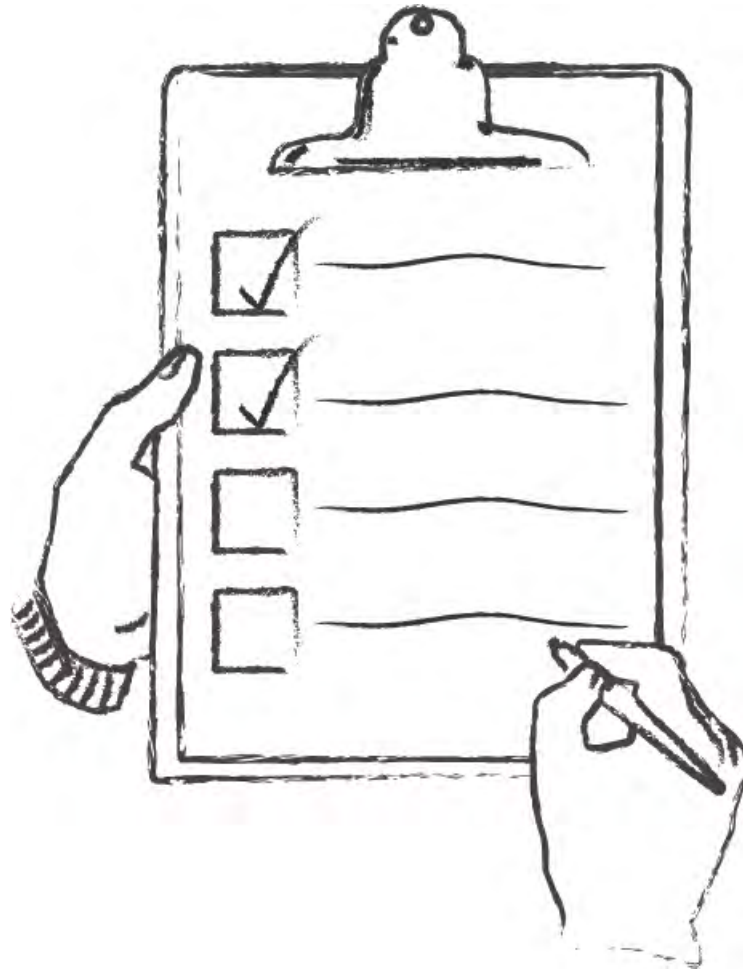


Section VIII

Quality Assurance Performance Improvement, Credentialing, and Utilization Management



Quality Assurance and Performance Improvement

Quality Assurance and Performance Improvement (QAPI) is an integrative process that links together the knowledge, structure and processes throughout a Managed Care Organization to assess and improve quality. This process also assesses and improves the level of performance of key processes and outcomes within an organization. Opportunities to improve care and service are found primarily by examining the systems and processes by which care and services are provided.

Purpose and Scope

The purpose of the QAPI Program is to provide the infrastructure for the continuous monitoring, evaluation, and improvement in care and service. The QAPI Program is broad in scope and encompasses the range of clinical and service issues relevant to Members. The scope includes quality of clinical care, quality of service, and preventive health services. The QAPI Program continually monitors and reports analysis of aggregate data, intervention studies and measurement activities, programs for populations with Special Needs and surveys to fulfill the activities under its scope. The QAPI Program centralizes and uses performance monitoring information from all areas of the organization and coordinates quality improvement activities with other departments.

Objectives

The objectives of the QAPI Program are to systematically develop, monitor and assess the following activities:

- Maximize utilization of collected information about the quality of clinical care and service and to identify clinical and service improvement initiatives for targeted interventions
- Ensure adequate practitioner and Provider availability and accessibility to effectively serve the membership
- Maintain credentialing/recredentialing processes to assure that the Managed Care Organization's network is comprised only of qualified practitioners/Providers
- Oversee the functions of delegated activities
- Continue to enhance physician profiling process and optimize enhanced systems to communicate performance to participating practitioners
- Coordinate services between various levels of care, Network Providers, and community resources to assure continuity of care
- Optimize Utilization Management to assure that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- To ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize Member and Network Provider satisfaction study results when implementing quality activities
- Implement and evaluate Disease Management programs to effectively address chronic illnesses affecting the membership
- Maintain compliance with evolving National Committee for Quality Assurance (NCQA) accreditation standards

- Communicate results of our clinical and service measures to Network Providers, and Members
 - Identify, enhance and develop activities that promote Member safety
 - Document and report all monitoring activities to appropriate committees
- An annual QAPI work plan is derived from the QAPI Program goals and objectives. The work plan provides a roadmap for achievement of program goals and objectives, and is also used by the QM Department as well as the various quality committees as a method of tracking progress toward achievement of goals and objectives
 - QAPI Program effectiveness is evaluated on an annual basis. This assessment allows Keystone First to determine how well it has deployed its resources in the recent past to improve the quality of care and service provided to Keystone First membership. When the program has not met its goals, barriers to improvement are identified and appropriate changes are incorporated into the subsequent annual QI work plan. Feedback and recommendations from various committees are incorporated into the evaluation

Quality Assurance and Performance Improvement Program Authority and Structure

Keystone First's Quality Assurance and Performance Improvement Committee (QAPIC) provides leadership in Keystone First's efforts to measure, manage and improve quality of care and services delivered to Members and to evaluate the effectiveness of Keystone First's QAPI Program through measurable indicators. All other quality-related committees report to the QAPIC.

Other quality-related committees include the following:

Credentialing Committee

The Credentialing Committee is a peer review committee whose purpose is to review Providers' credentialing/recredentialing application information in order to render a decision regarding qualification for membership to Keystone First's Network.

Health Education Advisory Committee

The Health Education Advisory Committee is responsible for advising on the health education needs of Keystone First, specifically as they relate to public health priorities and population-based initiatives. The Health Education Advisory Subcommittee is also responsible for ensuring coordination of health education activities with DHS for the benefit of the entire HealthChoices population or populations with Special Needs.

Pharmacy and Therapeutics (P&T) Subcommittee

The P&T Subcommittee is responsible for evaluating the clinical efficacy, safety, and cost-effectiveness of medications in the treatment of disease states through product evaluation and drug Formulary recommendations. The Subcommittee also uses drug prescription patterns to develop Network Provider educational programs.

Quality Assurance and Performance Improvement Committee (QAPIC)

The Quality Assurance and Performance Improvement Committee (QAPIC) coordinates the Keystone First’s efforts to measure manage and improve quality of care and services delivered to Keystone First Members and evaluates the effectiveness of the QAPI Program. It is responsible for directing the activities of all clinical care delivered to Members.

Quality of Service Committee (QSC)

The QSC is responsible for measuring and improving services rendered to Members and Providers in the Member Services, Claims, Provider Services, and Provider Network Management Departments.

Recipient Restriction Subcommittee

The Recipient Restriction Subcommittee is responsible for identifying, evaluating, monitoring, and tracking potential misutilization, Fraud and abuse by Members.

Operational Compliance Committee

The purpose of the Operational Compliance Committee (OCC) is to assist the Chief Compliance Officer and the Privacy Officer with the implementation and maintenance of the Corporate Compliance and Privacy Programs.

Southeast Behavioral Health/Physical Health MCO Pharmacy & Therapeutics Committee

The Southeast Behavioral Health/Physical Health MCO Pharmacy & Therapeutics Committee reviews behavioral health medication policies and concerns and provides input to the Pharmacy and Therapeutics Subcommittee. This committee acts as a consultant to the Pharmacy and Therapeutics Subcommittee and meets quarterly.

Confidentiality

Documents related to the investigation and resolution of specific occurrences involving complaints or quality of care issues are maintained in a confidential and secure manner. Specifically, Members' and Health Care Providers' right to confidentiality are maintained in accordance with applicable laws. Records of quality improvement and associated committee meetings are maintained in a confidential and secure manner.

Credentialing/Recredentialing Requirements

Provider Practitioner Requirements

Keystone First maintains and adheres to all applicable State and federal laws and regulations, DHS requirements, and accreditation standards governing credentialing and recredentialing functions.

The following types of practitioners require initial credentialing and recredentialing (at a minimum of every 36 months):

- | | | |
|--------------------------|---------------------------|----------------------------|
| Audiologists | Dentists | Physicians (DO's and MD's) |
| Certified Nurse Midwives | Occupational Therapists * | Podiatrists |

Chiropractors	Oral Surgeons	Speech Therapists/ Speech & Language Pathologists *
Registered Dieticians	CRNPs	Physical Therapists*
Therapeutic Optometrists		

*Only private practice (practitioners who have an independent relationship with Keystone First) occupational, physical and speech therapists require credentialing.

Locum tenens employed by a healthcare system or a hospital would be required to be credentialed by that organization or for that organization by another credible body. If the provider will be serving for a longer term, greater than 60 days, and credentialing is not delegated to the organization, or its surrogate, Keystone First will credential those locum tenens identified by the organization.

All Provider and Facilities are required to be recredentialed or recertified at a minimum of every three years. All items noted in the Credentialing section are required at the time of recredentialed or recertification, with the exception of work history and education for practitioners. All primary source verifications noted above are conducted at the time of recredentialed and recertification.

Once the Provider or Facility application has been processed and all Primary Source Verifications have been completed, the file is presented to either the Medical Director (clean/routine files) or the Credentialing Committee (non-routine files) for review and approval.

The following criteria must be met as applicable, in order to evaluate a qualified Health Care Practitioner:

- **A current, active and unrestricted Individual Medicaid number** along with service location numbers for each address contracted with Keystone First (applications submitted without an active Medicaid or PPID number must be accompanied by a copy of the enrollment application; individual and/or service location applications);
- **An individual NPI number**
- A current unrestricted state license, not subject to probation, proctoring requirements or disciplinary action to specialty. A copy of the license must be submitted along with the application
- A valid DEA certificate, if applicable. The DEA certificate must have an address listed in the State where the Provider is treating Members. The DEA certificate is non-transferrable by location.
- Education and training that supports the requested specialty or service, as well as the degree credential of the Health Care Practitioner
- Foreign trained Health Care Providers must submit an Education Commission for Foreign Medical Graduates (ECFMG) certificate or number within the application
- Board certification Certificate, if applicable.
- The following board organizations are recognized by Keystone First for purposes of verifying specialty board certification:

- American Board of Medical Specialties – ABMS
- American Medical Association - AMA
- American Osteopathic Association - AOA
- American Board of Foot and Ankle Surgery - ABFS- ABPS
- American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
- Royal College of Physicians and Surgeons
- Work history containing current employment, as well as explanation of any gaps greater than six months within the last (5) years
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the Health Care Provider in the past 5 years
- A current copy of the professional liability insurance face sheet (evidencing coverage – minimum coverage amount of \$500,000/\$1.5million)
- Health Care Providers who require hospital privileges as part of their practice must have a hospital affiliation with an institution participating with Keystone First. PCPs must have the ability to admit as part of their hospital privileges. As an alternative, those Health Care Providers who do not have hospital privileges, but require them, may enter into a collaboration agreement with a participating Health Care Provider(s) who is able to admit. Those Providers who do not have admitting privileges may also utilize a hospitalist service at a Keystone First participating hospital. CRNP's and CNM's must have agreements with the covering participating physician.
- Explanation to any affirmative answers on the “General Questions” section of the application
- Current CLIA certificate, if applicable. CLIA certificate is required for all addresses where the practitioner has a lab in the office where services are being rendered to Keystone First Members.
- Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or other appropriate professional organization

Provider Application

Keystone First offers practitioners the Universal Provider Datasource through an agreement with The Council for Affordable Quality Healthcare (CAQH) that simplifies and streamlines the data collection process for credentialing and recredentialing.

Through CAQH, credentialing information is provided to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH.

There is no charge to providers to participate in CAQH or to submit applications. Keystone First encourages all providers to utilize this service.

Submit your application to participate with Keystone First via CAQH (www.caqh.org):

- Register for CAQH
- Grant authorization for Keystone First to view your information in the CAQH database
- Send your CAQH ID number to Keystone First (credentialing@keystonefirstpa.com)

Keystone First Paper Application Process

- Complete a PA Standard application and attestation that includes signature and current date
- Sign and date a release of information form that grants permission to contact outside agencies to verify or supply information submitted on the applications
- Submit all License, DEA, Board Certification, Education and Training, Hospital Affiliation and other required information with the application, which will be verified directly through the primary sources prior to the credentialing/recredentialing decision
- Submit a **PROMISE™**/Medicaid number issued by DHS along with the PPID/Service Location number for all addresses where the practitioner will be rendering services to Keystone First Members. If the Medicaid PPID number has not yet been received, a copy of the PPID enrollment application must be submitted along with the credentialing/recredentialing application.

As part of the application process, Keystone First will:

- Conduct a site visit and medical record keeping review upon initial credentialing for all PCP OB/GYN, general and pediatric dentists. Scores for these reviews must be 85% or greater.
- Request information on Health Care Provider sanctions prior to making a credentialing or recredentialing decision. Information from the National Provider Data Bank (NPDB), Health Integrity Provider Data Bank (HIPDB), Medichex (Medicaid exclusions), HHS Office of Inspector General (Medicare exclusions), System for Awards Management (SAM), Federation of Chiropractic Licensing Boards (CIN-BAD), Excluded Parties List System (EPLS) and Pennsylvania State Disciplinary Action report will be reviewed as applicable
- Perform primary source verification on required items submitted with the application as required by the National Committee for Quality Assurance (NCQA), State and Federal regulations
- Performance review of complaints, quality of care issues and utilization issues will be reviewed on a monthly basis by the Quality Management Department. A summary of their review will be presented at the Credentialing Committee meeting
- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees

After the submission of the application, Health Care Practitioners:

- Have the right to review the information submitted to support their credentialing application, with the exception of recommendations, and peer protected information obtained by Keystone First.
- Have the right to correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the Provider provided, the Credentialing Department will notify the Health Care Provider to correct the discrepancy
- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision

- Have the right to appeal any credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision

*To request any of the above, the Provider should contact Keystone First's Credentialing Department at the following address:

**Attn: Credentialing Department
Keystone First
200 Stevens Drive
Philadelphia, PA 19113
Phone – 1-800-642-3510
Fax: 1-215-863-6369**

Facility Requirements

Facility Providers must meet the following criteria:

- Keystone First will confirm that the facility is in good standing with all state and regulatory bodies, and has been reviewed by an accredited body as applicable
- If there is no accreditation status results, a current CMS State Survey will be accepted. If the Facility is not accredited and does not have a CMS State Survey, Keystone First's Provider Network Management Department will schedule a site visit of the facility. Recertification of facilities must occur a minimum of every (3) years
- The following types of facilities are credentialed and recertified:
 - Hospitals (acute care and acute rehabilitation)
 - Skilled Nursing Facilities (SNF)
 - Skilled Nursing Facilities providing sub-acute services
 - Nursing Homes
 - Sub-Acute Facilities
 - Outpatient Rehabilitation Facilities
 - Home Health Agencies
 - Hospice
 - Ambulatory Surgical Center (ASC)
 - Durable Medical Equipment
 - Home Infusion
 - Dialysis Centers
 - Free Standing Sleep Centers/Sleep Labs
 - Free Standing Radiology Centers
 - Diabetic Education Programs
 - Portable X-ray Suppliers/Imaging Centers
- A current copy of the facility's unrestricted license not subject to probation, suspension, or other disciplinary action limits
- A current copy of the facility's malpractice coverage and history of liability
- A current copy of the accreditation certificate or letter or current CMS State Survey, if applicable (if the facility is not accredited and has not had a CMS State Survey, Keystone First's Provider Network Management Department will schedule a site visit of the facility)

- The facility must submit a **PROMISE™**/Medicaid number issued by DHS under which service will be rendered
- The facility must submit an active Medicare number if applicable
- The facility must submit a Group NPI number

Facility Application

Facilities must:

- Complete the facility application with signature and current date from the appropriate facility officer. A facility application must be completed for each location where the provider renders services to Keystone First Members. Supporting documents noted above must be provided for each location.
 - **Note:** A parent facility with branch locations is required to submit one application listing all addresses. A copy of one license, accreditation or CMS State Survey, and malpractice insurance is also required. Proof that additional locations are branch locations must also be provided (this is usually documented on the Accreditation Certificate or CMS State Survey).
- Attest to the accuracy and completeness of the information submitted to Keystone First
- Submit documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid sanctions, or loss, limitation, or cancellation of professional liability insurance

Keystone First will:

- Verify the facility's status with state regulatory agencies through the State Department of Health
- Request information on facility sanctions prior to rendering a credentialing or recredentialing decision, by obtaining information from the National Practitioners Data Band (NPDB)/ Health Integrity and Protection Data Bank (HIPDB) Medichex (Medicaid exclusions) ,HHS Office of Inspector General (Medicaid/Medicare exclusions), and System for Award Management (SAM)
- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees

After the submission of the application, Facilities:

- Have the right to correct any erroneous information*. When information is obtained by the Credentialing Department that varies substantially from the information the provider provided, the Credentialing Department will notify the Facility to correct the discrepancy.
- Have the right to appeal credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision
- Have the right to review the credentialing information submitted to support the credentialing application*

- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application*
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision

*This information should be sent to Keystone First's Credentialing Department at the following address:

**Attn: Credentialing Department
Keystone First
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-800-642-3510
or
Fax: 1-215- 863-6369**

Member Access to Physician Information

Members can call Member Services to request information about Network Providers, such as where they went to medical school, where they performed their residency, and if the Network Provider is board-certified.

Provider Sanctioning Policy

It is the goal of Keystone First to assure Members receive quality health care services. In the event that health care services rendered to a Member by a Network Provider represent a serious deviation from, or repeated non-compliance with, Keystone First's quality standards, and/or recognized treatment patterns of the organized medical community, the Network Provider may be subject to Keystone First's formal sanctioning process.

Prohibition on Payment to Excluded/Sanctioned Persons

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, Keystone First may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs.

A Sanctioned Person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any

state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Upon request of Keystone First, a Provider will be required to furnish a written certification to Keystone First that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

A Provider is required to immediately notify Keystone First upon knowledge that any of its contractors, employees, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that a Provider cannot provide reasonably satisfactory assurance to Keystone First that a Sanctioned Person will not receive payment from Keystone First under the Provider Agreement, Keystone First may immediately terminate the Provider Agreement. Keystone First reserves the right to recover all amounts paid by Keystone First for items or services furnished by a Sanctioned Person.

All sanctioning activity is strictly confidential.

Informal Resolution of Quality of Care Concerns

When a Keystone First Quality Review Committee (Quality Improvement Committee, Medical Management Committee or Credentialing Committee) determines that follow-up action is necessary in response to the care and/or services begin delivered by a Network Provider, the Committee may first attempt to address and resolve the concern informally, depending on the nature and seriousness of the concern.

- The Chairperson of the reviewing Committee will send a letter of notification to the Network Provider. The letter will describe the quality concerns of the Committee, and what actions are recommended for correction of the problem. The Network Provider is afforded a specified, reasonable period of time appropriate to the nature of the problem. The letter will recommend an appropriate period of time within which the Network Provider must correct the problem

**The letter is to be clearly marked:
Confidential: Product of Peer Review**

- Repeated non-conforming behavior will subject the Network Provider to a second warning letter. In addition, the Network Provider's Member panel (if applicable) and referrals and/or admissions are frozen while the issue is investigated and monitored
- Failure to conform thereafter is considered grounds for initiation of the formal sanctioning process.

Formal Sanctioning Process

In the event of a serious deviation from, or repeated non-compliance with, Keystone First's quality standards, and/or recognized treatment patterns of the organized medical community, the Keystone First Quality Improvement Committee or the Chief Medical Officer (CMO) may immediately initiate the formal sanctioning process.

- The Network Provider will receive a certified letter (return receipt requested) informing him/her of the decision to initiate the formal sanctioning process. The letter will inform the Network Provider of his/her right to a hearing before a hearing panel.
- The Network Provider's current Member panel (if applicable) and referrals and/or admissions are frozen immediately during the sanctioning process.

Notice of Proposed Action to Sanction

The Network Provider will receive written notification by certified mail stating:

- That a professional review action has been proposed to be taken
- Reason(s) for proposed action
- That the Network Provider has the right to request a hearing on the proposed action
- That the Network Provider has 30 days within which to submit a written request for a hearing, otherwise the right to a hearing is forfeited. The Network Provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action s/he wishes to contest
- Summary of rights in the hearing
- The Network Provider may waive his/her right to a hearing

Notice of Hearing

If the Network Provider requests a hearing in a timely manner, the Network Provider will be given a notice stating:

- The place, date and time of the hearing, which date shall not be less than thirty (30) days after the date of the notice
- That the Network Provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the CMO of Keystone First and/or upon the advice of Keystone First's Legal Department
- A list of witnesses (if any) expected to testify at the hearing on behalf of Keystone First

Conduct of the Hearing and Notice

- The hearing shall be held before a panel of individuals appointed by Keystone First
- Individuals on the panel will not be in direct economic competition with the Network Provider involved, nor will they have participated in the initial decision to propose Sanctions
- The panel will be composed of physician members of the Keystone First's Quality Committee structure, the CMO of Keystone First, and other physicians and administrative persons affiliated with Keystone First as deemed appropriate by the CMO of Keystone First. The Keystone First CMO or his/her designee serves as the hearing officer

- The right to the hearing will be forfeited if the Network Provider fails, without good cause, to appear

Provider's Rights at the Hearing

The Network Provider has the right:

- To representation by an attorney or other person of the Network Provider's choice
- To have a record made of the proceedings (copies of which may be obtained by the Network Provider upon payment of reasonable charges)
- To call, examine, and cross-examine witnesses
- To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law
- To submit a written statement at the close of the hearing
- To receive the written recommendation(s) of the hearing panel within 15 working days of completion of the hearing, including statement of the basis for the recommendation(s)
- To receive the Plan's written decision within 60 days of the hearing, including the basis for the hearing panel's recommendation

Appeal of the Decision of the Keystone First Peer Review Committee

The Network Provider may request an appeal after the final decision of the Panel

- The Keystone First Quality Improvement Committee must receive the appeal by certified mail within 30 days of the Network Provider's receipt of the Committee's decision; otherwise the right to appeal is forfeited
- Written appeal will be reviewed and a decision rendered by the Keystone First Quality Improvement Committee (QIC) within 45 days of receipt of the notice of the appeal

Summary Actions Permitted

The CEO, President of PA Managed Care, the Executive Vice President and Chief Operating Officer, and/or the CMO, can take the following summary actions without a hearing:

- Suspension or restriction of clinical privileges for up to 14 days, pending an investigation to determine the need for professional review action
- Immediate revocation, in whole or in part, of panel membership or Network Provider status subject to subsequent notice and hearing when failure to take such action may result in imminent danger to the health and/or safety of any individual. A hearing will be held within 30 days of this action to review the basis for continuation or termination of this action

External Reporting

The CMO will direct the Credentialing Department to prepare an adverse action report for submission to the National Provider Data Bank (NPDB), the Healthcare Integrity and Protection Data Bank (HIPDB), and State Board of Medical or Dental Examiners if formal Sanctions are imposed for quality of care deviations and if the Sanction is to last more than 30 days, and as otherwise required by law. (NOTE: NPDB reporting is applicable only if the Sanction is for quality of care concerns.)

If Sanctions against a Network Provider will materially affect Keystone First's ability to make available all capitated services in a timely manner, Keystone First will notify DHS of this issue for reporting/follow-up purposes.

Utilization Management Program

The Utilization Management (UM) program description summarizes the structure, processes and resources used to implement Keystone First's programs, which were created in consideration of the unique needs of its Enrollees and the local delivery system. All departmental policies and procedures, guidelines and UM criteria are written consistent with DHS requirements, the National Committee for Quality Assurance (NCQA), Pennsylvania's Act 68 and accompanying regulations, and other applicable State and federal laws and regulations. Where standards conflict, Keystone First adopts the most rigorous of the standards.

Annual Review

Annually, Keystone First reviews and updates its UM and policies and procedures as applicable. These modifications, which are approved by the Keystone First Medical Management Committee, are based on, among other things, changes in laws, regulations, DHS requirements, accreditation requirements, industry standards and feedback from Health Care Providers, Members and others.

Mission and Values

The Keystone First UM Program provides an interactive process for Members that generally assesses whether the physical health care services they receive are Medically Necessary and delivered in a quality manner. Behavioral health services are provided through a separate arrangement between DHS and Behavioral Health Managed Care Organizations. The Keystone First UM Program promotes the continuing education of, and understanding amongst, Members, participating physicians and other healthcare professionals.

UM Program techniques that are used to evaluate medical necessity, access, appropriateness and efficiency of services include, but are not limited to, the following programmatic components: intake, Prior Authorization, concurrent review, discharge planning and alternate service review, DME review. The UM Program also generally seeks to coordinate, when possible, emergent, urgent and elective health care services. Members are assisted by the UM Program in obtaining transitional care benefits such as transitional care for new Members/covered persons and continuity of coverage for Members/covered persons whose Health Care Providers are no longer participating with Keystone First. The UM Program also outlines the responsibility for oversight of entities to whom Keystone First delegates Utilization Management functions.

Criteria Availability

Keystone First has adopted clinical practice guidelines for use in guiding the treatment of Members, with the goal of reducing unnecessary variations in care. The clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace, the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

The following complete clinical practice guidelines are available upon request by calling the www. Provider Services Department or by visiting the Provider Center of our website at www.keystonefirstpa.com:

Acute Pharyngitis in Children

Asthma

Chlamydia

Cholesterol

Chronic Obstructive Pulmonary Disease

Diabetes

Heart Failure

Hemophilia

HIV

Hypertension

Pennsylvania EPSDT

Preventive Health Guidelines

Maternity

Sickle Cell

Keystone First will provide its Utilization Management (UM) criteria to Network Providers upon request. To obtain a copy of the Keystone First UM criteria:

- Call the UM Department at **1-800-521-6622**
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

You will receive a faxed copy of the requested criteria within 24 hours or written copy by mail within 5 business days of your request.

Please remember that Keystone First has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, Home Health Care and Concurrent Review. Call the Medical Director Hotline at: **1-877-693-8480**.

Additionally, Keystone First would like to remind Health Care Providers of our affirmation statement regarding incentives:

- UM decision-making is based only on appropriateness of care and the service being provided
- Keystone First does not reward Health Care Providers or other individuals for issuing denials of coverage or service
- There are no financial incentives for UM decision makers to encourage underutilization

Hours of Operation

A toll free number (1-800-521-6622) is available for Providers and Members to contact the Plan's UM staff. The UM Department is available to answer calls during normal business hours, 8:30 a.m. - 5:00pm. Translation services are available as needed.

Keystone First has realigned its clinical services department, which includes integration with Provider Network Management. We have formed Unified Interdisciplinary Teams (UNITS) with the ultimate goal of improving administrative processes, identifying and bridging gaps in patient care early.

Each UNIT is comprised of utilization managers, case managers, rapid response associates, physician reviewers, provider network account executives, behavioral health, pharmacy and claims associates works collaboratively with assigned facilities. Each UNIT team member brings diverse knowledge and skills that improve efficiency, response time, communication and ultimately patient care.

To determine the UNIT assigned to a facility, call 1-800-521-6622 and choose the concurrent review prompt.

After business hours and on weekends and holidays, Health Care Providers and Members are instructed to contact the On-Call Nurse through the Keystone First’s Member Services number **1-800-521-6860**. After obtaining key contact and Member information, the Member Service Representative pages the on-call Nurse. The on-call Nurse contacts the Health Care Provider or Member, as needed, to acquire the information necessary to process the request. The on-call Nurse will call the on-call Physician Reviewer to review the request, if necessary. The on-call Nurse is responsible to contact the requesting Health Care Provider or Member with the outcome of their request.

Utilization Management Inpatient Stay Monitoring

The Utilization Management (UM) Department is mandated by the Department of Human Services to monitor the progress of a member’s inpatient hospital stay. This is accomplished by the UM Department through the review of appropriate Member clinical information from the Hospital. Hospitals are required to provide Keystone First, within two (2) business days from the date of a Member’s admission (unless a shorter timeframe is specifically stated elsewhere in the Provider Manual), all appropriate clinical information that details the Member’s admission information, progress to date, and any pertinent data.

As a condition of participation in the Keystone First Network, Providers must agree to the UM Department’s monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the Keystone First Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, Keystone First must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

Timeliness of UM decisions

Several external standards guide Keystone First’s timeline standards. These include NCQA, DHS HealthChoices standards, Pennsylvania’s Act 68 and accompanying regulations, and other applicable state and federal laws and regulations. Where standards conflict, Keystone First adopts the more rigorous of the standards. Table 1 identifies Keystone First’s timeliness standards.

Table 1: Timeliness Of UM Decisions – Excludes Pharmacy

			Written
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Case Type	Decision	Initial Notification	Confirmation*
Urgent Precertification (including Home Health Care)	24 hours from receipt of request**	24 hours from receipt of request	24 hours from initial notification
Non-Urgent Precertification (excluding Home Health Care)	2 business days from receipt of the request **	2 business days from receipt of the request	2 business days from initial notification
Concurrent Review	24 hours from receipt of the request**	24 hours from receipt of the request	24 hours of the initial notification
Retrospective Review	30 calendar days from receipt of the records	30 calendar days from receipt of the records	The earlier of 15 business days or 30 calendar days from receipt of the records
Home Health Care Non-Urgent Pre-certification	48 hours from receipt of request**	48 hours from receipt of request	48 hours from initial notification

* *Written confirmation is provided for all cases where coverage for the requested service is partially or completely denied.*

** *The timeframes for decisions and notification may be extended if additional information is needed to process the request. In these instances, the member and requesting Health Care Provider are notified of the required information in writing (not applicable to retrospective review).*

Denial and Appeal Process

Medical necessity denial decisions made by a Medical Director, or other physician designee, are based on the DHS definition of Medically Necessary, in conjunction with the Member's benefits, applicable MA laws and regulations, the Medical Director's medical expertise, medical necessity criteria, as referenced above, and/or published peer-review literature. At the discretion of the Medical Director, in accordance with applicable laws, regulations or other regulatory and accreditation requirements, input to the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Medical Director or physician designee makes the final decision. Prior authorization is not a guarantee of payment for the service(s) authorized. Keystone First reserves the right to adjust any payment made following a review of the medical record and determination of medical necessity of the services provided. Upon request of a Member or Network Provider, the criteria used for making Medically Necessary decisions is provided, in writing, by the Medical Director or physician designee.

Physician Reviewer Availability to Discuss Decision

If a practitioner wishes to discuss a medical necessity decision, Keystone First's physician reviewers are available to discuss the decision with the practitioner. A call to discuss the determination is accepted from the Practitioner:

- At any time while the Member is an inpatient
- Up to 2 business days after the Member's discharge date, whichever is later
- Up to 2 business days after a determination for a Prior (Pre-Service) request has been rendered
- Up to 2 business days after a determination of a retrospective review has been rendered, whichever is later.

A dedicated reconsideration line with a toll-free number has been established for practitioners to call at **1-877-693-8480**. A physician reviewer is available at any time during the business day to interface with practitioners. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a Formal Provider Appeal. For information on the types of issues that may be the subject of a Formal Provider Appeal, please see Section VII.

Denial Reasons

All denial letters include specific reasons for the denial, the rationale for the denial and a summary of the UM criteria. In addition, if a different level of care is approved, the clinical rationale is also provided. These letters incorporate a combination of NCQA standards, DHS requirements and Department of Health requirements. Denial letters are available in six languages for Members with Limited English Proficiency. Letters are translated into other languages upon request. This service is available through the cooperation of Member Services and Utilization Management.

Appeal Process

All denial letters include an explanation of the Member's rights to appeal and the processes for filing appeals through the Keystone First Complaint and Grievance Process and the DHS Fair Hearing Process. Members contact the Member Service Unit to file Complaint and Grievance appeals where a Member advocate is available to assist Members as needed.

Evaluation of New Technology

When Keystone First receives a request for new or emerging technology, it compiles clinical information related to the request and reviews available evidence-based research and/or DHS technology assessment group guidelines. Keystone First Medical Directors make the final determination on coverage.

Evaluation of Member & Provider Satisfaction and Program Effectiveness

Not less than every two years, the UM department completes an analysis of Member and Network Provider satisfaction with the UM program. At a minimum, the sources of data used in the evaluation include the annual Member satisfaction survey, Member Complaints, Grievances and Fair Hearings, and Provider Network surveys and complaints.

To support its objective to create partnerships with physicians, Keystone First actively seeks information about Network Provider satisfaction with its programs on an ongoing basis. In

addition to monitoring Health Care Provider complaints, Keystone First holds meetings with Network Providers to understand ways to improve the program.

Monthly, the department reports telephone answering response, abandonment rates and decision time frames.