site reviewers to follow reasonable hospital or facility procedures, including checking in with designated hospital or facility personnel.

UM-6

~~[This Standard number is reserved to synchronize with URAC's Workers' Compensation Utilization Management Standards. There is no current Standard UM-6.]~~

Initial Screening

UM 7 – Limitations in Use of Non-Clinical Staff

For initial screening, the organization limits use of non-clinical administrative staff to:

- (a) Performance of “review of service requests” for completeness of information;
- (b) Collection and transfer of non-clinical data;
- (c) Acquisition of structured clinical data; and
- (d) Activities that do not require evaluation or interpretation of clinical information.

UM 8 – Pre-Review Screening Staff Oversight

The organization ensures that licensed health professionals are available to non-clinical administrative staff while performing initial screening.

UM 9 – Pre-Review Screening Non-Certifications

The organization does not issue non-certifications based on initial screening.

Initial Clinical Review

UM 10 – Initial Clinical Reviewer Qualifications

Individuals who conduct initial clinical review:

- (a) Are appropriate health professionals; and
- (b) Possess an active professional relevant license.

UM 11 – Initial Clinical Reviewer Resources

Individuals who conduct initial clinical review have access to consultation with a:

- (a) Licensed doctor of medicine or doctor of osteopathic medicine; or
- (b) Licensed health professional in the same licensure category as the ordering provider; or
- (c) Health professional with the same clinical education as the ordering provider in clinical specialties where licensure is not issued.

UM 12 – Initial Clinical Reviewer Non-Certifications

The organization does not issue non-certifications based on initial clinical review.

Peer Clinical Review

UM 13 – Peer Clinical Review Cases

The organization conducts peer clinical reviews for all cases where a certification is not issued through initial clinical review or initial screening.

UM 14 – Peer Clinical Reviewer Qualifications

Individuals who conduct peer clinical review:

- (a) Are appropriate health professionals;
- (b) Are qualified, as determined by the medical director or clinical director, to render a clinical opinion about the medical condition, procedures, and treatment under review; and
- (c) Hold a current and valid license:
 - (i) in the same licensure category as the ordering provider; or
 - (ii) as a doctor of medicine or doctor of osteopathic medicine.

Peer-to-Peer Conversation

UM 15 – Peer-to-Peer Conversation Availability

Health professionals that conduct peer clinical review are available to discuss review determinations with attending physicians or other ordering providers.

UM 16 – Peer-to-Peer Conversation Alternate

When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred:

- (a) The organization provides, within one business of a request by the attending physician or ordering provider, the opportunity to discuss the non-certification decision:
 - (i) With the clinical peer reviewer making the initial determination; or
 - (ii) With a different clinical peer, if the original clinical peer reviewer cannot be available within one business day); and
- (b) If a peer-to-peer conversation or review of additional information does not result in a certification, the organization informs the provider and consumer of the right to initiate an appeal and the procedure to do so.

Timeframes for Initial UM Decision

UM 17 – Prospective Review Timeframes

For prospective review, the organization issues a determination:

- (a) As soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of request for a utilization management determination, if it is a case involving urgent care; or

- (b) Within 15 calendar days, of the receipt of request for a utilization management determination, if it is a non-urgent case.
- (c) For non-urgent cases this period may be extended one time by the organization for up to 15 calendar days:
 - (i) Provided that the organization determines that an extension is necessary because of matters beyond the control of the organization; and
 - (ii) Notifies the patient, prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; and
 - (iii) If a patient fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the patient must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.

UM 18 – Retrospective Review Timeframes

For retrospective review, the organization issues a determination:

- (a) Within 30 calendar days of the receipt of request for a utilization management determination.
- (b) This period may be extended one time by the organization for up to 15 calendar days:
 - (i) Provided that the organization determines that an extension is necessary because of matters beyond the control of the organization; and
 - (ii) Notifies the patient, prior to the expiration of the initial 30 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; and
 - (iii) If a patient fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the patient must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.

UM 19 – Concurrent Review Timeframes

For concurrent review, the organization adheres to the following time frames:

- (a) For reductions or terminations in a previously approved course of treatment, the organization issues the determination early enough to allow the patient to request or review and receive a review decision before the reduction or termination occurs: and
- (b) For requests to extend a current course of treatment, the organization issues the determination within:
 - (i) 24 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments; or
 - (ii) 72 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.

Notice of Certification Decisions

UM 20 – Certification Decision Notice and Tracking

For certifications, the organization:

- (a) Has a process for notification of the attending physician or other ordering provider, facility rendering service, and patient:
- (b) Includes tracking information (such as reference number) in the notice of certification; and
- (c) Upon request from the attending physician or other ordering provider, facility rendering service, or patient, provides written notification of any certification.

UM 21 – Continued Certification Decision Requirements

Confirmation of certification for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new

total number of days or services approved, and the date of admission or onset of services.

Notice of Non-Certification Decisions

UM 22 – Written Notice of Non-Certification Decisions & Rationale

For non-certifications, the organization issues written notification of the non-certification decision to the patient and attending physician or other ordering provider or facility rendering service that includes:

- (a) The principal reasons for the determination not to certify;
- (b) A statement that the clinical rationale used in making the non-certification decision will be provided, in writing, upon request; and
- (c) Instructions for:
 - (i) Initiating an appeal of the non-certification; and
 - (ii) Requesting a clinical rationale for the non-certification.

UM 23 – Clinical Rationale for Non-Certification Requirements

Upon request from the patient, attending physician, or other ordering provider or facility rendering service, the organization provides specific clinical review criteria upon which the non-certification was based.

UM Procedures

UM 24 – Reversal of Certification Determinations

The organization does not reverse a certification determination unless it receives new information that is relevant to the certification and that was not available at the time of the original certification.

UM 25 – Frequency of Continued Reviews

The organization ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity (i.e., not routinely conducted on a daily basis).

Information upon Which Utilization Management Is Conducted

UM 26 – Scope of Review Information

The organization, when conducting routine prospective review, concurrent review, or retrospective review:

- (a) Accepts information from any reasonably reliable source that will assist in the certification process;
- (b) Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services
- (c) Does not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;
- (d) Does not routinely request copies of all medical records on all patients reviewed;
- (e) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and
- (f) Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or providers.

- (g) Requests a review of all records on all patients. This shall not preclude a request for copies of relevant clinical records retrospectively for clinical review for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or utilization review provisions. With the exception of reviewing records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers shall be entitled to reimbursement for the reasonable direct costs of duplicating requested records.
- (h) Health care providers shall be entitled to reimbursement for the reasonable direct costs of duplicating requested records, unless specified in the contract between the health plan, URO, and provider.

UM 27 – Prospective and Concurrent Review Determinations

For prospective review and concurrent review, the organization bases review determinations solely on the medical information obtained by the organization at the time of the review determination.

UM 28 – Retrospective Review Determinations

For retrospective review, the organization bases review determinations solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

UM 29 – Lack of Information Policy and Procedure

The organization implements policies and procedures to address situations in which it has insufficient information to conduct a review. Such policies and procedures provide for:

- (a) Procedural time frames that are appropriate to the clinical circumstances of the review (i.e., prospective, concurrent, retrospective reviews);
- (b) Resolution of cases in which the necessary information is not provided to the organization within specified time frames; and
- (c) Processes by which the organization issues an administrative non-certification due to lack of information.

Appeals Considerations

UM 30 - Non-Certification Appeals Process

The organization maintains a formal process to consider appeals of non-certifications that includes:

- (a) The availability of standard appeal for non-urgent cases and expedited appeal for cases involving urgent care; and
- (b) Written appeals policies and procedures that:
 - (i) Clearly describe the appeal process, including the right to appeal of the patient, provider, or facility rendering service;
 - (ii) Provide for explicit time frames for each stage of the appeal resolution process; and
 - (iii) Are available, upon request, to any patient, provider, or facility rendering service.

UM 31 – Appeals Process

As part of the appeals process:

- (a) The organization provides the patient, provider, or facility rendering service the opportunity to submit written comments, documents, records, and other information relating to the case, and
- (b) Takes all such information into account during the appeals process without regard to whether such information was submitted or considered in the initial consideration of the case, and
- (c) In instance of a first level appeal, the organization implements the decision of the first level clinical appeal if it overturns the initial denial.

UM 32 – Appeal Peer Reviewer Qualifications

Appeals considerations are conducted by health professionals who:

- (a) Are clinical peers;
- (b) Hold an active, unrestricted license to practice medicine or a health profession;
- (c) Are board-certified (if applicable) by:
 - (i) A specialty board approved by the American Board of Medical Specialties (doctors of medicine); or
 - (ii) The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine); or
- (d) Are in the same profession, same licensure category as the ordering provider, and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and
- (e) Are neither the individual who made the original non-certification, nor the subordinate of such an individual.

UM 33 – Expedited Appeals Process Timeframe

Expedited appeals are completed, with verbal notification of determination within 72 hours of the request followed by a written confirmation of the notification within 3 calendar days.

UM 34 – Standard Appeals Process Timeframe

Standard appeals are completed, and written notification of the appeal decision issued, within 30 calendar days of the receipt of the request for appeal.

UM 35 – Written Notification of Upheld Non-Certifications

For appeals determinations, the organization issues written notification of the adverse appeal decision to the patient and attending physician or other ordering provider or facility rendering service that includes:

- (a) The principal reasons for the determination to uphold the non-certification;

- (b) A statement that the clinical rationale used in making the appeal decision will be provided, in writing, upon request; and
- (c) Information about additional appeal mechanisms available, if any.

UM 36 – Appeal Record Documentation

The organization maintains records for each appeal that includes:

- (a) The name of the patient, provider, and/or facility rendering service;
- (b) Copies of all correspondence from the patient, provider, or facility rendering service and the organization regarding the appeal;
- (c) Dates of appeal reviews, documentation of actions taken, and final resolution;
- (d) Minutes or transcripts of appeal proceedings (if any); and
- (e) Name and credentials of the clinical peer that meets the qualifications in Standard UM 28.

Definitions (~~defined terms appear in italics throughout the standards~~)

~~This glossary is a compilation of all defined terms in the following URAC Standards: Core, Health Utilization Management, Workers' Compensation Utilization Management, Case Management, Disease Management, Independent Review Organization, Credentials Verification Organization, Health Plan, Health Network, Health Call Center, and Provider Credentialing. Not all terms appear in each module.~~

~~In the Standards, defined terms are italicized. Being familiar with these definitions is critically important to accurate understanding of URAC Standards. Readers are encouraged to refer to the definitions section each time they encounter an italicized term until they feel they have committed the meaning of that term to memory.~~

~~Abandonment Rate — The percentage of calls offered into a communications network or telephone system --i.e., automatic call distribution (ACD) system of a call center — that are terminated by the persons originating the call before answer by a staff person.~~

Access - The consumer's ability to obtain services at the time which they are needed. The ease of access is determined by components such as the availability of services, their acceptability to the consumer, consumer wait time, and the hours of operation.

~~Adverse Event - An occurrence that is inconsistent with or contrary to the expected outcomes of the organization's functions.~~

Advisory Board of Osteopathic Specialists (ABOS) - American Osteopathic Association (AOA) certification agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and pattern of training.

~~Advocacy - The act of recommending to speak or write in favor of a consumer to promote consumer autonomy and independence. It involves educating consumers about their rights, health care and human services, resources and benefits, and facilitating appropriate and informed decision making and includes considerations for the consumer's values, beliefs, and interests.~~

American Board of Medical Specialties (ABMS) - Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

Appeal - Formal request for review of an organizational determination (i.e., services have been denied, reduced, etc.) ~~Note: Specific terms used to describe appeals vary, and are often determined by law or regulation. URAC's UM Standards apply to first-level appeal.~~

Appeals Consideration - Clinical review conducted by appropriate clinical peers, who were not involved in peer clinical review, when a decision not to certify a requested admission, procedure, or service has been appealed. Sometimes referred to as “third level review.”

~~Assessment - A systematic process of collecting in-depth information about a consumer's situation and functioning to identify individual needs in order to develop a comprehensive case management plan that will address those needs. In addition to direct consumer contact, information should be gathered from other relevant sources (patient/consumer, professional caregivers, non-professional caregivers, employers, health records, educational/military records, etc.)~~

Attending Physician - The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a patient in a hospital or other health care facility.

~~Attending Provider - The physician or other health care practitioner with primary responsibility for the care provided to a consumer.~~

Availability - The extent to which the organization has participating providers of the appropriate type and number geographically distributed to meet the needs of consumers.

~~Average Speed of Answer - The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a staff person.~~

Barrier Analysis - Post-baseline interpretation of performance data that identifies root causes and key improvements and evaluates the effectiveness of improvements by comparing actual to expected results.

~~Blockage Rate – The percentage of incoming telephone calls “blocked” or not completed because switching or transmission capacity is not available as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in consumers receiving a busy signal.~~

~~Board-Certified - A certification – approved by the American Board of Medical Specialties, the American Osteopathic Association, or recognized by the appropriate state licensing body another organization as accepted by URAC – that a physician has expertise in a particular specialty or field. To the extent that future URAC standards include other certifications, URAC will specify further approved boards.~~

~~Note: URAC recognizes that ABMS and AOA-approved board certifications may not be the only certification programs that may be acceptable for health professionals in URAC-accredited organizations. For example, non-physician professionals will have appropriate certifications that are not ABMS or AOA-approved. Any applicant wishing to have URAC recognize another board certification program should notify URAC early in the accreditation process. URAC will then take this recommendation to URAC’s Accreditation Committee. The Accreditation Committee will review all requests, and will decide to approve or reject the certification. The Accreditation Committee will consider the following criteria in judging whether a certification is acceptable:~~

- ~~• Is the certification accepted within its target community of health professionals?~~
- ~~• Was the certification developed through an open, collaborative process?~~
- ~~• Does the certification reflect accepted standards of practice?~~
- ~~• Is the certification administered through an objective process open to all qualified individuals?~~

~~All approved organizations will be listed in relevant materials provided by URAC. Note also that the term board certification appears only once in the Core Standards, in standard 19, which relates to the clinical qualifications of senior clinical staff people who are physicians.~~

~~Care Plan –The process of determining specific objectives, goals, and actions designed to meet the consumers’ needs as identified through the assessment process. The plan should be action-oriented and time-specific.~~

Case - A specific request for medical or clinical services referred to an organization for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not. It is a non-approval regarding medical necessity and medical appropriateness decisions for services covered under a health benefits plan's terms and conditions or for coverage decisions regarding experimental or investigational therapies that is at issue during the independent review process.

Case Involving Urgent Care - Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or b) in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case. ~~(Note: This definition is derived from the Department of Labor's definition of "claim involving urgent care.") Note: While the URAC standards are silent on the methods by which a claim is determined to be a "case involving urgent care," the Department of Labor claims regulation (29 C.F.R. § 2560.503-1(m)(1)) specifies that Whether a claim is a "claim involving urgent care" is to be determined by an individual acting on behalf of the health benefits plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" shall be treated as a "claim involving urgent care. Note: The Department of Labor claims regulations do not apply to the URAC Workers' Compensation Utilization Management Standards.~~

~~Case Management - A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a consumer's health needs through communication and available resources to promote quality cost-effective outcomes.~~

Certification - A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization. To qualify under these standards, the certification program must:

- Establish standards through a recognized, validated program;
- Be research-based; and
- Be based (at least partially) on passing an examination.

Certification (UM) - A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefits plan. Note: ~~“Determination” may vary depending on context.~~

~~Claims Administrator - Any entity that recommends or determines to pay claims to enrollees, physicians, hospitals, or others on behalf of the health benefits plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third party administrators, or other private contractors.~~

Client - A business or individual that purchases services from the organization. Note: ~~Here are some examples of client relationships:~~

- ~~• If a health plan provides health coverage to an employer, the employer is the client.~~
- ~~• If a health plan contracts for utilization management or case management services from a utilization management organization, the health plan is the client.~~
- ~~• If a PPO contracts for credentialing services with a CVO, the PPO is the client.~~

~~Clinical Activities - Operational processes related to the delivery of clinical triage and health education services performed by clinical staff.~~

Clinical Decision Support Tools - Protocols, guidelines, or algorithms that assist in the clinical decision-making process.

Clinical Director - A health professional who: (1) is duly licensed or certified; (2) is an employee of, or party to a contract with, an organization; and (3) who is responsible for clinical oversight of the utilization management program, including the credentialing of professional staff and quality assessment and improvement functions.

Clinical Peer - A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. ~~Generally, as~~ As a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.

Clinical Rationale - A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review Criteria - The written screens, decision rules, medical protocols, or guidelines used by the organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefits plan.

Clinical Staff - Employees or contracted consultants of the health care organization who are clinically qualified to perform clinical triage and provide health education services.

~~Clinical Triage - Classifying consumers in order of clinical urgency and directing them to appropriate health care resources according to clinical decision support tools.~~

Comparable - Data about performance is compared to an historical baseline (which may be internal) and ongoing progress is recorded in regular intervals (e.g., monthly, quarterly, or annually). External benchmarks also may be used for purposes of comparison.

Complaint - An expression of dissatisfaction regarding the organization's products or services. Note: This term is sometimes referred to as "grievance." This definition does not include appeals.

Concurrent Review - Utilization management conducted during a patient's hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review."

Condition - A diagnosis, clinical problem or set of indicators such as signs and symptoms a consumer may have that define him/her as eligible and appropriate to participate in a disease management program.

Conflict of Interest - Any relationship or affiliation on the part of the organization or a reviewer that could compromise the independence or objectivity of the independent review process. Conflict of interest includes, but is not limited to:

- An ownership interest of greater than 5% between any affected parties;
- A material professional or business relationship;
- A direct or indirect financial incentive for a particular determination;
- Incentives to promote the use of a certain product or service;
- A known familial relationship;
- Any prior involvement in the specific case under review.

Consumer - An individual person who is the direct or indirect recipient of the services of the organization. Depending on the context, consumers may be identified by different names, such as "member," enrollee," "beneficiary," "patient," "injured worker," "claimant," etc. ~~Note: A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization. In the case of a consumer who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the consumer behalf may be a consumer for the purposes of these standards.~~

Consumer Safety - The prevention of harm to consumers.

Contractor - A business entity that performs delegated functions on behalf of the organization. ~~Note:~~ For the purposes of these standards, the term “contractor” includes only those contractors that perform functions related to the key processes of the organization. ~~It is not URAC’s intent to~~ This does not include contractors that provide services unrelated to key processes. ~~For example, a contractor that provides catering services would not fall within the definition of “contractor” in these standards.~~ Conversely, A company that provides specialty physician reviewers to a utilization management organization would clearly fall within the definition of “contractor.”

Criteria - A broadly applicable set of standards, guidelines, or protocols used by the organization to guide the case management process. Criteria should be:

- Written;
- Based on professional practice;
- Literature-based;
- Applied consistently; and
- Reviewed annually.

Credentials Verification - A process of reviewing and verifying specific credentialing criteria of a practitioner.

~~Credentials Verification Organization - An organization that gathers data and verifies the credentials of health care practitioners.~~

Delegation - The process by which the organization permits another entity to perform functions and assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.

Discharge Planning - The process that assesses a consumer's needs in order to help arrange for the necessary services and resources to affect an appropriate and timely discharge.

~~Disease Management — According to the Disease Management Association of America, “Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. Disease management components include: population identification processes; evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); process and outcomes measurement, evaluation, and management; routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling.”~~

~~Disease Management Program — A program or entity that provides the scope of functions~~

~~and activities necessary to provide disease management.~~

~~Engagement — Proactive outbound contact with consumers, by phone or mail, within some specified time frame of identification of eligible consumers, with tracking of interactions.~~

Error - The failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).

~~Evidence-Based — Recommendations based on valid scientific outcomes research, preferably research that has been published in peer reviewed scientific journals. Evidence-based information can be used to develop protocols, pathways, standards of care or clinical practice guidelines and related educational materials.~~

Expedited Appeal - An appeal of a non-certification in a case involving urgent care.

Facility - An institution that provides health care services.

Facility Rendering - The institution or organization in or by which the requested Service admission, procedure, or service is provided. Such facilities may include, but are not limited to: hospitals; outpatient surgical facilities; individual practitioner offices; rehabilitation centers; residential treatment centers; skilled nursing facilities; laboratories; imaging centers; and other organizational providers of direct services to patients.

~~Family - Individuals whom the consumer chooses to involve in the decision-making process regarding the consumer's health care. In the case of a consumer who is unable to participate in the decision-making process, "family" shall include any individual legally authorized to make health care decisions on the consumer's behalf.~~

~~Health Care Team - The attending physician and other health care providers with primary responsibility for the care provided to a consumer.~~

~~Health Benefits Plan - An arrangement to pay for medical services provided to a consumer. "Health benefits plan" includes (but is not limited to):~~

- ~~• HMOs;~~
- ~~• PPOs;~~
- ~~• Indemnity health insurance programs;~~
- ~~• Self-insured plans;~~
- ~~• Public programs, such as Medicare and Medicaid;~~
- ~~• Workers' Compensation insurance programs; and~~

• ~~Self-directed/consumer directed health plans.~~

Health Benefits Plan - Any public or private organization's written plan that insures or pays for specific health care expenses on behalf of enrollees or covered persons.

(A) “Health benefit plan” shall include the following:

(i) Any individual, group, or blanket policy of accident and sickness, medical, or surgical expense coverage; and

(ii) any provision of a policy, contract, plan, or agreement for medical service, including any contract of a health maintenance organization, nonprofit medical and hospital service corporation, or municipal group-funded sickness and accident pool.

(B) “Health benefit plan” shall not include any of the following:

(i) A policy or certificate covering only credit;

(ii) a policy or certificate covering only disability income;

(iii) coverage issued as a supplement to liability insurance;

(iv) insurance arising out of a workers compensation or similar law;

(v) automobile medical payment insurance;

(vi) insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy;

(vii) medicare; or

(viii) medicaid.

~~Health-Related Field - A professional discipline that promotes the physical, psychosocial, or vocational well-being of individual persons.~~

~~Health Education - Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.~~

Health Professional - An individual who: (1) has undergone formal training in a health care field; (2) holds a license in a health care field issued by ~~a state~~ one of the states of this country and the license allows the professional to practice within the scope of the license without the supervision of another licensed professional; (3) has professional experience in providing direct patient care; and (4) holds a post-secondary degree in health care. A postsecondary degree is defined as any college, university, or nursing school diploma obtained after graduating from high school (nursing diploma or associates, bachelors, masters, or doctorate degree).

~~Independent Review - A process, independent of all affected parties, to determine if a health care service is medically necessary and medically appropriate or experimental/investigational. Independent review typically (but not always) occurs after all appeal mechanisms available within the health benefits plan have been exhausted. Independent review can be voluntary or mandated by law.~~

Individually-Identifiable Health Information - ~~URAC uses the Health Insurance Portability and Accountability Act (HIPAA) definition of this term.~~ - Information that is a subset of health information, including demographic information collected from an individual, and:

Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - i. That identifies the individual; or
 - ii. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Initial Clinical Review - Clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification. Sometimes referred to as “first level review.”

Initial Screening - Automated or semi-automated screening of requests for authorization that may include: (1) collection of structured clinical data (including diagnosis, diagnosis codes, procedures, procedure codes); (2) asking scripted clinical questions; (3) accepting responses to scripted clinical questions; and (4) taking specific action (certification and assignment of length of stay explicitly linked to each of the possible responses). It excludes: (1) applying clinical judgment or interpretation; (2) accepting unstructured clinical information; (3) deviating from script; (4) engaging in unscripted clinical dialogue; (5) asking clinical follow-up questions; and (6) issuing non-certifications.

~~Knowledge Domains - Areas of specific expertise.~~

License - A license or permit (or equivalent) to practice medicine or a health profession that is (1) issued by a state regulatory body or jurisdiction in the United States; and (2) required for the performance of job functions. ~~Note: In this definition, the word "equivalent" includes certifications, registrations, permits, etc. Specific terms will vary by state and health profession.~~

Medical Director - A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and who is an employee of, or party to a contract with, an organization, and who has responsibility for clinical oversight of the organization's utilization management, credentialing, quality management, and other clinical functions.

~~Medical Management - A general term encompassing activities such as utilization management, case management, and the clinical aspects of quality management.~~

Non-Certification - A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefits plan.

Non-Clinical Administrative Staff - Staff who do not meet the definition of health professional (including intake personnel).

Non-Clinical Staff - Employees or contracted consultants of a health care organization who do not perform clinical assessments or provide consumers with clinical advice. They may be responsible for obtaining demographic information, providing benefit information, and re-directing consumers.

~~Opt-In - Affirmative consent actively provided by a consumer to participate in an activity or function of the disease management program, provided after the disease management program has fully disclosed the terms and conditions of participation to the consumer, including:~~

- ~~• The duration of the opt-in (is it indefinite or does it apply for a specified period?);~~
- ~~• The type of information to be collected from the user, the purposes for which the information will be used, to whom the information may be disclosed; and~~
- ~~• The mechanism by which the user may opt out.~~

~~Opt-Out - A process by which a consumer declines to participate in an activity or function of the disease management program.~~

Ordering Provider - The physician or other provider who specifically prescribes the health care service being reviewed.

Organization - A business entity that seeks accreditation under these standards.

~~Outcome - An outcome is a measure that indicates the result of the performance (or nonperformance) of a program, service, or intervention. The evaluation measures may include: clinical, financial, utilization, economic, quality, and humanistic outcomes (e.g. patient and provider satisfaction).~~

~~Participant (participating) — An eligible consumer or treating provider that has had one or more inbound or outbound contacts with the disease management program, and if a consumer, has not opted out of the program.~~

Participating Provider - A provider that has entered into an agreement with the organization to be part of a provider network.

Patient - The enrollee, covered person, or consumer who requests or for whom a request for certification has been filed. The term “patient” may include an agent or representative authorized to act on the patient’s behalf. ~~Note: Try to clarify when the term “patient” includes an agent or representative authorized to act on the patient’s behalf (sometimes defined in benefit contract or by law).~~

Peer Clinical Review - Clinical review conducted by an appropriate clinical peer when a request for an admission, procedure, or service was not approved during initial clinical review. Sometimes referred to as “second level review.”

Peer-to-Peer Conversation - A request by telephone for additional review of a utilization management determination not to certify, performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

~~Personally-Identifiable Information - Any information that can be tied to an individual identifier.~~

Population - Depending on the model of the disease management program, the population for which it is responsible may be all of the consumers identified with the disease condition, or the population may be only those consumers identified to the disease management program by client referral or another mechanism. In some instances the disease management program may be responsible for identification of the population, and in other instances the client may conduct identification (and stratification) activities.

Practitioner - An individual person who is licensed to deliver health care services without supervision.

~~Primary Physician - The physician who is primarily responsible for the medical treatment and services of a consumer.~~

~~Primary Source Verification or Primary Source - Verification of a practitioner's credentials based upon evidence obtained from the issuing source of the credential.~~

Principle Reason(s) - A clinical or non-clinical statement describing the general reason(s) for the non-certification determination ("lack of medical necessity" is not sufficient to meet this).

~~Professional Competency - The ability to perform assigned professional responsibilities.~~

Prospective Review - Utilization management conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient procedures and services). Sometimes it can be called "pre-certification review", "pre-service", or "prior authorization."

Provider - Any person or entity that provides health care services. Includes both practitioners and facilities.

~~Provider Network - A group of providers with which the organization contracts to provide health services to consumers.~~

~~Provider-Specific Information - Information that is sufficient to allow identification of the individual provider.~~

Quality Improvement Project - A process that documents the variation of performance or variance from baseline standards in order to achieve a better outcome for the organization's consumers.

Quality Management Program - A systematic data-driven effort to measure and improve consumer and client services and/or health care services including consumer safety.

~~Quality Review Study - A scientific and systematic measurement of the effects or results of treatment modalities or practices for a particular disease or condition. The goal of quality measurement is to improve health care services by monitoring and analyzing the data and modifying practices in response to this data.~~

Rationale - The reason(s) or justification(s) – commonly based on criteria – for a specific action or recommendation.

~~Re-Assessment - Re-evaluation of an individual participating in the disease management program on a specified frequency, using the same or similar tools that were used in the initial assessment. Re-assessment may also include re-stratification.~~

~~Referring Entity - The organization or individual that refers a case to an organization. Referring entities may include insurance regulators, health benefits plans, consumers, and attending providers. Some states may limit by law which individuals or organizations may be a referring entity.~~

Retrospective Review - Review conducted after services (including outpatient procedures and services) have been provided to the patient. This can also be called post-service. ~~Note: Retrospective medical necessity determinations are considered utilization management (and subject to these standards).~~

~~Reviewer(s) – The individual (or individuals) selected by the organization to consider a case. Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 and IR 5. All reviewer(s) who are health care practitioners must have the following qualifications:~~

- ~~• Active licensure;~~
- ~~• Recent experience or familiarity with current body of knowledge and medical practice;~~
- ~~• At least 5 years experience providing health care;~~
- ~~• If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.~~
- ~~• If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery.~~

~~Review of Service Request - Review of information submitted to the organization for health care services that do not need medical necessity certification nor result in a non-certification decision.~~

~~Second Opinion – Requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.~~

~~Secondary Source Verification or Secondary Source – Verification of a practitioner's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of licenses and certifications and data base queries).~~

~~Service Requests - Screening inquiries to determine the services that are necessary at the time of the inquiry. This is usually performed by a non-clinical staff person to determine if the inquiry is clinical and requires transfer to a clinical staff person.~~

Staff - The organization's employees, including full-time and part-time employees.

Standard Appeal - An appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals of expedited appeals.

~~Stratification - A process for sorting a population of eligible consumers into groups relating to the need for disease management interventions. Stratification and assessment are interrelated, and both provide data used to assign interventions. Stratification may use a variety of data sources, including but not limited to claims, pharmacy, laboratory, or consumer-reported data.~~

Structured Clinical Data - Clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation.

~~Treating Provider - The treating provider is the individual or provider group who is primarily managing the treatment for a consumer participant in the disease management program. The treating provider is not necessarily the consumers' primary physician. The consumer may have a different treating provider for different conditions.~~

Utilization Management - Evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan; sometimes called "utilization review."

~~Valid - Based on accepted principles of study design, research methodology, and statistical analysis.~~

~~Worker - An ill or injured individual who is eligible for workers' compensation benefits and who files for, or for whom a workers' compensation claim has been filed.~~

Written Agreement - A document – including an electronic document – that specifies the terms of a relationship between the organization and a client, consumer, or contractor. This term may include a contract and any attachments or addenda.

Written Notification - Correspondence transmitted by mail, facsimile, or electronic medium.