POLICY MANUAL
Volume VII

MEDICAL MANAGEMENT

The policies and procedures contained in this manual are a general guide rather than a precise exposition of all of the policies and procedures underlying every aspect of the operation of Apogee Health Partners; good management and/or professional discretion should be applied to the implementation of these policies and procedures.

The policies and procedures in this manual are reviewed at least annually and updated as needed. Reviews of the policies and procedures are not explicitly documented. Updated policies updated show revision dates different from their effective date.

Medical Director

Managing Partner

October 27, 2016

Date

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Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 00**
TITLE	**Basic Policy Statement and Review of Policies**	EFFECTIVE	January 2011
		LAST REVISED	September 2015
APPROVED		BY WHOM	R. W. Ree
		REVISION NO.	05

Apogee Health Partners, Inc. is committed to efficient and effective operation. The entire organization, including the Board of Directors and Managing Partners thru Associates will work together to make certain that administrative and operational matters are handled with integrity and in a way that is consistent with applicable standards, laws, regulations and reporting requirements.

The Managing Partners and Partners have the responsibility for administering these policies. Exceptions to these policies may only be made with the prior approval of a Managing Partner.

Management and administrative positions are expected to be familiar with and operate within the parameters of these policies and guidelines.

The policies and procedures contained in this manual are a general guide rather than a precise exposition of all of the policies and procedures underlying every aspect of the operation of Apogee Health Partners; good management and/or professional discretion should be applied to the implementation of these policies and procedures.

The policies and procedures in this manual are reviewed at least annually and updated as needed. Documentation of the last annual review is documented on the page(s) immediately following this page; reviews of the policies and procedures are not explicitly documented on the individual policies. Updated policies and procedures, however, will show revision dates different from their effective date. Electronic and/or paper copies of earlier versions of policies are kept indefinitely.

All policies and procedures are available on the desktop of all personnel. Changes to the policies and procedures will usually be communicated, to employees and affected outside entities including managed care plans, 30 days in advance of the effective date via e-mail and updated copy(ies) of the policies available on the desktop.

Annual Policy Review Documentation

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Patients Application of Clinical Standards	**MM - 11**	_____	_____
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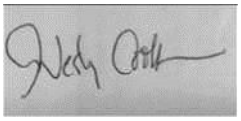
Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**
TITLE **Medical Management Plan**

APPROVED 

NUMBER	**MM - 01a**
EFFECTIVE	January 2007
LAST REVIEWED	October 2016
LAST REVISED	October 2016
BY WHOM	J. W. Cook, DO
REVISION NO.	19

Apogee Health Partners, Inc.

Medical Management Plan

AHP Medical Management Program uses nationally recognized and accepted clinical review criteria, guidelines, and protocols, which are evaluated and updated on an annual basis by the QIMMC. Apollo's Medical Review Criteria Guidelines for Managing Care are used in the precertification, concurrent review, and referral management processes for determining medical necessity and appropriateness. A Medical Director supervises all review decisions made under the Medical Management program.

Apogee Health Partners, Inc. (AHP) encourages its physicians to have patients actively participate in decisions regarding their health care and be part of candid discussions regarding appropriate or medically necessary treatment options for their condition(s). Physicians are also encouraged to provide information to patients about an illness, the course of treatment, including medications and possible side effects, and prospects for recovery in terms that they can understand.

AHP does not discriminate in any manner against any physician or other provider who openly discusses medically necessary treatment options, regardless of cost or benefit coverage, with their patients. AHP bases its decision-making only on appropriateness of care and/or service and existence of coverage.

AHP does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Nor has AHP been offered or receive any incentives for issuing denials of coverage or service. The utilization management decisions are based solely on the evaluation of clinical data presented, as compared with nationally recognized criteria for appropriateness of care and service.

AHP complies with state regulations pertaining to the performance of utilization management activities, which include maintaining applicable State Utilization Review license/registration.

1. OVERSIGHT

A. At the discretion of Apogee Health Partners' Board of Directors, day to day utilization and health management activities follow AHP's written procedures for training, orientation, and on-going performance monitoring of clinical and non-clinical utilization management staff. The healthcare staff consist of clinical professionals (RNs and/or LPNs) who perform all aspects of utilization management for the medical group in accordance with specific policies and procedures defined by AHP and as required by contracted Payers. The clinical staff report to the AHP Medical Director and/or Managing Partner.

The utilization management functions include, but are not limited to the following:

- Precertification of ambulatory services and hospital admissions
- Out of area utilization management
- Concurrent and retrospective review
- Discharge planning and arrangement of ancillary services
- Case Management
- Behavioral Health
- Referral Management
- The denial process (including letter production)

- Quality improvement
- Complaints and appeals

B. Each quarter, the QIMMC will monitor and evaluate the performance of the utilization management activities, either through review of the UM functions and statistics or through an audit process. Results will be recorded in the QIMMC meeting minutes.

2. UTILIZATION MANAGEMENT PLAN

A. Utilization Management Structure and Responsibilities

1. The AHP Medical Director is a licensed professional in the state of Illinois and is responsible for the implementation and oversight of the AHP Utilization Management Plan and the ongoing processes of the UM staff. The Medical Director acts as a physician advisor and supervises all utilization management decisions and reviews all cases where the potential for a medical denial is raised. This may occur during the prospective, concurrent, or retrospective review processes.

2. The UM staff consists of clinical professionals (RNs and/or LPNs) who are responsible for day to day utilization management activities. The staff is in direct contact with the Medical Director daily regarding review activity, and refers all cases in which there is the potential for a medical denial.

B. Medical Criteria

Throughout the utilization management process, the UM staff reviews cases for the following:

- Medical necessity
- Appropriate level of care
- Timely discharge
- Quality of care
- Appropriate discharge placement and follow-up

The medical criteria used during the review process are Apollo's Medical Review Criteria Guidelines for Managing Care. The medical criteria will be communicated to the PCPs and Specialists via AHP's website, upon their request, and can either be read to the physicians over the phone, faxed, or are available for review on-site during AHP's normal business hours. AHP, through the QIMMC, will review, select, update and approve a set of nationally recognized criteria on an annual basis.

If a procedure or diagnosis is not listed in the nationally recognized criteria, the case is referred to the Medical Director for review and determination of medical necessity and medical appropriateness.

3. TYPES OF REVIEW AND REVIEW PROCESS

A. Prospective Review /Precertification

The basic elements of Prospective Review or Precertification include eligibility verification, benefit interpretation, and medical necessity review for authorization of services provided in the inpatient, outpatient and ambulatory settings. Requests for services that require precertification are evaluated using established clinical criteria, and determinations are made by the UM staff and/or the AHP Medical Director.

Precertification is required for the following:

- Acute Inpatient Care
- Ambulatory surgeries
- High Cost Diagnostic Testing Performed in the ASU Setting
- Hospice Care
- Transitional Care
- Skilled Nursing Facilities
- Sub-Acute Care
- Rehabilitation, Inpatient and Outpatient
- Home Health Care and DME
- Non-emergency Ambulance Transport
- Organ Transplants
- Outpatient Hemodialysis
- Pain Management Program
- Specialist office visits

- Other High Cost Treatments as determined by QIMMC

Precertification Process:

The PCP/treating physician or his/her office staff may initiate the precertification process via telephone, fax, or by electronic submission to the precertification functional area. Once the precertification process is completed, the PCP's staff is responsible for notifying the patient and issuing the written referral for the authorized service(s.)

Case specific information is collected by the UM staff and stored in a database to be used for claims payment and reporting purposes. The required database documentation includes:

- Source of relevant clinical information utilized (medical record, provider information, lab and test results, other)
- Date of review determination
- Estimated length of stay (LOS) (inpatient only)
- Medical criteria met and code
- Provider notification date, within precertification time frames based on urgency

Additional information needed in order to complete a prospective review, as appropriate:

- Patient name

- Subscriber ID number
- Proposed date of service
- Primary Care Physician name
- Treating or Consulting Physician name
- Facility name
- Diagnosis
- Treatment plan
- History and clinical findings
- Results of evaluation and tests
- Lab/x-rays/scan reports
- Appropriate diagnosis and procedure codes
- Other pertinent information to facilitate authorization decision

Services that require precertification must be reported not more than thirty (30) days and not less than one (1) day prior to the anticipated date of service. Non-urgent medical determinations are made within fourteen (14) days from receipt of all required information (15 days for commercial members). However, the goal is that the determination will be completed within five (5) business days from receipt of all required information. Urgent determinations are made within seventy-two (72) hours from receipt of all required information. However, the goal is that the determination will be completed within twenty-four (24) hours of receipt of all required information.

If, upon review and evaluation of the clinical information, the requested service does not meet established criteria, the case is referred to the Medical Director for further review. The Medical Director may confer with the treating physician to discuss the clinical information. If additional information is required, the treating physician may be asked to forward documentation outlining the working diagnosis, focus of treatment, intensity of services, treatment modalities, plan of management, etc.

If the Medical Director determines that the requested service does not meet established criteria, the denial process is initiated. Physician consultants from the appropriate specialty areas of medicine and surgery, who are participating physicians in AHP, are available as needed, to act in a consultative role to the Medical Director during this process.

There are various situations that occur during the precertification process that require further attention by the UM staff:

1. Lack of Medical Necessity:

All reasonable efforts will be made by the AHP UM staff to obtain the necessary information from the provider and/or his/her designee, required to make a timely decision related to requests for medical services. If additional information is needed in order to make a valid determination, the UM staff notifies the PCP or authorized representative, of what specific information is necessary to make a decision. The UM staff will limit the request for additional information to only the information necessary to authorize the service, procedure, or treatment. The provider and/or his/her designee

may submit requests for services to AHP UM Department by phone, fax, or electronic submission.

For urgent pre-service decisions, if the AHP UM staff is unable to make a decision due to lack of necessary information, AHP extends the decision time frame for up to two (2) business days within the 24 hours of receipt of the request. For non-urgent pre-service decisions, the AHP UM staff will allow the PCP/Specialist ten (10) business days to provide the medical information required, in order to complete the medical necessity review.

The request for additional information is made as soon as possible, from the date of receipt of the original request. The AHP UM staff will send at least two faxed requests to the provider, requesting the additional information. If there is no response from the provider regarding the two faxed requests within two working days of the second faxed request, the UM Staff will make a call to the Provider to request the information. For commercial members, the UM Staff will make three (3) attempts to contact the provider within a twenty-four (24) hour time-frame, by at least two (2) different routes of communication (fax and phone.) If there is still no response from the Provider, within ten (10) days of the final information request, the UM Staff will cancel the request. The request can then be resubmitted by the PCP with all required information.

If the request is authorized by the Medical Director (or Physician Advisor), the referral form is completed, inclusive of authorization number, and sent to the PCP's office, by facsimile or through the portal.

If denied by the Medical Director (or Physician Advisor), the PCP is notified of the denial by phone and/or facsimile and afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis with the AHP Medical Director, if requested. The Medical Director may call the Provider directly or an AHP UM staff member may call the provider's office leaving information as to when the Medical Director will be available to discuss the potential adverse determination, as well as the telephone number for contacting the Medical Director. If the case results in an adverse determination, all requirements related to an adverse determination will be followed. A letter will be sent to both the Provider and the patient, stating that processing of the request cannot be completed without the necessary information and that the referral has been denied. The letter will also indicate that the processing of the request can be reinitiated once the necessary information has been received.

2. Administrative Denials:

An Administrative denial is a denial of authorization for requested services based on non-medical issues such as: member not eligible, non-covered services, benefit limits, failure to obtain pre-certification within the required time frame, and requests for services via non-AHP preferred providers that are available via AHP preferred providers. Administrative denials are issued by the UM Staff.
AHP will notify the patients' Provider of an administrative denial made during the course of UM activities. The UM Staff will send a letter to both the Provider and the patient, inclusive of all requirements related to an adverse determination.

3. Admission Evaluation

A. Initial Admission Review

Initial Admission Review is the process of evaluating the medical necessity and appropriateness of medical services and setting of care for emergency or urgent inpatient admissions. The UM staff is typically notified of an urgent or emergency admission by the Hospital or Hospital UM staff.

Initial Admission reviews, admissions will be evaluated within one business day of admission/notification for medical necessity and appropriateness using established clinical review criteria, and screened for possible discharge needs. The UM Staff will make a review determination within one (1) business day of obtaining all relevant clinical information, and an initial length of stay is assigned.

The UM staff follows the same review process as for pre-admission review. If the admission is approved, the physician is notified within one (1) business day of the determination. If criteria are not met, the case is referred to the Medical Director for review and determination. If the Medical Director determines that the requested service does not meet established criteria, the denial process is initiated. The Admitting Physician is notified and asked for additional information. If the additional information does not find cause for the admission or continued stay, the Medical Director notifies the Admitting Physician that the case is no longer authorized and discharge is encouraged. This peer exchange allows for evaluation and subsequent development of treatment protocols. Suggested alternatives are provided to the physician to help address the patient's needs through the utilization of alternative health care.

B. Concurrent Review

After the initial admission review, concurrent review is initiated and performed on the last day of the assigned LOS until the patient is discharged. Apogee Health Partners UM Staff will provide the initial notification to the physician of inpatient approval, the physician will not receive ongoing concurrent review notification, unless continued stay criteria is not met.

Concurrent review may be performed on-site at the health care facility or telephonically. Telephonic reviews may be conducted with the hospital UM staff or the treating physician(s). On-site reviews consist of a review of the medical record and face to face discussion of the patient's care with the health care delivery team.

During the concurrent review process, the Health Management Specialist collects clinical information and evaluates the medical necessity and appropriate ness of continued stay using the established review criteria. If the information no longer meets medical necessity criteria, the Admitting Physician is notified and asked for additional information. Once received, the information will be forwarded to the Medical Director. If the information does not alter the decision, the Medical Director reviews the case. If the Medical Director does not find cause for the continued stay, the Medical Director notifies the Admitting Physician that the case is no longer authorized and discharge is

encouraged. This peer exchange allows for evaluation and subsequent development of treatment protocols. Suggested alternatives are provided to the physician to help address the patient's needs through the utilization of alternative health care.

Potential discharge planning needs are also monitored. When evaluating the appropriateness of the setting of care and services provided, the Health Management Specialist will also take into consideration the individual medical and psychosocial needs of the patient, as well as the availability of services in the community.

C. Retrospective Review

Retrospective review is conducted by the UM/Claims staff, in concert with the Medical Director, using established clinical criteria for cases that were not evaluated in the appropriate time frame. Upon notification, a request for all relevant clinical information is made to the admitting facility. Retrospective review determinations are made within thirty (30) days of receipt of all necessary information. If the decision results in a denial, the physician and member are notified in writing within five (5) working days of the review determination. The member does not receive a written notice of denial when the services have already been rendered.

D. Discharge Planning

Discharge Planning is a critical component of the Medical Management process and an integral part of the overall treatment plan of care for the patient. Discharge Planning is initiated at the time of or prior to admission to a hospital or health care facility, and is coordinated by the Medical Management staff in collaboration with the PCP, treating physician, and health care delivery team. The goal of Discharge Planning is to facilitate a patient's transition from one health care setting to utilizing available information and resources to optimize continuity of care. Discharge Planning may also include educating the patient and family about the patient's discharge needs.

E. Case Management

Case Management is an essential component of the Medical Management Program, fully integrated with prospective and concurrent review. Case Management is a collaborative process used to identify opportunities to coordinate care, control costs and optimize outcomes.

Apogee Health Partners will work in a collaborative manner to ensure that potentially high-risk patients will be proactively identified in terms of utilization of services, diagnosis, or catastrophic illness. Case Management may be initiated when the patient first visits the primary care physician, is referred for specialty care, or when the practitioner requests prior authorization of treatment or services. Case Management also extends into the discharge planning process for patients identified as needing coordination of a comprehensive or interdisciplinary program of care.

An essential component of the Case Management process is early identification of potential or actual health care needs, patient and practitioner involvement and

education, and coordination of care across a variety of care settings. The Case Manager is a Nurse with Case Management experience and/or certification. The Case Manager serves as the coordinator of the interdisciplinary team consisting of the patient and family, primary care practitioner and/or the attending physician, the facility discharge planners, and specialty practitioners deemed necessary for managing the patient's needs.

Key elements documented by the Case Manager include but are not limited to:

- Assessment of member's needs including psychosocial needs;
- Development of treatment plan;
- Implementation of service;
- Evaluation of treatment plan; and
- Evaluation of outcome

4. PRECERTIFICATION MANAGEMENT

The precertification process is initiated by the PCP and requires the completion of either a written precertification form or an electronic precertification submission. The precertification form enhances the exchange of medical information between physicians or other providers.

Each AHP member selects a PCP at the time of enrollment. The PCP is the individual who directs the care needs of that member. Should the member need specialty care, a precertification form is completed by the PCP, requesting authorization for the patient to seek the care of a specific specialty provider. Precertification requests may also be submitted electronically, through the AHP Provider Portal. The precertification form is entered into AHP's database including the number of visits approved and the AHP assigned authorization number. Completion of a precertification form is required for all care provided in a setting other than the PCP's office, unless the request is submitted electronically through the AHP Provider Portal.

A member will usually not receive authorization for referrals to medical providers or facilities not associated with AHP, unless these services cannot be provided by AHP Preferred Providers. This process not only monitors and limits the cost of care delivered outside AHP, but ensures that the physician provides the level of quality care which has been established.

A. Primary Care Physician (PCP) Responsibilities

PCPs (Family Practitioners, Internist, Pediatricians, OB/Gyn) are responsible for both the basic provision and coordination of medical care for those members who have chosen them as their PCP. Other medically necessary services are provided through referral by the PCP, to contracted Specialists and/or Ancillary Care Providers.

PCPs are expected to utilize medical resources in an appropriate manner to assure that medically necessary services are provided in the most efficient and effective manner.

The PCP is expected to submit a referral request form to AHP UM staff, prior to referring a member for services, unless the required services are emergent. The PCP must provide a copy of the precertification form, with the number of visits approved and the AHP assigned authorization number, to the member.

The PCP retains a copy for member's ambulatory medical record. The member is instructed to bring the original copy with them to their scheduled appointment with the Specialist or Ancillary Provider.

B. Preferred Specialist/Ancillary Care Provider Responsibilities

Contracted specialists should, prior to consultation, examination or treatment, confirm that the patient has been properly referred and that all necessary authorizations have been obtained. In addition, they should remember to:

- Provide only the services authorized by the PCP on the Referral form;
- Communicate with the PCP, concerning proposed treatment plans;
- Contact the PCP, if in their medical judgment, the member may require additional care;
- The PCP must authorize initial and subsequent care;
- Forward copies of treatment record(s) to the member's PCP;
- Should additional care be needed; it is the responsibility of the Specialist to obtain a referral from the PCP.

Following this process will help to ensure a comprehensive and appropriate treatment plan for the member.

Precertification is required for all of the following:

- Specialist consultation
- Outpatient Surgery/Procedure/Service
- Physical or Occupational Therapy
- Podiatric and Chiropractic Care
- Infertility Treatment
- Cardiac Rehabilitation
- Radiation Therapy/Chemotherapy

Failure to preauthorize may result in denial of payment and/or sanction.
The following elements are documented in the referral process:

- The date received by AHP
- Member name and Subscriber ID number
- The reason for the services requested
- The number of visits or the extent of treatment
- Written precertification form must be signed and dated by the PCP or his/her designee
- Written precertification form includes a statement that the precertification does not authorize benefits for non-covered services
- If the precertification is denied, the Medical Director will sign and date the form, and the UM Staff will initiate the denial process. (If electronic submission is used, the Medical Director will include electronic identifier.)

Any member having a disease or condition requiring an ongoing course of treatment from a specialist or another health care provider may request a standing referral from his/her PCP. This is a single referral, provided at the discretion of the PCP, specifying duration, type and frequency of specialist services to complete an ongoing course of treatment.

The following are common errors where the referral form is returned to the PCP within one (1) business day, indicating the reason(s) for the return:

a. Duplicate referral form requests.
b. Blank Patient Name and/or Date of Birth
c. Blank Referred Provider/Facility name and/or Practice name
d. No signature by PCP or designated individual

e. No diagnosis (ICD-10) or procedure (CPT) codes on referral

The request for additional information is made as soon as possible, from the date of receipt of the original request. The AHP UM staff will send at least two faxed requests to the provider, requesting the additional information. If there is no response from the provider regarding the two faxed requests within two working days of the second faxed request, the UM Staff will make a call to the Provider to request the information. For commercial members, the UM Staff will make three (3) attempts to contact the provider within a twenty-four (24) hour time-frame, by at least two (2) different routes of communication (fax and phone.) If there is still no response from the Provider, within ten (10) days of the final information request, the UM Staff will cancel the request. The request can then be resubmitted by the PCP with all required information.

C. AHP Utilization Management Staff Responsibilities

AHP's UM staff reviews all request for services. This review ensures the approved services are clinically indicated, are delivered by cost efficient providers and in the most effective

manner, and those that are marginal or of no benefit, are not authorized. To further impact utilization, only a specific number of visits, for a specified length of time, are authorized at one time. This helps to encourage re-evaluation of the patient's current response to treatment and additional needs. If additional services are warranted, the AHP UM staff must be contacted to perform continued service monitoring and additional services are authorized, if appropriate. If approved, the physician is issued an authorization number.

Non-Urgent medical determinations are made within fourteen (14) days from receipt of all required information (15 days for commercial members.) However, the goal is that the determination will be completed within five (5) business days from receipt of all required information. Urgent determinations are made within seventy-two (72) hours or less from receipt of all required information, with a goal of twenty-four (24) hours. If the referral is denied, the member and practitioner(s) will receive written notification in the specified timeframe.

5 DENIALS

At any stage during the review process the UM staff may determine that the case does not meet medical necessity criteria. The case is then referred to the Medical Director (or Physician Advisor) for determination.

The Medical Director conducts a review of all available clinical information prior to the issuance of any medical denial. Efforts are made to obtain all necessary clinical information about the patient, through review of clinical information and consultation with the treating physician, in order to make authorization determinations. Only information necessary to make a determination of medical necessity, will be obtained. The Medical Director can authorize or deny services based on established clinical criteria and benefit guidelines. The determination of approval or denial by the Medical Director will occur within one (1) business day after the nurse reviewer refers the case, or sooner as required by the urgency of the situation. The treating practitioner is notified of a denial by phone or facsimile, within one (1) business day of the denial decision and is afforded the opportunity to discuss the determination with the Medical Director. A denial letter is issued to the physician and member (and other health care practitioners as applicable) within one (1) business day of the denial decision.

The following information must be documented with each case:

- Case entered in a denial log
- The services which were denied
- The denial reason, inclusive of the clinical rationale that is specific to the patient
- The Medical Director's determination and recommendations for treatment alternatives
- A summary of the criteria upon which the denial was based, in language that the member can understand

- Written notification to the member/PCP that they may receive a copy of the criteria used to make the denial decision
- The rights to an appeal and how to initiate the appeal process, explained and documented
- Information about the expedited appeal process
- Information about how to contact the Physician Reviewer to discuss the denial decision
- Signature and title of Medical Director

Denial determinations are reviewed on a quarterly basis by QIMMC. Meeting minutes shall include:

- The number of cases that were not medically necessary or not in the benefit
- The committee discussion concerning denied services
- Interventions or recommendations regarding denied services

AHP shall assure that all clinical staff involved in UM activities and review determinations do not receive incentives, direct or indirect, for rendering inappropriate or denial decisions.

6. TERMINATION OF BENEFITS

For services in an approved facility deemed not medically necessary by the Medical Director, and the patient refuses discharge, the following process is initiated:

- PCP must contact the attending physician within two (2) business days of notification of admission to determine medical necessity;
- If the PCP determines that continued services are no longer medically necessary, the PCP notifies the Payer UM Staff and/or Medical Director. The PCP must supply a written statement verifying that continued services for the member are no longer medically necessary;
- Written notification will be sent to the member from the Payer, stating that the PCP had determined that continued services are no longer medically necessary;
- The UM staff will submit a copy of the letter to the business office of the facility, PCP, the Medical Director and the appropriate Payer representative, notifying the member of the denial of benefits
- AHP will send a copy of the termination of benefits letter to the business office of the facility, the Medical Director, and the Payer's claims department.

7. EXHAUSTION OF LIMITED BENEFITS

AHP will notify the member in writing within two (2) business days of exhausted benefits for services that have limited benefits, i.e. outpatient rehabilitation, or outpatient therapies. A copy of the written notice will be sent to the Payer.

Written notification to the member will contain the following information:

- Fact that the benefits are exhausted
- PCP name
- Appeals rights and procedure
- Reminder that any charges incurred beyond the benefit limit are the financial responsibility of the member

- Alternatives to continuation of care and ways to obtain further care as appropriate in

all cases, the PCP continues to be responsible for coordinating the member's care.

OTHER PROGRAM COMPONENTS

A. Emergency Room Care

The use of the emergency room by members, should be preauthorized by their PCP. The exception to this is when the member has a life threatening illness/injury which can be described as the onset of a condition which requires immediate care and attention of a physician and which, if not treated immediately, would jeopardize or impair the health of the member. AHP will adhere to the policies for emergency services.

B. Out-of-Area/Out-of-Plan Admissions

Care delivered out-of-area or out-of-plan is covered in an emergency or urgent situation. Routine care delivered out of area or out-of-plan is not covered unless prior authorization by AHP is given. Typically, the specifics regarding out-of-area and out-of-plan coverage, as well as the process required for notifying the PCP and Payer regarding the need for out of area or out of plan services, is outlined in each members' Payer handbook.

If the member is admitted to an out-of-area or out-of-plan hospital, the UM staff will:

- Contact the admitting facility and request an initial admission review as soon as notice of the admission is received.
- Notify the PCP of the admission within one (1) business day of notification.
- Monitor the member's condition to determine medical stability for transfer to an in-plan or in-network facility
- Facilitate and coordinate transfer to in-plan or in-network facility when patient medically stable
- Contact the member concerning the decision to transfer
- Coordinate discharge plans
- Follow patient through the acute care review process, regardless of location

If the attending physician and PCP agree that the member is stable for transfer and the member refuses transfer, the denial process is initiated.

C. Infertility Services

The PCP or WPHCP may establish a diagnosis of infertility by performing the appropriate testing, and may refer the member for infertility services to the appropriate Participating Infertility Provider. As AHP is not delegated to provide this service, once the referral is made, the Payer will be responsible for coordinating all services for infertility treatment. Organ Transplant
AHP will monitor all aspects of clinical care including referral, precertification, and concurrent review related to organ transplant. AHP will notify the appropriate Payer representative prior to the member's evaluation at an approved transplant network facility. If the patient is accepted as a transplant candidate, AHP will forward the appropriate documents to the Payer for medical review. Documentation includes:

- Member's clinical history
- Reason for transplant
- Letter from PCP indicating approval
- Letter from transplant facility indicating member's transplant candidate status

AHP is responsible for authorization determination and will provide written notice of the determination.

D. Maternity Admission/Discharge Program

Physician services for maternity and hospital care include all prenatal care, labor, delivery, and postpartum care through the first six weeks after the birth of the infant. Other services include care for any condition resulting from the pregnancy or resulting from childbirth complications, including miscarriage.

Maternity admissions require precertification, which is obtained by the treating physician upon diagnosis. Precertification enables early identification of pregnancy, any potential high risk cases, and facilitates education regarding the program. The physician (or AHP) will educate the patient, during the first or second trimester, regarding the Maternity Admission/Discharge program. Normal deliveries will typically be assigned a length of stay of 48 hours after delivery; Cesarean section deliveries will typically be assigned a length of stay of 96 hours after delivery.

If the infant is discharged less than 48 hours post-NVD or less than 96 hours post C-section, the UM Staff will be responsible for authorizing the home visit for an infant examination by a physician or nurse within 48 hours after discharge, in order to ascertain if there are any difficulties.

E. Transition of Care

Transition of care is applicable when a member is new to the Plan, is displaced by PCP de-participation, or is displaced by termination of the AHP contract. New members must request transitional services within ninety (90) days from the effective date of eligibility and existing members within ninety (90) days after receiving notification of displacement. Members in one of these situations, who are receiving frequent or ongoing care for a medical condition, or a pregnancy that has entered the third

trimester, may request assistance to continue with established specialists for a defined time.

F. Coordination of Benefits

All claims for service through AHP are subject to Coordination of Benefits (COB). When a member/patient holds two (2) or more insurance coverage's, benefits provided under the other health plan will be coordinated with those provided according to the contracting HMO's agreement. This includes benefits available under automobile no-fault (TPL), workman's compensation and medical payments coverage, as well as homeowner's insurance.

10. PROGRAM ADMINISTRATION

A. Operation

The Medical Management Department normal business hours are Monday through Friday from 8:00 a.m. to 5:00 p.m. (Central Time). Weekdays after normal business hours, and on weekends, there is voicemail back-up, which allows callers with non-urgent issues to leave a detailed message, and an answering service to direct urgent calls to the on-call UM staff member. Voicemail messages are returned the next business day. Staff is also available during normal business hours for inbound collect or toll-free calls.

AHP maintains a staff to member ratio consistent with industry standards, currently approximating 1 RN/LPN FTE for every 5,000 covered lives for the Medicare population and 1 RN/LPN FTE for every 15,000 covered lives for the Commercial/Medicaid population. Case Managers will carry a caseload generally not exceeding 100 active cases.

B. Evaluation of the Medical Management Staff

1. The Medical Director and the UM staff conduct weekly patient case reviews. Case details and action plans are discussed.

2. Monthly and quarterly audit reviews are performed on a representative sampling of cases for each non-clerical member of the UM staff to evaluate review decisions, compliance with policies and procedures, compliance with standard timeframes, and consistent application of clinical review criteria. The results of the audit reviews are discussed with each member of the UM staff on an individual basis and included as part of the Performance Evaluation process, and presented to the QIMMC for review on a quarterly basis.

C. Evaluation of Program Effectiveness

Medical Management Program effectiveness is monitored and evaluated through the use of data maintained by AHP and available data from the contracted Payer(s).

Essential system capabilities are maintained to provide utilization data for reporting purposes. The following reports, statistics and activities shall be performed by AHP as part of its ongoing quality improvement program.
(Reporting requirements may be revised by AHP as needed to comply with all Payer contracting requirements.)

1. Utilization Statistics

a) Quarterly: The QIMMC will review the raw monthly admissions to assist in identifying avoidable days, catastrophic cases and one day stays.

b) Quarterly: The Committee will analyze the statistics for the quarter to determine if there are any trends or patterns and perform studies as deemed appropriate.

c) Semi-annually: The Committee will make recommendations for corrective action plans on trends or patterns that have been identified from the monthly and quarterly reviews.

d) Annually: The Committee will perform a year-end review and analysis of the raw statistics, trends or patterns and an evaluation of any corrective actions that may have been imposed.

2. Referral Statistics

a) Quarterly: The QIMMC will review, discuss, and analyze the Dermatology, Urology and out of plan requests for specialists to identify appropriate referral patterns, over and underutilization, and turnaround time in the approval and denial of services. Behavioral Health referral logs will be maintained and available for the Committee or the Payer upon request, however Apogee is not delegated to authorize these services and patients are referred directly to the HMO or established Provider.

3. Denials

a) Quarterly: A denial log will be maintained. The QIMMC will review the denial logs monthly to ensure that they have been handled in an appropriate manner and documented according to protocol.

4. Ambulatory Services

Semi-annually: If required, AHP will provide the Payer with summary encounter data which will include the top ten (10) ambulatory diagnoses by frequency, and the top five (5) specialist referrals by type.

5. Member Complaint Process

Monthly: A complaint log is maintained of all member complaints related to quality of care, access, and complaints forwarded by the Payer. The QIMMC will review all complaints on a quarterly basis, except those who are members of Payers, for which Apogee Health Partners is not delegated to complete the function. All member complaints that are reviewed by QIMMC

are to be resolved in a 30-day timeframe with the development and implementation of an action plan devised from the Medical Director. Written documentation of the complaint resolution will be sent to the member. If the complaint(s) are not delegated to Apogee Health Partners, they will immediately be sent to the applicable HMO.

As this process only applies to members of Payers where Apogee Health Partners is delegated to review their complaints and/or grievances, if Apogee Health Partners should receive any complaints and/or grievances from a non- delegated Payer, they will be forwarded to the Payer's designated point-of- contact for resolution, in an immediate manner, but no later than 48 hours of receipt.

6. Medical Record Audit Analysis (See Medical Record Audit)

A minimum of ten (10) medical records or an equivalent of 1% of the total annualized enrollment, whichever is less, will be reviewed monthly and results reported to the QIMMC. (Records will be audited the month prior to the QIMMC meeting.) Medical records are reviewed for format, legibility, signature, date, appropriate documentation, diagnostic testing, treatment and follow-up care, and clinical indicators as required by the Payer. Corrective action and follow up will be developed for any deficiencies.

7. Case Discussion

If it is determined that the standards of care are not being met or members have been placed at risk due to inaccurate diagnosis and/or inappropriate treatment, the QIMMC will seek improvement through:

- Oral communication between the Medical Director and the physician in question.
- Written notice to the physician, which clearly explains the deficiency and corrective action and allows for a maximum of two-week response period.
- Education, counseling and or disciplinary action.

The QIMMC shall discuss such deficiencies at the quarterly meetings, and corrective action shall be created and recorded in the minutes. The Committee may recommend dismissal of a physician from AHP if there is no improvement or repeated infractions.

8. MEMBER/PRACTITIONER SATISFACTION

It is the AHP goal to have its UM Program use a synergistic approach for analyzing its practitioners' satisfaction. The AHP UM Program provides a valuable service to

its members by providing quality health services through assisting and facilitating coordination of medical services, and insuring that
they are rendered in the most medically appropriate and cost-effective setting.

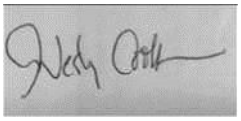
Member satisfaction with the UM program is measured annually by the Payer via specific questions in their annual survey. Practitioner satisfaction surveys are also conducted bi-annually and assess the practitioner's satisfaction with pre-certification, authorization and educational activities provided by AHP, as well as overall satisfaction with the UM program.

CONFIDENTIALITY

All AHP members required to sign a confidentiality agreement annually. The confidentiality agreement is maintained in the provider file. All AHP and member information shall be regarded as confidential and will be available only to authorized users. Member specific information will be utilized discreetly and for the sole purpose of medical review, involving only Medical Management staff members and health care practitioners directly involved in the care of a specific member (See Confidentiality Policy).

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**
TITLE **Quality Improvement Plan**

APPROVED 

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LAST REVISED	October 2016
BY WHOM	J. W. Cook, DO
REVISION NO.	19

Apogee Health Partners, Inc.

Quality Improvement Plan

PURPOSE

Apogee Health Partners (AHP) will effectively manage the health care services delivered by its participating physicians, with quality care being foremost in its Program and Plan. Furthermore, AHP consistently strives to reduce the cost of care through continuous improvement in the delivery of health care services rendered by the practitioners and members it manages.

GOALS/OBJECTIVES

It is the goal of the Quality Improvement and Medical Management Program to:

- Assure access to appropriate levels of care;
- Provide high-quality, cost-effective services for all patients, and;
- Continually improve the quality of patient care through appropriate utilization, community-based resource referrals and the promotion of disease prevention and wellness designed to keep the patient at their optimal level of health.

PROGRAM REQUIREMENTS:

1. PROGRAM RESPONSIBILITY AND REPORTING:

The AHP Board of Directors has ultimate responsibility and authority for oversight of the AHP Quality Improvement/Medical Management Program and Plan and medical management activities. The Quality Improvement/Medical Management Committee (QIMMC) of the Board is responsible for establishing and maintaining policies and procedures for the program, and reports directly to the Board of Directors. Day-to day Utilization Management activities are coordinated and conducted by the AHP Medical Management Department under the direction of the Medical Director and/or AHP Managing Partner.

The QIMMC is also responsible for monitoring all aspects of care delivered by participating practitioners, as well as identifying and monitoring quality of care trends. The QIMMC will consider quality of care issues when evaluating physicians for continued network participation, and may develop internal programs to improve quality. The Board of Directors receives a quarterly summary of all medical management activities for review, comment and proposed follow-up. An updated QI/Medical Management Program is presented to the Board of Directors on an annual basis for their review and approval. In addition, the updated Program will be submitted to contracted Payers, as required, for review and approval.

Additionally, the Medical Director and QIMMC oversee all reporting requirements for risk contracts. This may include monthly and/or quarterly reports and audits, as well as annual presentations. The QIMMC is responsible for implementation of the QI/Medical Management Program and Plan.

2. COMMITTEE STRUCTURE/FUNCTION

A. The QIMMC is comprised of AHP participating physicians with representation from primary and specialty care. The Committee is chaired by the Medical Director and may include an AHP Managing Partner, Director of Medical Management and other practitioner and administrative representatives as appropriate. The QIMMC meets on a quarterly basis (the last Thursday of the month, at 10:00 a.m.) individual members may be consulted between meetings or special meetings, in person or by telephone, may be scheduled, if needed. The schedule is subject to change pending approval by a majority of Committee members.

B. A written record of QIMMC meeting activities will be maintained by AHP and, the Medical Director will sign each set of minutes within five (5) weeks of the corresponding meeting.

C. The primary function of the QIMMC is to serve as a steering committee for the Medical Management Program and to ensure appropriate utilization and medical necessity of services in the most cost-effective setting. This is accomplished through the development and implementation of medical management policies and procedures, programs and benchmarks, and the review of utilization and outcomes resulting from the program.

D. Additionally, the Committee addresses network-wide quality management issues, reviews quality of care issues and reports issues to the Board of Directors and the contracted Payers, as appropriate, and identifies actions to eliminate or reduce problems.

E. AHP Medical Management Program uses nationally recognized and accepted clinical review criteria, guidelines, and protocols, which are evaluated and updated on an annual basis by the QIMMC. Apollo Medical Review Criteria Guidelines for Managed Care (Apollo) are used in the precertification, concurrent review, and referral management processes for determining medical necessity and appropriateness. A Medical Director supervises all review decisions made under the Medical Management program.

F. AHP complies with state regulations pertaining to the performance of utilization management activities, which include maintaining applicable State Utilization Review license/registration.

4. OVERSIGHT

A. At the discretion of Apogee Health Partners' Board of Directors, day to day utilization and health management activities and follow written procedures for training, orientation, and on-going performance monitoring of clinical and non-clinical utilization management staff (see Attachment B, Staff Training: Medical Management). The healthcare staff should consist of clinical professionals (RN and LPN) who perform all aspects of utilization

management for the medical group in accordance with specific policies and procedures defined by AHP required by contracted Payers. The clinical staff should, at some level, report to the AHP Medical Director and/or Managing Partner.

The quality improvement/utilization management functions AHP delegates to an outside party may include, but are not limited to the following:

- Precertification of ambulatory services and hospital admissions
- Out of area utilization management
- Concurrent and retrospective review
- Discharge planning and arrangement of ancillary services
- Case Management
- Referral Management
- The denial process (including letter production)
- Quality improvement
- Complaints and appeals

B. Each quarter the QIMMC will monitor and evaluate the performance of the utilization management activities, either through review of the UM functions and statistics or through an audit process. Results will be recorded in the QIMMC meeting minutes.

5. UTILIZATION MANAGEMENT PLAN

A. Utilization Management Structure and Responsibilities

1. The AHP Medical Director is a licensed professional in the state of Illinois and is responsible for the implementation and oversight of the AHP Utilization Management Plan and the ongoing processes of the UM staff. The Medical Director acts as a physician advisor and supervises all utilization management decisions and reviews all cases where the potential for a medical denial is raised. This may occur during the prospective, concurrent, or retrospective review processes.

2. The UM staff consists of clinical professionals (RN and LPN) who are responsible for day to day utilization management activities. The staff is in direct contact with the Medical Director on a daily basis regarding review activity, and refers all cases in which there is the potential for a medical denial.

B. Medical Criteria

Throughout the utilization management process, the UM staff reviews cases for the following:

- Medical necessity
- Appropriate level of care
- Timely discharge
- Quality of care

- Appropriate discharge placement and follow-up

The medical criteria used during the review process are Apollo Medical Review Criteria Guidelines for Managed Care. On an annual basis, all AHP participating physicians are notified in writing of the criteria being used. The medical criteria will be communicated to the PCPs and Specialists upon their request, and can either be read to the physicians over the phone, faxed, or are available for review on-site, during Apogee Health Partners' normal business hours. AHP, through the QIMMC, will review, select, update and approve a set of nationally recognized criteria on an annual basis.

If a procedure or diagnosis is not listed in the nationally recognized criteria, the case is referred to the Medical Director for review and determination of medical necessity and medical appropriateness.

6. TYPES OF REVIEW AND REVIEW PROCESS

A. Prospective Review /Precertification

The basic elements of Prospective Review or Precertification (also referred to as Prior Authorization) include eligibility verification, benefit interpretation, and medical necessity review for authorization of services provided in the inpatient, outpatient and ambulatory settings. Requests for services that require precertification are evaluated using established clinical criteria, and determinations are made by the UM staff and/or the AHP Medical Director.

Precertification is required for the following:

- Acute Inpatient Care
- Ambulatory surgeries
- High Cost Diagnostic Testing Performed in the ASU Setting
- Hospice Care
- Transitional Care
- Skilled Nursing Facilities
- Sub-Acute Care
- Rehabilitation, Inpatient and Outpatient
- Home Health Care and DME
- Non-emergency Ambulance Transport
- Organ Transplants
- Outpatient Hemodialysis
- Pain Management Program
- Specialist consultation

- Other High Cost Treatments as determined by QIMMC

<u>Precertification Process</u>:

The Precertification Process may be initiated via the PCP/treating physician or his/her office staff via telephone or fax, or by electronic submission to the precertification functional area. The PCP's staff is responsible for notifying the patient and issuing the written referral for the approved services.

Case specific information is collected by the UM staff and stored in a database to be used for claims payment and reporting purposes.

Required database documentation includes:

- Source of relevant clinical information utilized (medical record, provider information, lab and test results, other)
- Date of review determination
- Estimated length of stay (LOS) (inpatient only)
- Medical criteria met and code
- Provider notification date, within precertification time frames based on urgency

Additional information needed in order to complete a prospective review, as appropriate:

- Patient name
- Subscriber ID number
- Proposed date of service
- Primary Care Physician name
- Treating or Consulting Physician name
- Facility name
- Diagnosis
- Treatment plan
- History and clinical findings
- Results of evaluation and tests
- Lab/x-rays/scan reports
- Appropriate diagnosis and procedure codes
- Other pertinent information to facilitate authorization decision

Services that require precertification must be reported not more than thirty (30) days and not less than one (1) day prior to the anticipated date of service. Non-urgent medical determinations are made within fourteen (14) days from receipt of all required information (15 days for commercial members.) However, the goal is that the determinations will be completed within five (5) business days from receipt of all required information. Urgent determinations are made within seventy-two (72) hours, or less, from receipt of all required information.

If, upon review and evaluation of the clinical information, the requested service does not meet established criteria, the case is referred to the Medical Director for further review. The Medical Director may confer with the treating physician to discuss the clinical information. If additional information is required, the treating physician may be asked to forward documentation outlining the working diagnosis, focus of treatment, intensity of services, treatment modalities, plan of management, etc.

If the Medical Director determines that the requested service does not meet established criteria, the denial process is initiated. Physician consultants from the appropriate specialty areas of medicine and surgery, who are participating physicians in AHP, are available as needed, to act in a consultative role to the

Medical Director during this process.

B. Lack of Medical Necessity

All reasonable efforts will be made by the AHP UM staff to obtain the necessary information from the provider and/or his/her designee, required to make a timely decision related to requests for medical services. If additional information is needed to make a valid determination, the UM staff notifies the PCP or authorized representative, of what specific information is necessary to make a decision. The UM staff will limit the request for additional information to only the information necessary to authorize the service, procedure, or treatment. The provider and/or his/her designee may submit requests for services to AHP UM Department by phone, fax, or electronic submission.

For urgent pre-service decisions, if the AHP UM staff is unable to make a decision due to lack of necessary information, AHP extends the decision time frame for up to two (2) business days within 24 hours of receipt of the request. For non-urgent pre-service decisions, the AHP UM staff will allow the PCP/Specialist ten (10) business days to provide the medical information required, in order to complete the medical necessity review.

The request for additional information is made as soon as possible, from the date of receipt of the original request. The AHP UM staff will send at least two faxed requests to the provider, requesting the additional information. If there is no response from the provider regarding the two faxed requests within two working days of the second faxed request, the UM Staff will make a call to the Provider to request the information. If there is still no response from the Provider, the UM Staff will send the information to the Medical Director for review and determination of medical necessity.

If the request is authorized by the Medical Director (or Physician Advisor), the referral form is completed, inclusive of authorization number, and sent to the PCP's office, by facsimile.

If denied by the Medical Director (or Physician Advisor), the PCP is notified of the denial by phone and/or facsimile and afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis with the AHP Medical Director, if requested. The Medical Director may call the Provider directly or an AHP UM staff member may call the provider's office leaving information as to when the Medical Director will be available to discuss the potential adverse determination, as well as the telephone number for contacting the Medical Director. If the case results in an adverse determination, all requirements related to an adverse determination will be followed. A letter will be sent to both the Provider and the patient, stating that processing of the request cannot be completed without the necessary information and that the referral has been denied. The letter will also indicate that the processing of the request can be re-initiated once the necessary information has been received.

C. Administrative Denials

An Administrative denial is a denial of authorization for requested services based on non-medical issues such as: member not eligible, non-covered services, benefit

limits, failure to obtain pre-certification within the required time frame, and requests for services via non-AHP preferred providers that are available via AHP preferred providers. Administrative denials are issued by the UM Staff.

AHP will notify the patients' Provider of an administrative denial made during the course of UM activities. The UM Staff will send a letter to both the Provider and the patient, inclusive of all requirements related to an adverse determination.

D. Initial Admission Review

Whenever Apogee Health Partners is delegated for Initial Admission reviews, admissions will be evaluated, within one business day of admission/notification for medical necessity and appropriateness using established clinical review criteria, and screened for possible discharge needs. The UM Staff will make a review determination within one (1) business day of obtaining all relevant clinical information, and an initial length of stay is assigned.

The UM staff follows the same review process as for pre-admission review. If the admission is approved, the physician is notified within one (1) business day of the determination. If criteria are not met, the case is referred to the Medical Director for review and determination. If the Medical Director determines that the requested service does not meet established criteria, the denial process is initiated.

E. Concurrent Review

After the initial admission review, concurrent review is initiated and performed on the last day of the assigned LOS until the patient is discharged. Whenever Apogee Health Partners is delegated for Concurrent Reviews, the UM Staff will provide the initial notification to the physician of inpatient approval, the physician will not receive ongoing concurrent review notification, unless continued stay criteria is not met.

Concurrent review may be performed on-site at the health care facility or telephonically. Telephonic reviews may be conducted with the hospital UM staff or the treating physician(s). On-site reviews consist of a review of the medical record and face to face discussion of the patient's care with the health care delivery team.

During the concurrent review process, the Health Management Specialist collects clinical information and evaluates the medical necessity and appropriateness of continued stay using the established review criteria. Potential discharge planning needs are also monitored. When evaluating the appropriateness of the setting of care and services provided, the Health
Management Specialist will also take into consideration the individual medical and psychosocial needs of the patient, as well as the availability of services in the community.

Once again, if criteria are not met, the case is referred to the Medical Director for review and determination. If the Medical Director determines that the requested

service does not meet established criteria, the denial process is initiated. The Admitting Physician is notified and asked for additional information. If the additional information does not alter the decision, the Payer Medical Director reviews the case. If the Medical Director does not find cause for the admission or continued stay, the Medical Director notifies the Admitting Physician that the case is no longer authorized and discharge is encouraged. This peer exchange allows for evaluation and subsequent development of treatment protocols. Suggested alternatives are provided to the physician to help address the patient's needs through the utilization of alternative health care.

F. Retrospective Review

Retrospective review is conducted by the UM staff, in concert with the Medical Director, using established clinical criteria for cases that were not evaluated in the appropriate time frame. Upon notification, a request for all relevant clinical information is made to the admitting facility. Retrospective review determinations are made within thirty (30) days of receipt of all necessary information. If the decision results in a denial, the physician and member are notified in writing within five (5) working days of the review determination. The member does not receive a written notice of denial when the services have already been rendered.

G. Discharge Planning

Discharge Planning is a critical component of the Medical Management process and an integral part of the overall treatment plan of care for the patient. Discharge Planning is initiated at the time of or prior to admission to a hospital or health care facility, and is coordinated by the Medical Management staff in collaboration with the PCP, treating physician, and health care delivery team. The goal of Discharge Planning is to facilitate a patient's transition from one health care setting to another, utilizing available information and resources to optimize continuity of care. Discharge Planning may also include educating the patient and family about the patient's discharge needs.

H. Case Management

Case Management is an essential component of the Medical Management Program, fully integrated with prospective and concurrent review. Case Management is a collaborative process used to identify opportunities to coordinate care, control costs and optimize outcomes.

Whenever Apogee Health Partners is delegated for providing case management services, the staff will work in a collaborative manner to ensure that potentially high-risk patients will be proactively identified in terms of utilization of services, diagnosis, or catastrophic illness. Case Management may be initiated when the patient first visits the primary care physician, is referred for specialty care, or when the practitioner requests prior authorization of treatment or services. Case Management also extends the discharge planning process for patients identified as needing coordination of a comprehensive or interdisciplinary program of care.

An essential component of the AHP Case Management process is early identification of potential or actual health care needs, patient and practitioner

involvement and education, and coordination of care across a variety of care settings. The Case Manager is a registered nurse with Case Management experience and/or certification. The Case Manager serves as the coordinator of the interdisciplinary team consisting of the patient and family, primary care practitioner and/or the attending physician, the facility discharge planners, and specialty practitioners deemed necessary for managing the patient's needs.

Key elements documented by the Case Manager include:

- Assessment of member's needs including psychosocial needs;
- Development of treatment plan;
- Implementation of service;
- Evaluation of treatment plan; and
- Evaluation of outcome

7. PRECERTIFICATION MANAGEMENT

The precertification process is initiated by the PCP and requires the completion of either a written precertification form or an electronic precertification submission. Precertification is required for the following:

- Specialist consultation
- Physical or Occupational Therapy (more than 3 visits)
- Podiatric and Chiropractic Care (out on network)
- Infertility Treatment
- Cardiac Rehabilitation
- Radiation Therapy/Chemotherapy

Precertification decisions are rendered and the practitioner(s) is notified within fourteen (14) days of receipt of the request (15 days for commercial members.) If the referral is denied, the member and practitioner(s) will receive written notification in the specified timeframe. The PCP, upon request, must provide a copy of the precertification form to the member.

The following elements are documented in the referral process:

- The date received by AHP
- Member name and Subscriber ID number
- The reason for the services requested
- The number of visits or the extent of treatment
- Written precertification form must be signed and dated by the PCP or his/her designee
- Written precertification form includes a statement that the precertification does not authorize benefits for non-covered services
- If the precertification is denied, the Medical Director will sign and date the form. (If electronic submission is used, the Medical Director will include electronic identifier.)

Any member having a disease or condition requiring an ongoing course of treatment

from a specialist or another health care provider may request a standing referral from his/her PCP. This is a single referral, provided at the discretion of the PCP, specifying duration, type and frequency of specialist services to complete an ongoing course of treatment.

8. DENIALS

At any stage during the review process the UM staff may determine that the case does not meet medical necessity criteria. The case is then referred to the Medical Director (or Physician Advisor) for determination.

The Medical Director conducts a review of all available clinical information prior to the issuance of any medical denial. Efforts are made to obtain all necessary clinical and psychosocial information about the patient, through review of clinical information and consultation with the treating physician, to make authorization determinations. Only information necessary to make a determination of medical necessity will be obtained. The Medical Director can authorize or deny payment for services based on established clinical criteria and benefit guidelines. The determination of approval or denial by the Medical Director will occur within one (1) business day after the nurse reviewer refers the case, or sooner as required by the urgency of the situation. The treating practitioner is notified of a denial by phone within one (1) business day of the denial decision and is afforded the opportunity to discuss the determination with the Medical Director. A denial letter is issued to the member (and other health care practitioners as applicable) within one (1) business day of the denial decision. The denial letter states the reason for the determination including a summary of the criteria upon which the denial was based, alternative care recommendations as appropriate, the right to an appeal and how to initiate the appeal process, information about the expedited appeal process, and information about how to contact the Physician Reviewer to discuss the denial decision.

The following information must be documented with each case:

- Case entered in a denial/appeal log
- Relevant clinical information for the basis of the denial
- The Medical Director's determination and recommendations for treatment alternatives
- Reason for the denial in language that the member can understand
- Written notification to the member/PCP
- Standard and expedited appeals process explained and documented
- Signature of Medical Director

Denial determinations are reviewed on a quarterly basis by QIMMC. Meeting minutes shall include:

- The number of cases that were not medically necessary or not in the benefit
- The committee discussion concerning denied services
- Interventions or recommendations regarding denied services

Findings will also be reported to AHP Providers Relations Department via one or more appropriate communication vehicles.

AHP shall assure that all clinical staff involved in utilization management activities and review determinations do not receive incentives, direct or indirect, for rendering inappropriate or denial decisions. Each staff member shall sign an affirmation statement attesting to this, and these signed statements shall be submitted to the Payer on an annual basis, as required. New hires shall also be required to complete an affirmation statement, which shall be submitted to the Payer within thirty (30) days of hire date if requested or within thirty (30) of a request, at a later time, from the Payer. (See Attachment E, Utilization Management Affirmation Statement.)

9. TERMINATION OF BENEFITS

No termination of inpatient benefits will be made by AHP without the concurrent participation of the Payer.

For services in an approved facility deemed not medically necessary by the Medical Director, and the patient refuses discharge, the following process is initiated:

- PCP must contact the attending physician within two (2) business days of notification of admission to determine medical necessity;
- If the PCP determines that continued services are no longer medically necessary, the PCP notifies the Health Management Specialist and/or Medical Director. The PCP must supply a written statement verifying that continued services for the member are no longer medically necessary;
- The UM staff will report the case to the Payer;
- Written notification will be sent to the member from AHP stating that the PCP had determined that continued services are no longer medically necessary;
- AHP will submit a copy of the letter to the business office of the facility, PCP, the AHP Medical Director and the appropriate Payer representative;
- The Payer representative will notify the member of the denial of benefits; and The Payer will send a copy of the termination of benefits letter to the business office of the facility, the AHP Medical Director, and the Payer's claims department.

10. EXHAUSTION OF LIMITED BENEFITS

AHP will notify the member in writing within two (2) business days of exhausted benefits for services that have limited benefits, i.e. outpatient rehabilitation, therapies, infertility and outpatient behavioral health services. A copy of the written notice will be sent to the Payer.

Written notification to the member will contain the following information:

- Fact that the benefits are exhausted
- PCP name
- Appeals rights and procedure
- Reminder that any charges incurred beyond the benefit limit are the financial responsibility of the member
- Alternatives to continuation of care and ways to obtain further care as appropriate

In all cases, the PCP continues to be responsible for coordinating the member's care.

12. OTHER PROGRAM COMPONENTS

A. Out-of-Area/Out-of-Plan Admissions

Care delivered out-of-area or out-of-plan is covered in an emergency or urgent situation. Routine care delivered out of area or out-of-plan is not covered unless prior authorization by AHP is given. Typically, the specifics regarding out-of-area and out-of-plan coverage, as well as the process required for notifying the PCP and Payer regarding the need for out of area or out of plan services, is outlined in the Payer's member handbook.

As AHP is not delegated for this service, if the member is admitted to an out- of-area or out-of-plan hospital, the Payers' UM staff will:

- Contact the admitting facility and request an initial admission review as soon as notice of the admission is received.
- Notify the PCP of the admission within one (1) business day of notification.
- Monitor the member's condition to determine medical stability for transfer to an in-plan or in-network facility
- Facilitate and coordinate transfer to in-plan or in-network facility when patient medically stable
- Contact the member concerning the decision to transfer
- Coordinate discharge plans with the PCP
- Follow patient through the acute care review process, regardless of location

If the attending physician and PCP agree that the member is stable for transfer and the member refuses transfer, the Termination of Benefits policy is followed.

B. Infertility Services

The PCP or WPHCP may establish a diagnosis of infertility by performing the appropriate testing, and may refer the member for infertility services to the appropriate Participating Infertility Provider. As AHP is not delegated to provide this service, once the referral is made, the Payer will be responsible for coordinating all services for infertility treatment.

C. Organ Transplants

As AHP is not delegated to provide this service, the Payer will monitor all aspects of clinical care including referral, precertification, and concurrent review related to organ transplant. AHP will notify the appropriate Payer representative prior to the member's evaluation at an approved transplant network facility. If the patient is accepted as a transplant candidate, AHP will forward the appropriate documents to the Payer for medical review. Documentation includes:

- Member's clinical history

- Reason for transplant
- Letter from PCP indicating approval
- Letter from transplant facility indicating member's transplant candidate status

Following medical review by the Payer, the Payer will be responsible for authorization determination and will provide written notice to AHP of the determination.

D. Maternity Admission/Discharge Program

Physician services for maternity and hospital care include all prenatal care, labor, delivery, and postpartum care through the first six weeks after the birth of the infant. Other services include care for any condition resulting from the pregnancy or resulting from childbirth complications, including miscarriage.

Maternity admissions require precertification, which is obtained by the treating physician upon diagnosis. Precertification enables early identification of pregnancy, any potential high risk cases, and facilitates education regarding the program. The physician (or AHP) will educate the patient, during the first or second trimester, regarding the Maternity Admission/Discharge program. Normal deliveries will typically be assigned a
length of stay of 48 hours after delivery; Cesarean section deliveries will typically be assigned a length of stay of 96 hours after delivery.

As Apogee Health Partners is not delegated for authorization of this service, if the infant is discharged less than 48 hours post-NVD or less than 96 hours post C-section, the Payer will be responsible for authorizing the home visit for an infant examination by a physician or nurse within 48 hours after discharge, in order to ascertain if there are any difficulties.

E. Transition of Care

Transition of care is applicable when a member is new to the Plan, is displaced by PCP de-participation, or is displaced by termination of the AHP contract. New members must request transitional services within ninety (90) days of eligibility and existing members within ninety (90) days after receiving notification of displacement. Members in one of these situations, who are receiving frequent or ongoing care for a medical condition, or a pregnancy which has entered the third trimester, may request assistance to continue with established specialists for a defined time. Such members will be directed to the appropriate Payer representative for help in this matter.

13. PROGRAM ADMINISTRATION

A. Operation

The Medical Management Department normal business hours are Monday through Friday from 8:00 a.m. to 5:00 p.m. (Central Time). Weekdays after normal business hours, and on weekends, there is voicemail back-up, which allows callers with non-urgent issues to leave a detailed message, and an

answering service to direct urgent calls to the Health Management Specialist on-call. Voicemail messages are returned the next business day. Staff is also available during normal business hours for inbound collect or toll-free calls.

AHP maintains a staff to member ratio consistent with industry standards, currently approximating 1 RN FTE for every 5,000 covered lives for the Medicare population and 1 RN FTE for every 15,000 covered lives for the Commercial/Medicaid population. Case Managers will carry a caseload generally not exceeding 100 active cases.

14. QUALITY IMPROVEMENT MONITORING

The objectives of the AHP internal quality improvement process are to measure and evaluate the clinical performance of practitioners, the health status of patients, access to care through an adequate network, and the efficiency and effectiveness of medical management processes, both internal operations and those performed through delegated entities. Improvement in AHP performance is assessed through the review of case specific and aggregate data to identify opportunities to improve care and services delivered by the network. AHP recognizes the importance of implementing programs for self-monitoring, evaluation, and improvement.

A. Evaluation of the Medical Management Staff

1. The Medical Director, the UM staff conduct weekly patient case reviews. Case details and action plans are discussed.

2. Monthly and quarterly audit reviews are performed on a representative sampling of cases for each non-clerical member of the UM staff to evaluate review decisions, compliance with policies and procedures, compliance with standard timeframes, and consistent application of clinical review criteria. The results of the audit reviews are discussed with each member of the UM staff on an individual basis and included as part of the Performance Evaluation process, and presented to the QIMMC for review on a quarterly basis.

B. Evaluation of Program Effectiveness

Medical Management Program effectiveness is monitored and evaluated using data maintained by AHP and available data from the contracted Payer(s).

Essential system capabilities are maintained to provide utilization data for reporting purposes. The following reports, statistics and activities shall be performed by AHP as part of its ongoing quality improvement program. (Reporting requirements may be revised by AHP as needed to comply with all Payer contracting requirements.)

1. Utilization Statistics

a) Monthly: The QIMMC will review the raw statistics monthly as well as review the monthly admissions to assist in identifying avoidable days, catastrophic cases, and one day stays.

b) Quarterly: The Committee will analyze the statistics for the quarter to determine if there are any trends or patterns and perform studies as deemed appropriate.

c) Semi-annually: The Committee will make recommendations for corrective action plans on trends or patterns that have been identified from the monthly and quarterly reviews.

d) Annually: The Committee will perform a year-end review and analysis of the raw statistics, trends or patterns and an evaluation of any corrective actions that may have been imposed.

2. Referral Statistics

a) Monthly: The QIMMC will review, discuss, and analyze the Dermatology, Urology and out of plan requests for specialists to identify appropriate referral patterns, over and underutilization, and turnaround time in the approval and denial of services. Behavioral
Health referral logs will be maintained and available for the Committee or the Payer upon request.

3. Denials/Appeals

a) Monthly: A denial and appeal log will be maintained. The QIMMC will review the denial/appeal logs monthly to ensure that they have been handled in an appropriate manner and documented per protocol.

4. Inter-rater reliability and Adherence to Time Frames

a) Quarterly: The QIMMC will review staff adherence to all time frames.

b) Semi-annually: The Committee will assess inter-rater reliability based on the application of Apollo Medical Review Criteria Guidelines for Managed Care.

When inconsistencies are identified, corrective action plans are developed. Findings will also be reported to the AHP Providers Relations Department via one or more appropriate communication vehicles.

5. Contract Management Firm

Monthly: The QIMMC will review and discuss the delegated service organizations' performance and review required reports, as applicable.

6. Ambulatory Services

Semi-annually: If required, AHP will provide the Payer with summary encounter data which will include the top ten (10) ambulatory diagnoses by frequency, and the top five (5) specialist referrals by type.

7. Member Complaint Process

Monthly: A complaint log is maintained of all member complaints related to quality of care, access, and complaints forwarded by the Payer. The QIMMC will review all complaints. All member complaints are to be resolved in a 30-day timeframe with the development and implementation of an action plan. Written documentation of the complaint resolution will be sent to the member. Findings will also be reported to the AHP Providers Relations Department via one or more appropriate communication vehicles.

This process only applies to members of Payers where Apogee Health Partners is delegated to review their complaints, grievances and/or complaints. If Apogee Health Partners should receive any provider complaints and/or grievances from a non-delegated Payer, they will be forwarded to the Payer's designated point-of-contact for resolution, in an immediate manner, but no later than 48 hours of receipt.

8. Medical Record Audit Analysis

A minimum of ten (10) medical records or an equivalent of 1% of the total annualized enrollment, whichever is less, will be reviewed monthly and results reported to the QIMMC. (Records will be audited the month prior to the QIMMC meeting.) Medical records are reviewed for format, legibility, signature, date, appropriate documentation, diagnostic testing, treatment and follow-up care, and clinical indicators as required by the Payer. Corrective action and follow up will be developed for any deficiencies. Findings will also be reported to the AHP Providers Relations Department via one or more appropriate communication vehicles.

9. Case Discussion

If it is determined that standards of care are not being met or members have been placed at risk due to inaccurate diagnosis and/or inappropriate treatment, the QIMMC will seek improvement through:

- Oral communication between the Medical Director and the physician in question.
- Written notice to the physician, which clearly explains the deficiency and corrective action and allows for a maximum of two-week response period.

- Education, counseling and or disciplinary action.

The QIMMC shall discuss such deficiencies at the monthly meetings, and corrective action shall be created and recorded in the minutes. The Committee may recommend dismissal of a physician from AHP if there is no improvement or repeated infractions. Findings will also be reported to the AHP Providers Relations Department via one or more appropriate communication vehicles.

ATTACHMENT LOCATOR

ATTACHMENT		LOCATION	
Attachment A	Confidentiality	MM - 03 GA - 03 GA - 04	Confidentiality: Patient Info Security and Confidentiality IS Security
Attachment B	Staff Training	MM - 09	Staff Training
Attachment C	Delegation Oversight Policy	GA - 01	Delegation
Attachment D	Standing Referral Policy	MM - 04	Standing Referrals
Attachment E	Utilization Management Affirmation Policy	MM - 10	Affirmation Statement
Attachment F	Transition of Care Policy	MM - 05	Transition of Care
Attachment G	Denial/Appeal Log	Immediately following	
Attachment H	Audit of Medical Management Staff Performance	MM - 07	Staff Performance
Attachment I	Member Complaint Log	Immediately following	
Attachment J	Medical Record Audit	Immediately following	

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**
TITLE	**Appeals**
APPROVED	

NUMBER	**MM - 02**
EFFECTIVE	June 2005
LAST REVIEWED	October 2016
LAST REVISED	January 2010
BY WHOM	V. Thompson, RN
REVISION NO.	06

POLICY

Apogee Health Partners is committed to providing swift resolution for enrollees, patients and providers who have concerns or disagree with an adverse (denial) determination, and maintains a standard and expedited appeal process, both of which are readily available to enrollees, patients and providers. The appeal process is described in all denial notification letters distributed to providers and enrollees, and complies with state and federal regulatory requirements, as well as NCQA and URAC guidelines.

PROCEDURE

1. **Level One Standard Appeal:**

   a) If medical services or authorization of services is denied, the enrollee, patient, provider or their designee may appeal the denial determination rendered by Apogee Health Partners. A standard appeal request may be submitted by telephone or in writing to the Payer, pursuant to their specific process and deadline.

   b) Apogee Health Partners works closely with the Payer to collect all relevant information in order to make a determination. Information considered in the appeal review may include relevant comments, documents or other information submitted by the enrollees, all or part of the medical record, a written statement from the provider, and any additional information that was not available at the time of the denial decision.

   c) A determination is made as soon as possible, but in no case later than fifteen (15) business days after receipt of all necessary documentation. The Payer can uphold or overturn the original denial decision.

   d) Written notification describing the appeal determination and the clinical rationale for the decision is issued to the enrollee. The letter describes the process for initiating a second level appeal, along with the signature of the reviewing physician. AHP may also receive notice of the appeal decision.

e) All written notification letters show the signature and title of the physician reviewer who renders the denial decision

f) Enrollees can have access to all documents relevant to the appeal, if requested.

2. Level Two Standard Appeal

Level Two Appeals are also handled by the Payer. Enrollees can have access to all documents relevant to the appeal, if requested.

3. Expedited Appeal:

a) If, due to the nature or timing of the treatment or services requested by the provider a denial requires immediate reconsideration, the provider or enrollee may request an expedited appeal. An expedited appeal request should be made by telephone or fax to the Payer. The provider requesting the appeal should state the rationale for an expedited process.

b) The Payer will provide reasonable access within one business day to a clinical peer reviewer who shall render a determination.

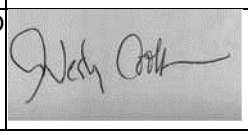
c) A decision is rendered within one working day of the request for appeal and communicated via telephone to the requesting provider.

d) Written notification of the expedited appeal decision is sent to the enrollee. If the expedited appeal results in an adverse determination, the letter will include instructions for initiating the standard appeal process.

e) All written notification letters show the signature and title of the physician reviewer who renders the denial decision

f) Enrollees can have access to all documents relevant to the appeal, if requested.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 03**
TITLE	**Confidentiality - Patient Information**	EFFECTIVE	March 2001
		LAST REVIEWED	October 2016
APPROVED		LAST REVISED	January 2006
		BY WHOM	V. Thompson, RN
		REVISION NO.	04

POLICY

The Medical Management Department will take steps to assure that confidentiality is maintained for all information collected through any medical management related activity or process. Only information necessary to carry out medical management functions, as describe in the policies and procedures, will be collected.

PROCEDURE

1. At the time of employment, all medical management staff and physician advisors shall be advised of the following provisions:

    a) All patient specific information obtained during any medical management activity or process will be kept strictly confidential.

    b) Information pertaining to patients will be shared only with the patient themselves or their designee, and their health care practitioner.

    c) Only authorized Medical Management Department personnel shall obtain confidential information.

    d) Any breach of confidentiality or the confidentiality agreement is grounds for immediate dismissal.

2. Apogee Health Partners (AHP) shall ensure confidentiality of all information obtained through any medical management related activity or process by having each employee, consultant or independent agent sign a Confidentiality Agreement (See Exhibit A) at the initiation of employment and annually thereafter, attesting to the following:

    a) Subject to the provisions of employment, Employee or designee shall not disclose any portion of the information whether transmitted or revealed, verbal, written or in any other form that is designated confidential, to any other person, entity or corporation without written consent of the patient; or use it for its own benefit, except as provided in the normal course of business or with: (1) persons who participate in medical management decisions; (2) the patient about whom the information relates; or (3) as required by law.

    b) AHP employees or designees shall not disclose any individually identifiable health care information in relation to the review of a patient's medical records except as in compliance with the Apogee Health Partners' confidentiality policy or as required by law.

c) All information and physical media gathered by AHP employees or designees shall remain the property of Apogee Health Partners. Employees shall not retain information and physical media or any copies thereof.

d) In order to maintain confidentiality, all information and physical media obtained by AHP in connection with medical management activity shall be stored in a secure, locked file that is accessible only to AHP employees or designees authorized to participate in medical management activity.

e) The information shall not be copied, reproduced in any form, stored or retained in any retrieval system or database by AHP employees or designees without the prior written consent of Apogee Health Partners. Exceptions may be made for such copies and storage as may reasonably be required for "purpose" on a temporary basis. Employees or designees shall relinquish any and all copies of stored or retained information to Apogee Health Partners immediately on request.

f) AHP employees or designees shall notify their immediate supervisor in the event he/she is uncertain whether information constitutes "Confidential Information", or in the event the employee or designee is uncertain as to whether it is necessary to reveal such information.

g) The Confidentiality Agreement shall survive termination of any employment relationship with Apogee Health Partners.

Apogee Health Partners, Inc.
CONFIDENTIALITY AGREEMENT

Apogee Health Partners, Inc. has a legal and ethical responsibility to safeguard the privacy of all members, providers and agents and to protect the confidentiality of information. Strict standards are adhered to within Apogee Health Partners regarding member and provider records and other information which is considered to be of a confidential nature.

I recognize that I have access to confidential or privileged information regarding members, providers, or processes. I will treat the information I have access to as strictly confidential and will share the information only with those who have a "need to know", as specified in Apogee Health Partners' policies, procedures, and otherwise.

I attest that I have read and understand the above information regarding confidentiality and hereby agree to adhere to the confidentiality standards of Apogee Health Partners, Inc.

Print Name

Signature

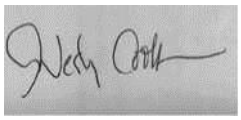
Title or Position

Date

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Standing Referrals**

APPROVED 

NUMBER	**MM - 04**
EFFECTIVE	March 2001
LAST REVIEWED	October 2016
LAST REVISED	December 2001
BY WHOM	V. Thompson, RN
REVISION NO.	03

POLICY

A member who has a disease or condition that requires an ongoing course of treatment from a specialist or other health care provider may request a standing referral from his/her Primary Care Physician. Examples of ongoing treatment would be dialysis (nephrologists), chemotherapy (Oncologist), or transplant patients. A standing referral will allow an Apogee member to have a single referral instead of multiple referrals. Standing referrals will require prior authorization by Apogee Health Partners, Inc. (AHP) medical management staff.

PROCEDURE

1. The Primary Care Physician will consult with the specialist and/or other health care provider to confirm that the member's plan of treatment calls for repeated services most appropriately provided by that specialty care provider.

2. The Primary Care Physician at his/her discretion may request a single referral (Standing Referral) specifying the duration, type and frequency of the specialty services needed to complete the member's ongoing course of treatment.

3. The medical management staff will review the referral for completeness and will perform a medical necessity review using nationally recognized medical criteria. The review will also evaluate the appropriateness of the site for services requested.

4. Referrals that lack sufficient clinical or other information will be faxed back to the PCP's office with a note identifying why the referral requires more information.

5. If the Standing Referral is approved, the PCP and member will be notified within the appropriate timeframe. Notice of approval shall also be sent to the specialist (either in writing or electronically) by AHP staff.

6. If the clinical information received does not meet criteria, the case will be referred to the Medical Director for a medical determination and decision within the appropriate timeframes for preauthorization. Referrals that are denied by the Medical Director and/or physician advisor as not meeting medical necessity or site/out of plan appropriateness will follow the standard denial process.

7. The Standing Referral will remain valid for a specified time period or for six (6) months, whichever comes first. The time frame will be determined during the medical review process.

8. The Primary Care Physician may request a renewal of a standing referral if the member continues to need specialist services for the same ongoing course of treatment.

9. When the standing referral expires, AHP medical management staff will notify the member in a timely manner, and assist in redirecting the member to an appropriate specialist who can provide the services related to the member's ongoing course of treatment.

10. If the member's benefits or the specialist's contract is terminated, the standing referral will no longer be valid, except if all conditions in the Transition of Care Policy are met.

11. When a specialist no longer has referral arrangements with AHP, the member will be notified, and the Primary Care Physician and AHP will redirect the member to an appropriate specialist who can provide the services necessary for the member's ongoing course of treatment. (Services specified in the original standing referral.)

12. If the member changes Primary Care Physician within the AHP group, and the change does not affect the medical group's contractual arrangements with the specialist, the original standing referral will remain valid.

13. If a member changes medical groups, the standing referral will no longer be valid.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Transition of Care**

APPROVED 

NUMBER	**MM - 05**
EFFECTIVE	March 2011
LAST REVIEWED	October 2016
LAST REVISED	January 2010
BY WHOM	J. W. Cook, DO
REVISION NO.	03

POLICY

Apogee Health Partners, Inc. (AHP) is committed to ensuring that patients who are new members of a Managed Care Plan, or are displaced due to the de-participation of a physician or termination of an IPA/Medical Group, receive uninterrupted care, especially in situations where the patient has a chronic condition, or degenerative or disabling disease. Transition of care services will allow AHP to assist in minimizing disruption of care, avoiding adverse clinical outcomes, and providing appropriate care expectations for the member.

PROCEDURE

1. Transition of care services are coordinated for new and existing members who are currently undergoing a course of evaluation and/or medical treatment, or have entered into the second or third trimester of pregnancy. Coverage is provided only for benefits outlined in the member's certificate.

2. Examples of medical treatment may include, but are not limited to the following:
    - 3rd trimester obstetrics
    - High risk obstetrics (as diagnosed during pregnancy)
    - Chemotherapy and other cancer treatments
    - Physical/Occupational/Speech Therapies
    - Allergy treatments
    - Psychotherapy
    - Scheduled invasive procedures (e.g. angioplasty, surgery)
    - Chronic illness (e.g. diabetes, hypertension) which requires frequent monitoring by a physician
    - Home Health Care
    - Current hospitalizations
    - Skilled Nursing Care
    - Infertility

3. Members are subject to the following:

    - New members must request the option of transitional services in writing to the Payer within 90 days after their eligibility effective date.

- Existing members must request the option of transitional services in writing to the Payer within 90 days after receiving notification of displacement.

4. Members who are receiving frequent or ongoing care for a medical condition, or a pregnancy that has entered the third trimester, may request assistance to continue with established specialists for a defined time. Such members will be directed to the appropriate Payer representative for help in this matter.

5. All member inquiries or requests regarding transition of care services will be referred to the appropriate Payer representative.

6. Upon receipt of confirmation from the Payer, AHP will record/document and authorize services approved by the Payer.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **UM Timeframes**

APPROVED 

NUMBER	**MM - 06**
EFFECTIVE	June 2005
LAST REVIEWED	October 2016
LAST REVISED	October 2016
BY WHOM	J. W. Cook, DO
REVISION NO.	04

POLICY

Timeframes have been established for Utilization Management activities including Preauthorization, Concurrent and Retrospective Review, Referrals, Denials, and Appeals. AHP will monitor compliance with timeframes to ensure timely communication with practitioners and members in accordance with all Payer, NCQA and URAC requirements.

Timeframes:

Preauthorization Standard Request	A decision is made within fourteen (14) days of receipt of all necessary information (within 15 days for commercial members.) However, the goal is that the determination be completed within five (5) business days of receipt of all necessary information. Practitioner is notified of the determination by telephone or in writing within one business (1) day of the decision.
Urgent Request	A decision occurs within seventy-two (72) hours of receipt of all necessary information. Practitioner is notified of the determination by telephone within one business (1) day of the decision.
Emergent Request	A decision is rendered as soon as possible upon receipt of all necessary information. Practitioner is notified of the determination by telephone within one business (1) day of the decision.
Initial Admission Review	A decision is made within one (1) business day of receipt of all necessary information. Practitioner is notified of the determination and the assigned LOS by telephone within one business (1) day of the decision.
Concurrent Review	A decision is made within one (1) business day of receipt of all necessary information. Practitioner does not receive notification, so long as continued stay is approved.
Retrospective Review	A decision occurs within thirty (30) days of receipt of all necessary information. Denial decisions are communicated in writing to the practitioner within five (5) days of the determination.

Denials	The Practitioner and Member are notified in writing within one business (1) day of the decision.
Expedited Appeal	A decision will be rendered, within one (1) business day from the request. Written notice of the determination will be issued to the member within fifteen (15) business days of the determination.
Standard Appeal (Member)	A decision will be rendered within fifteen (15) business days of receipt of all necessary information.

AUDIT PROCEDURE

1. The medical management staff will log all initial requests, decisions, notifications and confirmations in the utilization management information system.

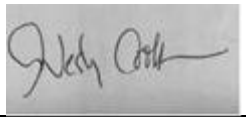
2. A monthly audit of five randomly selected cases in each of the review categories listed above will be conducted by the Director of Clinical Services, or designee, to evaluate compliance with timeframes for rendering determinations and providing notification to practitioners and members.

3. Issues of non-compliance to requisite timeframes are identified and addressed with the individual Health Management Specialist. Plans for performance improvement are implemented and evaluated on an ongoing basis by the Director or designee.

4. Quarterly audit results are presented to the QI/MM Committee to assess quality and diligence of medical management activities.

5. The QIMMC will develop appropriate corrective actions for processes that consistently deviate (> 5% of the time) from the established timeframes. The Medical Director will be responsible for implementing those actions and monitoring performance improvement.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 07**
TITLE	**Audit of Medical Management Staff Performance**	EFFECTIVE	March 2001
		LAST REVIEWED	October 2016
APPROVED		LAST REVISED	December 2001
		BY WHOM	V. Thompson, RN
		REVISION NO.	03

POLICY

Apogee Health Partners (AHP) audits or requires that any contracted entities performing medical management functions to audit the utilization review activities and determinations performed by the medical management staff and to evaluate the accuracy, timeliness and compliance with departmental, contracted payer, NCQA and any other applicable standards and guidelines.

GOAL

To provide quality control of utilization reviews performed by the medical management staff to assure fair, impartial, and consistent application of clinical review criteria in the decision-making process.

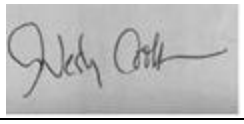
PROCEDURE

1. On a monthly basis, the Director of Medical Management or designee will audit a minimum of 5 randomly selected utilization management files for each Patient Care Coordinator who have been employed for 6 months or less. After 6 months of employment, the number of audited cases may be reduced to 3 per month, as long as a minimum 95% accuracy rate is maintained. The files will be evaluated for accuracy and completeness of data, compliance with established timeframes, compliance with program policies and procedures, appropriate application of review criteria, and appropriate referrals to the Medical Director. (See Exhibit A.) *(Note: Audit Tool may be modified based on available data.)*

2. All MM Staff must maintain an audit score of 95% or better. If an individual's audit score drops below 95%, the areas of non-conformance will be addressed with the staff member. If an individual's scores are below 95% for three consecutive audit periods, a corrective action plan will be developed.

3. The Director will be responsible to monitor the corrective active plan for performance improvement. If no improvement is observed, disciplinary action may be instituted.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 08**
TITLE	**Appointment and Accessibility Standards**	EFFECTIVE	March 2004
		LAST REVIEWED	October 2016
APPROVED		LAST REVISED	January 2005
		BY WHOM	V. Thompson, RN
		REVISION NO.	02

POLICY

The Appointment and Accessibility Standards were developed according to State standards established for office practices, accreditation standards established for ambulatory health providers. They contribute to a patient's overall quality of care and satisfaction of care. They are relevant, achievable and measurable.

These standards are communicated to all affected physicians and their offices staffs upon promulgation and when new physicians join Apogee Health Partners (AHP). AHP practitioners and their office staffs are responsible and held accountable for complying with the adopted standards.

PRIMARY STANDARDS

STANDARDS	DEFINITION	TIMEFRAME
Emergency	Emergency care is medical care given for a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the person afflicted with such condition in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person, and/or; (4) serious disfigurement of such person. Examples of emergency conditions include seizure, stab/gunshot wounds, diabetic coma, cardiac arrest, meningitis, obvious fracture (bone showing through skin).	Requires **immediate** face to face medical attention. If a practitioner, on-call or covering practitioner is not immediately available, the member or should be instructed to call 911 or go to the nearest emergency room.

Urgent Care	Urgent care is medical care given for a condition which, without timely treatment, could be expected to result in deterioration to an emergency, or cause prolonged, temporary impairment of one or more bodily function(s), or development of a chronic illness, or need for a more complex treatment. Examples of urgent conditions include, abdominal pain of unknown cause, unremitting new symptoms of dizziness, cause unknown; suspected fracture.	Requires triage and timely face-to-face medical attention within **24 hours** of member notification, if necessary.

Non-Urgent	Medical care given for an acute onset of symptoms which is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat, and nasal congestion.	Requires face-to-face medical attention within **two weeks** of member notification.
Routine Primary	Routine primary care services include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need for more complex treatment. Examples include, psoriasis, chronic low back pain.	Requires a face-to-face visit within **five weeks** of member request.

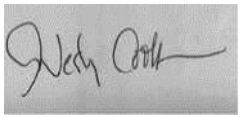
ADDITIONAL STANDARDS

STANDARDS	DEFINITION & BENCHMARK	OTHER INFORMATION
Office Waiting Time	Members with appointments are seen within **30 minutes** of their scheduled appointment time or arrival time, whichever is later. If a delay is unavoidable, the member should be informed and alternatives offered to the patient.	
24 Hour Accessibility	All AHP participating practitioners must be available either directly or through medical coverage arrangements 24 hours a day, 7 days a week, 365 days a year. Availability must be by live voice direct to the practitioner, on-call or covering practitioner or via an answering service that can reach the practitioner, on-call or covering practitioner. If an answering machine is utilized, it must connect the member to a live voice or a beeper number for emergencies and cannot simply refer the member to an emergency room. Response time to a call that is made after hours should be within **30 minutes**.	The practitioner answering the call must try to speak with the patient himself/herself, and not an intermediary to respect privacy concerns.
Emergency Services Access	At the initial visit with a PCP, members should be informed that they do not have to seek prior approval from their PCP for true emergency services. They should be instructed to call 911or go to the nearest emergency facility if an emergency occurs. They are also informed that they should notify their primary care provider the next business day, after receiving treatment. They are also reminded that all follow-up care must be coordinated through the primary care physician.	Via the 24-hour Accessibility Standard, the AHP primary care physicians are available to the members as needed on an emergency basis, twenty-four hours, seven days a week.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Staff Training: Medical Management**

APPROVED 

NUMBER	**MM - 09**
EFFECTIVE	July, 2001
LAST REVIEWED	October 2016
LAST REVISED	January 2009
BY WHOM	V. Thompson, RN
REVISION NO.	01

POLICY

All Apogee Health Partner, Inc. (AHP) staff performing Medical Management functions are trained by a Supervisor, Manager, Director, Medical Director or Managing Partner. The time required for training varies by individual based on their abilities, prior experience and specific job function.

PROCEDURE

1. All AHP personnel, who are answering phones or placing calls in the performance of utilization review procedures, shall indicate that they are AHP employees and provide their name and title.

2. The training includes core concepts in medical management, quality assurance and utilization management, legal/regulatory requirements and standards, managed care plan standards and requirements, position requirements as well as review of Apogee Health Partners operating policies and procedures.

3. A Training Checklist will be maintained and updated for all new employees, during the training process.

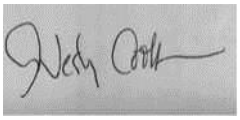
4. Appropriate reference materials should be available in the general work area and/or available on-line.

5. 100% of the work of newly trained professional staff members is reviewed for accuracy during the first thirty (30) days. After that period, and on an ongoing basis, the level of review is reduced based on the individual's performance per *Audit of Medical Management Staff Performance.*

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Affirmation Statement**

APPROVED 

NUMBER	**MM - 10**
EFFECTIVE	December 2001
LAST REVIEWED	October 2016
LAST REVISED	April 2011
BY WHOM	J. W. Cook, DO
REVISION NO.	03

POLICY

Apogee Health Partners makes all utilization and benefit coverage decisions based on information supplied by contracted health care plans and clinical data specific to a case in comparison with nationally recognized and/or locally developed criteria for appropriateness of care and service.

AHP affirms that the organization does not reward Providers or AHP Clinical Staff for issuing denial decisions. Neither does AHP Clinical Staff receive financial incentives to encourage decisions that result in underutilization.

PROCEDURE

In confirmation of the above policy, all personnel, whether directly employed or contracted by Apogee Health Partners (AHP), that are involved in utilization and/or benefit coverage decisions will sign the attached Affirmation Statement on an annual basis. Equivalent statements from contracted management organizations will be accepted.

Apogee Health Partners, Inc.
Utilization Management Affirmation Statement

My signature on this statement affirms that I have not been offered or received any incentives from Apogee Health Partners, Inc.(AHP) or any entities contracted with AHP for discouraging utilization of health care services. I have not been offered or received incentives for issuing denials of coverage and service. My utilization management decisions are based solely on the evaluation of clinical data presented as compared with nationally recognized criteria for appropriateness of care and service.

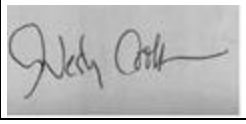
Print Name

Signature

Title

Date

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 11**
TITLE	**Clinical Guidelines for Physicians and Patients**	EFFECTIVE	May 2007
		LAST REVIEWED	October 2016
APPROVED		LAST REVISED	January 2009
		BY WHOM	J. W. Cook, DO
		REVISION NO.	01

POLICY

Apogee health Partners, Inc. (AHP) is committed to ensuring that medical criteria and guidelines are available to assist the UM staff when making clinical decisions about appropriate health care for patients in specific circumstances. These guidelines will:

- Describe appropriate care based on the best available scientific evidence and broad consensus
- Reduce inappropriate variation in practice
- Provide a more rational basis for decisions made about clinical referrals
- Act as a focus for quality control, including audit

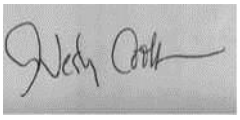
PROCEDURE

1. The medical criteria will be reviewed annually and modified as needed.
2. The clinical guidelines will be reviewed and approved as follows:
    - Review and approval by the Medical Director
    - Approval by the QIMMC
3. The medical criteria will be communicated to the PCPs and Specialists upon their request or to support a utilization or quality decision. At their request, it can either be read to the physician over the phone, faxed, mailed or e-mailed or be available for their review on-site during AHP's normal business hours.
4. In cases where a patient makes a request for the guidelines, the UM staff will speak with the member in order to make an assessment of the need to do telephonic education.
5. Based on the assessment done by the UM staff, the guidelines will be mailed to the patient when appropriate.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Application of Clinical Standards**

APPROVED 

NUMBER	**MM - 12**
EFFECTIVE	June 2004
LAST REVIEWED	October 2016
LAST REVISED	May 2007
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

Clinical standards serve as a reference for the medical management staff. All requested procedures and/or services must be medically necessary to be eligible for approval. Criteria and standards are provided for use in determining medical necessity. Procedures or services, which are not medically necessary, should not be approved by Apogee Health Partners, Inc. (AHP) medical management staff.

PROCEDURE

1. Medical management staff will review all requests for medical procedures, services and supplies for medical necessity. Medical necessity is met when all of the following criteria are met:

   a) Consistent with the symptoms or diagnosis and treatment of the member's injury or sickness

   b) Appropriate with regard to national or community standards or good medical practice as delineated by the following:

      - Widely used and accepted by practice peer group
      - Based on scientific evidence accepted by the majority of the practice peer group

   c) Not solely for the convenience of the member, physician, hospital or ambulatory care facility

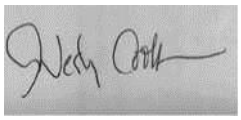
   d) FDA approved for the diagnosis (for applicable devices)

2. In the case of an appeal or a denied claim, the clinical standards serve as the governing document.

3. If the procedures, services or supplies are approved, the PCP and member will be notified within the appropriate timeframe. Notice of approval shall be sent either in writing or electronically, by AHP staff.

4. If the clinical information received does not meet criteria, the case will be referred to the Medical Director for a medical determination and decision within the appropriate timeframes. Referrals that are denied by the Medical Director and/or physician advisor as not meeting medical necessity will follow the standard denial process.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**
TITLE	**Second Opinion**
APPROVED	

NUMBER	**MM - 13**
EFFECTIVE	May 2007
LAST REVIEWED	October 2016
LAST REVISED	January 2009
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

Apogee Health Partners, Inc. (AHP) is committed to ensuring compliance with applicable state and federal regulations governing second opinions for patients. The plan shall provide for a second opinion from a qualified health care professional within its provider network, or arrange for the ability of the patient to obtain a second opinion. In cases where it may be necessary for the patient to seek services outside of the network, prior approval must be received from AHP.

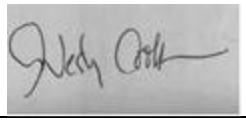
PROCEDURE

1. If the patient expresses that she/he wants to see another provider within the AHP network, the PCP must submit a referral to AHP.

2. If the patient expresses that she/he wants to see another provider outside the AHP network, prior approval is required and the PCP must submit a referral to AHP.

3. AHP will arrange for the out-of-network referrals as needed

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 14**
TITLE	**Transmission of Medical Information to Health Plans**	EFFECTIVE	June 2005
		LAST REVIEWED	October 2016
APPROVED		LAST REVISED	January 2009
		BY WHOM	J. W. Cook, DO
		REVISION NO.	01

POLICY

The Medical Management Department will take steps to assure that confidentiality is maintained for all information collected through any medical management related activity or process. Only information necessary to fulfill medical management requirements to contracted health plans will be communicated.

PROCEDURE

1. Medical Management staff will follow the procedures noted below:

    a) All patient specific information obtained during any medical management activity related to sentinel events or cases that meet the criteria for case/disease management will be submitted to the health plan within the agreed upon timeframes.

    b) Information pertaining to patients will be shared only with the designated health plan contact person(s).

    c) Only authorized medical management staff shall submit this confidential information to the health plan.

    d) Patient information will be captured on the referral log and the specific patients will be highlighted or marked in some fashion to identify it when information should be sent or has been sent to the health plan.

    e) All information obtained by AHP in connection with medical management activities shall be stored in secure files, physical or electronic, in accordance with AHP policies that shall accessible only to employees or designees authorized to participate in medical management activities.

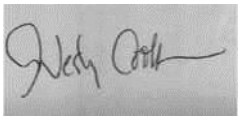
    f) AHP employees or designees shall notify their immediate supervisor in the event he/she is uncertain whether information meets criteria for submission, or in the event he/she is uncertain as to whether it is necessary to reveal such information.

g) A breach of confidentiality or the AHP Confidentiality Agreement may be grounds for immediate dismissal.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Cultural Competency Policy**

APPROVED 

NUMBER	**MM - 15**
EFFECTIVE	April 2008
LAST REVIEWED	October 2016
LAST REVISED	July 2014
BY WHOM	J. W. Cook, DO
REVISION NO.	02

POLICY

AHP acknowledges that its provider panel, as well as its patient panel, is culturally diverse. It is the intent of AHP to embrace the cultural diversity of its providers and patients. We believe this is an essential element required to grow our market share.

It is the goal of AHP to continue to build a “culturally appropriate” health organization that accommodates the preferences of its client population. AHP is committed to promoting access for patients with limited English proficiency, hearing impaired, cultural barriers and reducing health disparities in the provision of medical care to all racial/ethnic populations.

PROCEDURE:

1. AHP recruits multi-racial and multiethnic staff as part of diversity efforts, with intentions consideration in hiring bilingual individuals.

2. AHP recruits providers who reflect the composition of their patient population. Through monitoring incoming call requests on the cultural and special needs of the members, such as disability, gender, language and ethnicity, provider changes are made whenever necessary to meet those needs.

3. Utilization Management Staff will provide patients with the demographics of AHP physicians in their regional area, who speak their language. The staff understands that if the doctor and patient speak the same language, they will be able to communicate with each other and are more likely to have a successful medical encounter.

4. During the credentialing process, AHP collects information on the languages that providers speak. Utilizing that information, AHP is able to maintain a list of interpreters who could be available to provide interpreter services.

5. Upon receipt of a provider request for interpreter services in a specific situation where care is needed, AHP shall make contact with its TTY service provider to provide an interpreter in time to assist adequately, where technical, medical or treatment information is to be discussed or where use of a family member or friend as interpreter is inappropriate.

6. On request, AHP will assist enrollees in finding culturally appropriate care by an AHP preferred provider who can relate to the enrollee and provide care with sensitivity, understanding and respect for the enrollee's culture.

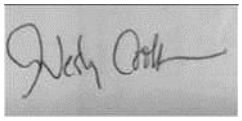
7. Orientation for new AHP staff is the most common venue for cultural competence training. Frequently cultural competence materials are integrated into the orientation program. AHP relies heavily on manuals and other written materials rather than in-person training to educate staff. Training topics ranged from cultural sensitivity to culture-specific information.

8. AHP will continue ongoing training and educational materials for AHP staff and providers to enhance their understanding of the values and practices of all cultures with which AHP interacts.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Inter-Rater Reliability Policy**

APPROVED 

NUMBER	**MM - 16**
EFFECTIVE	April 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2009
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

It is the policy of AHP to assure there is consistency in the review of submitted referrals. AHP will take steps to assure that there will be minor differences in the review of the submitted referrals. It is Apogee's goal to achieve less than a 5% variance among individuals reviewing referrals.

PROCEDURE:

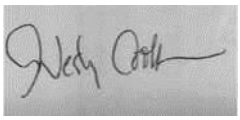
1. On a semi-annual basis, a minimum of 5 referrals will be reviewed for inter-rater reliability within the medical management team.

2. AHP Referrals reviewed by the nurse reviewer will be rated by the Medical Director or Associate Medical Director.

3. AHP Associate Medical Director referrals reviewed will be rated by the Medical Director and vice versa.

Attachment: RN Performance Audit Tool

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**
TITLE	**Case Management Services**
APPROVED	

NUMBER	**MM - 17**
EFFECTIVE	February 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2016
BY WHOM	J. W. Cook, DO
REVISION NO.	03

POLICY

Apogee Health Partners (AHP) works to help ensure that members receive quality services that are timely, medically appropriate, cost effective and provided in the most appropriate setting. AHP will watch for chronic care that is dynamic in nature and will help to ensure that it is focused on the individual and their family. Therefore, minimizing fragmentation and maximizing coordination of care via the health care team,

PROCEDURE:

1. The case management process is initiated as early as possible. As Apogee Health Partners is not delegated for providing the case management services, the AHP utilization management staff assists in ensuring that all members are assessed at the onset or diagnosis of an illness or injury, in order to evaluate the complexity of treatment.

2. While performing case review, the AHP utilization management staff actively work to identify members appropriate for case management based on established criteria for services, diagnoses for potential catastrophic case management or the severity of the case and identified needs.

3. The AHP utilization management staff will communicate with the member/family, primary care or attending physician, hospital discharge planner/case manager and/or social workers and outpatient and home care service providers and HMO help to coordinate and obtain medical services, as needed.

4. Resources available in the community and through the HMO and/or IHFS will be accessed to provide optimal post discharge care and follow-up.

5. The AHP utilization management staff will secure documentation of the member's care and progress toward treatment goals, as needed. Ongoing care will be routinely evaluated and the treatment plan will be adjusted as necessary.

6. On an as needed basis, the AHP utilization management staff will communicate with the member, family, primary care giver, primary care physician, and other providers, to provide education regarding insurance benefits so that informed decisions can be made regarding treatment plan options.

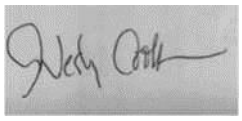
7. All members identified for case management will be recorded on the case management log for review and discussion at the monthly AHP Medical Management Committee meeting.

8. Case management logs will be forwarded to the individual patient's HMOs as required.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Referrals to Physician Advisor**

APPROVED 

NUMBER	**MM - 18**
EFFECTIVE	February 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2012
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

The Medical Management Department will take steps to assure effective health care is achieved for its members and that referrals to contracted Physician Advisors will be obtained in a timely manner and according to its approved guidelines. Thus, it is important that referrals to contracted Physician Advisors are made at the most appropriate point in the treatment process. Whenever appropriate, Board Certified Practioners will be utilized.

PROCEDURE

All referrals to contracted Physician Advisors will be handled by the utilization management staff under the direction of the Utilization Management Specialist and the Medical Director. In urgent and emergent situations, the utilization management staff will be required to contact contracted Physician Advisors by telephone to arrange timely appointments. In the unlikely event that a Physician Advisor cannot schedule an urgent review within one day, the member will be instructed to go to the nearest network facility to undergo an evaluation and, if necessary, a 23-hour observation. A referral to a Physician Advisor should fall into one of the following categories:

1. The member's clinical status indicates that there is a potential for danger to self, others, or property.

2. The member's clinical status has deteriorated to the point that increased symptoms interfere with the member's ability to care for himself/herself or carry out normal activities of daily living.

3. The member requires an outpatient evaluation or second opinion following the initial assessment of another contracted Provider or at the request of a PCP or other physician. .

4. Following a telephone intake assessment by the Utilization Management Specialist, if it is determined that the member is in need of medication management, then an expedited referral will be made to a local contracted Physician Advisor. A referral also will be made in conjunction with the member's PCP when he/she has a significant medical condition requiring the immediate coordination of all medical/psychiatric evaluations and treatments.

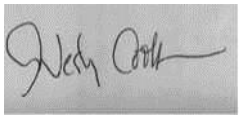
5. A referral to a Physician Advisor also will be made when the member has not responded

positively to a course of outpatient therapy, for a range of health conditions.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Flagging Sentinel Events**

APPROVED 

NUMBER	**MM - 19**
EFFECTIVE	February 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2009
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

The Utilization Management Department will take steps to assure that sentinel events are flagged. AHP will conduct continuous monitoring of healthcare delivery through the UM and CM processes and will investigate any unplanned, untoward patient occurrences, or quality indicators. The information will be reviewed in order to determine if a variance from expected provider performance and/or patient outcome is inconsistent with recognized standards of care.

PROCEDURE

All quality indicators, sentinel diagnoses, and potential quality indicators will be documented on the "Sentinel Diagnosis/Event Log"

The Utilization Management Staff will track the events individually and in the aggregate to identify provider trends. They will take the necessary steps to identify and report possible issues to the Medical Director.

The following sentinel diagnoses and events listed below are not always the result of a lapse in quality of care. They do, however, have the possibility of being caused by a deviation in the expected level of care. Thus, each occurrence will require investigation. The following are the defined sentinel diagnoses and events that are monitored on an ongoing basis. This list is not all-inclusive and used only as a guide:

- Diabetic coma (ketoacidosis)
- Revisit to an emergency room for the same diagnosis or condition within 48 hours
- Unplanned readmission within 14 days for the same diagnosis or a complication of the original diagnosis
- Unplanned return to surgery
- Nosocomial or post-operative infection / hospital incurred trauma
- Death - inpatient or known to the Plan

Clinical Quality Indicator Review

In addition to the defined quality indicators, any unplanned or untoward patient occurrence that the Utilization Management Staff, provider, Medical Director, or Physician Advisor feels is a variance from the expected outcome will be evaluated on a case-by-case basis. The level of intervention will depend on the severity of the issue and the participating or non-participating status of the provider.

Potential quality of care issues may be identified by the Utilization Management Staff or brought to their attention by another source. These are forwarded to the Managing Partner responsible for quality who will investigate and track them and if appropriate, forward them to the Medical Director for ranking and/or presentation to the Quality Improvement Medical Management Committee (QIMMC.)

The success of the investigation may depend on the participating or non-participating status of the provider. A participating provider, by contract, must cooperate with the UM and QM process, but a non-participating provider is under no obligation to cooperate. The Medical Director will attempt to contact the non-participating provider or the designated Quality Management representative, to discuss the issue and appropriate steps to correct the situation.

Severity Ranking

Following investigation and validation of the care provided, each occurrence will be given a severity ranking to designate the level of intervention and follow up. The level of follow up will be governed by the participating or non-participating status of the provider. In extreme cases (i.e. Level III or multiple Level I and Level II), the Committee will notify the AHP Provider Relations Department, appropriate facilities and/or regulatory agencies of the findings.

Severity Levels are as follows:

Level 0: No confirmed quality issue.

Level I: Confirmed quality of care issue with minimal or no adverse effect on the patient (i.e. Medication error that caused minimal or no patient signs or symptoms).

Level II: Confirmed quality of care issue with an adverse effect on patient (i.e. significant additional treatment).

Level III: Confirmed quality of care issue with a severe adverse effect on patient (i.e. temporary or permanent dysfunction or death).

AHP intervention and follow up:

- Level 0: Requires no further action and is not made part of a participating providers file.
- Levels I, II, and III: If it is determined that standards of care are not being met or members have been placed at risk due to inaccurate diagnosis and/or inappropriate treatment, the QIMMC will seek improvement through oral communication between the Medical Director and the physician in question.
- Level II and III: Requires written notice to the physician, which clearly explains the deficiency and corrective action and allows for a maximum of two-week response

period.

- If the details of the case and/or the severity level warrants, (i.e. Level III or multiple Level I and Level II), the process may result in restricting or terminating a provider's participation in the AHP network.

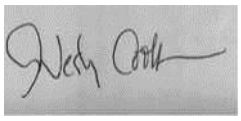
- Cases with severity Level I, II and III are included in a participating provider's file and reviewed at the time of recredentialing.

- The QIMMC shall discuss such deficiencies at the quarterly meetings, and corrective action shall be created and recorded in the minutes. The Committee may recommend dismissal of a physician from AHP if there is no improvement or repeated infractions.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Member/Provider Satisfaction Survey**

APPROVED 

NUMBER	**MM - 20**
EFFECTIVE	February 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2011
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

It is the goal of Apogee Health Partners, Inc. to have its UM Program use a synergistic approach for analyzing its members' and practitioners' satisfaction. Bi-annually, a customer satisfaction survey will be conducted to assess the satisfaction with pre-certification, authorization and overall satisfaction with the UM program. The appropriate steps will be taken to assure customer satisfaction and to comply with regulatory requirements and all applicable state and federal laws.

PROCEDURE:

1. The Managing Partner responsible for quality or his/her designee identifies a sample of eligible members according to the requirements as set by the Managed Care Organization. Care will be taken to make sure that all selected members have been eligible with AHP for one year with an allowable 45-day gap in coverage.

2. The customer satisfaction survey is then mailed out to all members on the list.

3. The results are obtained by the Managing Partner or his/her designee to analyze and prepare detailed report.

4. The results are sent to the Medical Director and the Quality Improvement Medical Management Committee (QIMMC).

5. The QIMMC will analyze the results and conduct a barrier analysis.

6. The Quality Improvement Committee develops a corrective action plan and interventions to address barriers.

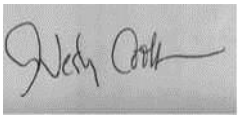
7. All analysis, results, barriers and interventions will be sent to the QIMMC for recommendations and approval.

8. Findings will be reported to providers, employees, AHP Providers Relations Department and members via one or more appropriate communication vehicles.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION Medical Management

TITLE Centralized Medical Record Policy

APPROVED 

NUMBER	MM - 21
EFFECTIVE	February 2008
LAST REVIEWED	October 2016
LAST REVISED	July 2011
BY WHOM	J. W. Cook, DO
REVISION NO.	02

POLICY

The Medical Management Department will take steps to assure that confidentiality is maintained for all centralized medical records, related to information collected through any medical management related activity or process. Only information that is used in authorizing or denying medical services, will be maintained for the members of Apogee Health Partners, Inc (AHP).

PROCEDURE:

1. Utilization Management Staff will enter all information regarding services authorized or denied into the AHP computer system.

2. The AHP computer system is password protected and it is the responsibility of all UM staff to maintain secure access to their medical electronic data.

3. All UM staff will maintain medical records in such a manner that access to it is restricted to those with a need to know and release of it is restricted to those with a legal right to know as mandated by federal, state and local laws.

4. All UM staff will store in a secure area and maintain in a confidential manner, hard copy data, supporting documents and printouts of aggregate and patient-identifiable data.

5. All claims records will be kept for Ten (10) years, as per regulatory requirements.

6. After ten (10) years, the physical medical records should be destroyed and electronic information deleted or purged in an authorized, systematic manner

7. Disposition action will consist of:

8. Immediate physical destruction, including purging, overwriting and deletion of electronic records

9. Destruction of hard copy documents via cross cut shredder or appropriate waste sacks.

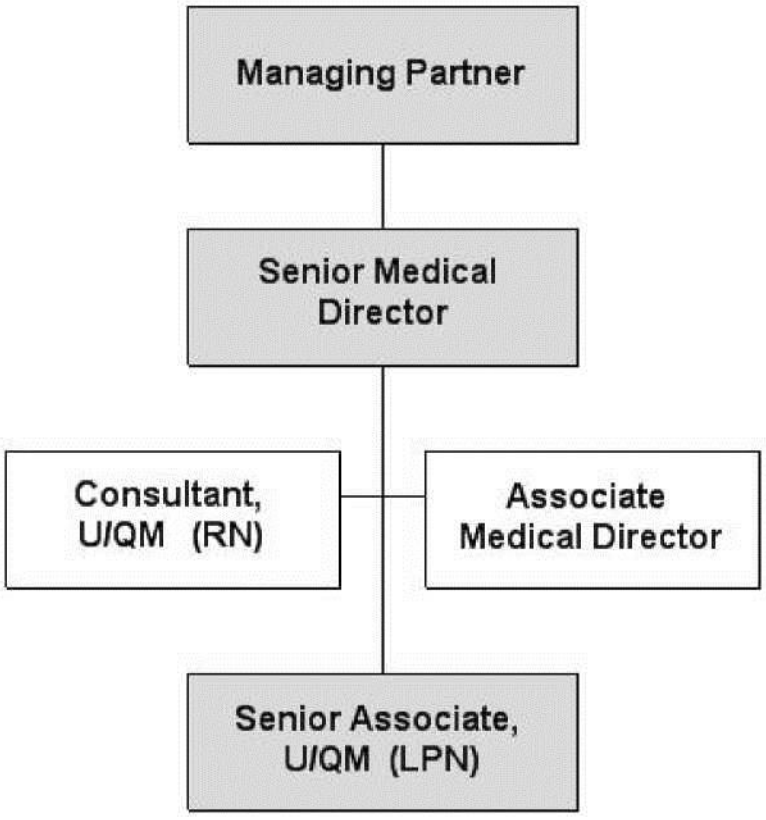
10. Disposal should be recorded on a log. Initials of the person destroying the document and date of destruction should be noted on the log.

11. AHP's management is responsible for enforcing this policy. Individuals who violate this policy will be subject to the appropriate and applicable disciplinary process, up to and including

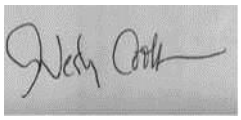
termination or dismissal

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 22**
TITLE	**Organizational Chart**	EFFECTIVE	May 2008
		LAST REVIEWED	October 2016
APPROVED		LAST REVISED	January 2009
		BY WHOM	R.W. Ree
		REVISION NO.	01



Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**
TITLE	**Lack of Information Policy**
APPROVED	

NUMBER	**MM - 23**
EFFECTIVE	April 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2011
BY WHOM	J. W. Cook, DO
REVISION NO.	02

POLICY

The Apogee Health Partners, Inc (AHP) Medical Management Department supports consistent processing of requests for health care services when medical information is not received for the requested service.

PROCEDURE:

1. PCP/Specialist makes contact with the AHP UM staff for the purpose of requesting authorization of health care services.

2. All reasonable efforts will be made by the AHP UM staff to obtain the necessary information from the provider and/or his/her designee, required to make a timely decision related to requests for medical services. If additional information is needed in order to make a valid determination, the UM staff notifies the PCP or authorized representative, of what specific information is necessary to make a decision. The UM staff will limit the request for additional information to only the information necessary to authorize the service, procedure, or treatment. The provider and/or his/her designee may submit requests for services to AHP UM Department by phone, fax, or electronic submission.

3. For urgent pre-service decisions, if the AHP UM staff is unable to make a decision due to lack of necessary information, AHP extends the decision time frame for up to two (2) business days within the 24 hours of receipts of the request. For non-urgent pre-service decisions, the AHP UM staff will allow the PCP/Specialist ten (10) business days to provide the medical information required, in order to complete the medical necessity review.

4. The request for additional information is made as soon as possible, from the date of receipt of the original request. The AHP UM staff will send at least two faxed requests to the provider, requesting the additional information. If there is no response from the provider regarding the two faxed requests within two working days of the second faxed request, the UM Staff will make a call to the Provider to request the information. For commercial members, the UM Staff will make three (3) attempts to contact the provider within a twenty-four (24) hour time-frame, by at least two (2) different routes of communication (fax and phone.) If there is still no response from the Provider, within five (5) days of the final information request, the UM Staff will cancel the request. The request can then be resubmitted by the PCP with all required information.

5. If denied by the Medical Director (or Physician Advisor), the PCP is notified of the denial by phone and/or facsimile and afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis with the AHP Medical Director, if requested.

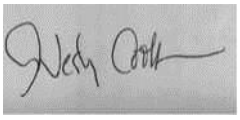
6. The Medical Director may call the Provider directly or an AHP UM staff member may call the provider's office leaving information as to when the Medical Director will be available to discuss the potential adverse determination, as well as the telephone number for contacting the Medical Director. If the case results in an adverse determination, all requirements related to an adverse determination will be followed. A letter will be sent to both the Provider and the patient, stating that processing of the request cannot be completed without the necessary information and that the referral has been denied. The letter will also indicate that the processing of the request can be re-initiated once the necessary information has been received.

7. If denied by the Medical Director, the denial letter will state: the reason for the determination, including a summary of the criteria upon which the denial was based; alternative care recommendations as appropriate; the right to an appeal; how to initiate the appeal process; information about how to contact the Medical Management Department in order to discuss the denial decision; and signature, with title of the Medical Director (or Physician Advisor).

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Patient Eligibility Policy**

APPROVED 

NUMBER	**MM - 24**
EFFECTIVE	April 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2009
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

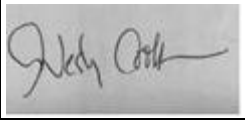
The Medical Management Department will be consistent in the process of identification, documentation and call handling of providers/patients. The staff will ensure that only AHP identified, eligible patients receive medically appropriate services.

PROCEDURE:

1. Eligibility is a term used to define who can use AHP services. If a patient is eligible, he/she has access to the components of medically necessary services as requested by the PCP. Before a patient record is selected, the UM staff will verify that the correct record is selected by confirming the patient's birth date or address.

2. The AHP Staff will never indicate that a patient is not eligible. They should simply indicate that the requested patient does not show as eligible for the service that is being requested. The person should be referred to the Health Plan's member service department in order to confirm eligibility.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 25**
TITLE	**Physician Credentialing Verification Policy**	EFFECTIVE	April 2008
		LAST REVIEWED	October 2016
APPROVED		LAST REVISED	January 2009
		BY WHOM	J. W. Cook, DO
		REVISION NO.	01

POLICY

It is the policy of AHP to assure there is consistency in the credentialing process for all physicians. Verification will take place for all physician consultants, as deemed necessary.

PROCEDURE:

1. Follow the credentialing process, as applicable.

2. Verify that physicians meet the following requirements upon review:

- Qualified and responsible to perform clinical services/programs provided.
- Have valid, active and applicable state licensure
- Have post-graduate experience in direct patient care
- Board Certification

3. Verify that physician applicants meet all established PHO requirements.

4. Have confidentiality and applicable agreements signed.

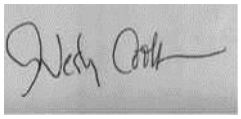
5. All pertinent information is input into the AHP computer system.

Apogee Health Partners, Inc.

Policies and Procedures

SECTION Medical Management

TITLE Medical Record Retention Policy

APPROVED 

NUMBER	MM - 26
EFFECTIVE	July 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2009
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

The Medical Management Department will take steps to assure that medical records are maintained as per legal and business requirements. All employees who are involved in the maintenance of proprietary records and information shall maintain the confidentiality and security of the stored information.

PROCEDURE:

1. All UM staff will maintain medical records in such a manner that access to it is restricted to those with a need to know and release of it is restricted to those with a legal right to know as mandated by federal, state ad local laws.

2. All UM staff will store in a secure area and maintain in a confidential manner, hard copy data, supporting documents and printouts of aggregate and patient-identifiable data.

3. All medical records will be kept for ten (10) years, as per regulatory requirements.

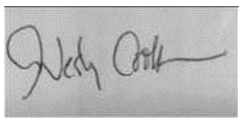
4. After ten (10) years, the physical medical records should be destroyed and electronic information deleted or purged in an authorized, systematic manner

5. AHP's management is responsible for enforcing this policy. Individuals who violate this policy will be subject to the appropriate and applicable disciplinary process, up to and including termination or dismissal

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Physician Office Chart Review Policy**

APPROVED 

NUMBER	**MM - 27**
EFFECTIVE	November 2008
LAST REVIEWED	October 2016
LAST REVISED	January 2009
BY WHOM	J. W. Cook, DO
REVISION NO.	01

POLICY

AHP has a Physician Office Chart Review program in place to evaluate physician performance by AHP providers. The reviews document the results and appropriate action taken. The analyses will enable the development of a corrective action plan for the individual physicians.

PROCEDURE:

1. A minimum of ten (10) medical records for an individual physician, or an equivalent of 1% of the total annualized enrollment, whichever is less, will be reviewed monthly and results reported to the QIMMC.

2. Records will be audited the month prior to the QIMMC meeting.

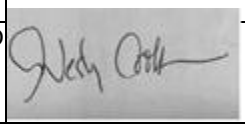
3. Medical records are reviewed for format, legibility, signature, date, appropriate documentation, diagnostic testing, treatment and follow-up care, and clinical indicators as required by the Payer.

4. Corrective action and follow up will be developed for any deficiencies.

5. Findings will be reported to providers, Quality Improvement Medical Management Committee (QIMMC) and AHP Providers Relations Department via one or more appropriate communication vehicles.

Attachment: Medical Record Evaluation Tool

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	NUMBER	**MM - 28**
TITLE	**Notice of Privacy Practices in the Physician Office Policy**	EFFECTIVE	November
		LAST REVIEWED	October 2016
		LAST REVISED	January 2009
APPROVED		BY WHOM	C Carriaga MD
		REVISION NO.	01

POLICY

AHP will ensure that all AHP Practitioners, Providers and their employees are in compliance with all state and federal regulations in regards to privacy and Protected Health Information. The document titled "Notice of Privacy Practices" will be one of the vehicles used to explain how medical information about the patient may be used and disclosed and how they can get access to the information.

PROCEDURE:

1. All AHP Practitioners, Providers and their employees are required to provide a "Notice of Privacy Practices" document to all of their members, as they present to their offices for services.

2. Compliance will be monitored via physician office chart audits and random patient Medical records will be reviewed.

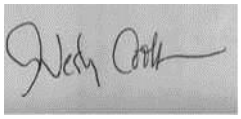
3. Corrective action and follow up will be developed for any deficiencies.

4. Findings will be reported to providers, Quality Improvement Medical Management Committee (QIMMC) and AHP Providers Relations Department via one or more appropriate communication vehicles.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **PHI Notification & Privacy Practices**

APPROVED 

NUMBER	**MM - 29**
EFFECTIVE	May 2009
LAST REVIEWED	October 2016
LAST REVISED	October 2014
BY WHOM	J. W. Cook, DO
REVISION NO.	00

POLICY

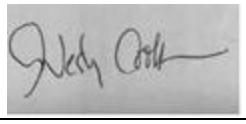
Apogee Health Partners, Inc (AHP)., on an annual basis, will inform its providers of their responsibility to provide a "Notice of Privacy Practices" to all of their patients insured through one of Apogee Health Partners' managed care plans. A sample policy or form will be included in the mailing. An example of a mailing is attached to this policy.

Compliance will be monitored through physician office chart audits and the findings will be reported to the Medical Management Committee.

PROCEDURE

A mailing will be sent to each of the AHP providers, as a remainder, on an annual basis.

Apogee Health Partners, Inc.
Policies and Procedures

SECTION	**Medical Management**	**NUMBER**	**MM - 30**
TITLE	**Primary Care Physician (PCP) Responsibilities**	**EFFECTIVE**	**January 2011**
		LAST REVIEWED	**October 2016**
APPROVED		**LAST REVISED**	**October 2011**
		BY WHOM	**J. W. Cook, DO**
		REVISION NO.	**00**

POLICY

A Primary Care Physician (PCP) with the Health Plan is responsible for providing, arranging, and coordinating all aspects of the member's health care for those members assigned to the PCP, and for directing and managing appropriate utilization of health care resources. Apogee Health Partners (AHP) recognizes the PCP as the focal point of all care management for members in the HMO. HMO contracted General Practice, Family Practice, Internal Medicine, Obstetricians/Gynecologist and Pediatric physicians are all recognized as PCPs.

PROCEDURE

1. A PCP is expected to provide all necessary care required by a member that is within the scope of his/her practice and expertise. The PCP is responsible for evaluating the patient's needs and directing their care, including working them into the schedule during normal office hours when at all practical.

2. The PCP should refer a member to a specialist or other provider only when he or she is not able to provide the specialty care.

3. A member will not usually receive authorization for referrals to medical providers or facilities not associated with AHP, unless these services cannot be provided by AHP Preferred Providers. Thus, the PCP must refer members to AHP Preferred Providers unless approval is received in advance from the AHP UM staff. The PCP must advise AHP that services are requested by non-AHP Preferred Providers, prior to the specialty visit, unless the member has an emergency situation, and if the PCP, in his/her best medical judgment at the time, feels that delay could reasonably be expected to result in physical harm to the member.

4. The PCP is expected to provide qualified, consistent, easily accessible on-call coverage seven days a week, 24 hours a day, either personally or by a reasonable call coverage arrangement with other appropriate individuals. The PCP instructs all of their members to contact them first, when they need urgent or emergent care. In urgent or emergent situations, after office hours, the PCP or his/her

qualified coverage, is expected to provide access to a health care provider to

advise the patient on the course of care they should follow. After-hours coverage may not solely consist of directing members to a hospital emergency room.

5. The PCP will receive a listing of members, with monthly updates, which have selected or been assigned to him or her, for which they are responsible to oversee delivery of health care services. If a member is not on the PCP's eligibility list, the PCP is required to contact the Health Plan's Member Services Department to determine eligibility when contacted by the member seeking care. Failure to verify assignment to the PCP may prevent the PCP from receiving reimbursement from the Health Plan for services rendered.

6. The PCP is expected to submit a referral request form to AHP UM staff, prior to referring a member for services, unless the required services are emergent.

7. The PCP must provide a copy of the precertification form, with the number of visits approved and the AHP assigned authorization number, to the member. The PCP retains a copy for member's ambulatory medical record. The member is instructed to bring the original copy with them to their scheduled appointment with the Specialist or Ancillary Provider.

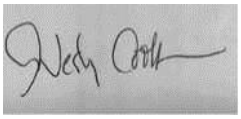
    Precertification is required for all of the following:

    - Specialist consultation
    - Outpatient Surgery/Procedure/Service
    - Physical or Occupational Therapy (more than 3 visits)
    - Non AHP Preferred Podiatric and Chiropractic Care
    - Infertility Treatment
    - Cardiac Rehabilitation
    - Radiation Therapy/Chemotherapy

Apogee Health Partners, Inc.
Policies and Procedures

SECTION **Medical Management**

TITLE **Emergency Care Services**

APPROVED 

NUMBER	**MM - 31**
EFFECTIVE	January 2011
LAST REVIEWED	October 2016
LAST REVISED	January 2011
BY WHOM	J. W. Cook, DO
REVISION NO.	00

POLICY

Apogee Health Partners, Inc. (AHP) provides coverage for emergency medical conditions. A medical emergency is defined as a medical condition with acute symptoms of sufficient severity, including but not limited to severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the lack of immediate medical attention to result in:

- serious jeopardy to the person's health or unborn child's health
- serious impairment to body functions
- serious dysfunction of any bodily organ or party

Claims payment for Emergency Room Services rests with AHP. Out of area emergency visits (defined as facilities located fifty (50) miles or more from the Cook County boundaries) and Emergency Room services incurred by the members of AHP, are the responsibility of the Payer (the HMO Health Plan).

PROCEDURE

1. AHP uses the following Emergency Room review protocols:

    - Emergency Room services are approved without precertification in cases where a prudent layperson, acting reasonably, believed that an emergency condition existed or if an authorized representative acting for AHP, authorized the provision of emergency services.
    - Presenting symptoms are reviewed prior to denial of emergency services.
    - Denials are based on discharge diagnosis alone
    - AHP does not retroactively deny a service because a condition, which appeared to be an emergency on the date of the service, turned out to be non-emergent.

2. AHP members, who feel that their situation life threatening, are instructed by their assigned PCP or designated AHP representative, to go to the nearest hospital, call an ambulance or call 911.

3. If AHP members call the AHP offices during office hours (at 773-737-7300), for permission to go to the Emergency Room, they will be immediately referred to the designated AHP Utilization Management Staff representative or the AHP Medical Director and instructed to make contact with their PCP.

4. If the members place a call to AHP after office hours, they will be instructed by the after- hour answering service to use their best judgment in determining whether to go to the Emergency Room or contact their PCP.

5. Please refer to Concepts - Emergency Services policy, CL - 30, for more specific procedural information.

Apogee Health Partners, Inc.
QUALITY IMPROVEMENT / MEDICAL MANAGEMENT COMMITTEE
Month XX, 200X

AGENDA

Call to Order	Chair	
APPROVAL OF MINUTES		
Minutes of Month XX, 200X [1] [2]	Chair	ACCEPT
OLD BUSUNESS		
Item #1*	Director	ACTION
STATISTICS		
Quarter X 200X *	Director	DISCUSSION
CREDENTIALING/RECREDENTIALING		
Physician #1 *	Director	ACTION
MEDICAL MANAGEMENT		
Case Management / Catastrophic Cases*	Director	DISCUSSION
Denial/Appeal Log Review *	Director	DISCUSSION
Complaint Log *	Director	DISCUSSION
Case Review *	Director	DISCUSSION
Chart/Office Audits *	Director	DISCUSSION
Referral Log Review *	Director	DISCUSSION
Internal Audit Results *	Director	DISCUSSION
OTHER BUSINESS		
Next Meeting Date	Chair	ACTION
Adjournment		

1 Attachments included with the agenda.
2 Material to be distributed at the meeting.