

NORTHCARE NETWORK

Prepaid Inpatient Health Plan

UTILIZATION MANAGEMENT PLAN

I. Overview

A. Purpose and Scope

NorthCare Prepaid Inpatient Health Plan (PIHP) operates under contract with the Michigan Department of Community Health (MDCH) to manage the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (Medicaid Program) and the 1115 Demonstration Program (ABW Program). NorthCare is responsible for payment of services included under each contract for individuals who require them. This provision presumes that NorthCare and its agents are fulfilling their responsibility to individuals according to the terms specified in these contracts. As the holder of the PIHP contract with the MDCH, NorthCare is accountable for managing the specialty services and support benefits for eligible persons in its service area. As a result, NorthCare has oversight authority to ensure these funds are used for authorized purposes and from that perspective, indirectly manages consumer care from the point of entry, through treatment and delivered services, to discharge.

Utilization Management (UM) is intended to complement quality improvement activities of provider organizations such as clinical practice improvement initiatives, service/billing integrity verification, and compliance risk monitoring. The UM Plan is designed specifically to identify roles and responsibilities for service and authorization functions and how those activities are implemented, monitored, and managed. The UM Plan establishes a framework for oversight and guidance of the Medicaid and ABW Programs by assuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services.

B. Philosophy and Guiding Principles

Utilization management is a process which is expected to evolve and change with the availability of new information, new research findings, or changes in regulatory mandates. Utilization management must be based on valid data in order to produce reliable reports required to analyze patterns of utilization and work with providers to make needed improvements. The UM program must operate within a common definition of medical necessity which must be consistently applied region-wide to ensure eligible persons have equitable access to services. The UM program should be transparent and strive to minimize administrative costs and limit authorization activities to services with a demonstrated need for review. Authorization activities must be clinically focused and conducted by qualified staff. Utilization management should focus primarily on outliers; specifically reviews of high-intensity service use, high-cost services, and patterns of underutilization and overutilization of services.

NorthCare is committed to assuring that services and supports identified in the individual plan of service meet medical necessity criteria, and are sufficient in amount, duration and scope to reasonably achieve the purpose of the service. NorthCare is equally committed to assuring the various programs within the provider network operate effectively and efficiently. This includes ensuring that value purchasing guides the service selection and service delivery process. As applied to services and supports, value purchasing assures appropriate access, quality, and the efficient and economic provision of supports and services.

II. Utilization Management Structure

A. NorthCare PIHP Board

Within its overall governance role, the NorthCare Board provides oversight to NorthCare including assuring adherence to all contractual obligations. With respect to this document, contract provisions stipulating Utilization Management activities are outlined in the MDCH/PIHP contract attachment P 6.7.1.1.

B. NorthCare Utilization Management Committee

The NorthCare UM committee is a standing committee responsible for implementing and monitoring the NorthCare UM plan. The purpose of the committee is to monitor utilization of clinical resources and provide supports that ensure services are used only for authorized purposes, uniformly available to eligible persons, and are provided in an effective and efficient manner. The ultimate goal of the UM committee is to assure the availability of high quality care by evaluating various aspects of service delivery, clinical practices, program eligibility determinations and service authorization decisions. Committee membership will include the NorthCare UM Coordinator, UM representatives from each of the five CMHSPs, and a consumer representative (consumer or family member). With the exception of the consumer representative, NorthCare UM committee members shall meet the minimum qualifications established by NorthCare. NorthCare and CMHSP committee members shall have access to clinical, demographic and encounter data necessary to carry out the primary functions of the committee. Primary functions of the committee include:

- 1) Identify and monitor over-utilization and under-utilization of services,
- 2) Identify and monitor utilization patterns that;
 - Compromise consumer health and safety,
 - Inappropriately use resources, or
 - Represent organizational risk.
- 3) Evaluate consistent use of medical necessity including:
 - Criteria used,
 - Information sources,
 - Review process used to approve the provision of services.
- 4) Review of initial and ongoing eligibility determinations and initial and continued service authorization decisions.
- 5) Provide support to other organizational functions
- 6) Perform special targeted monitoring activities as required by regional need or regulatory mandate

Examples of targeted monitoring activities include:

- Service-specific utilization reviews,
- Program lengths of stay,
- Reviews of service duration, volume and cost,
- Provider-specific treatment pattern analysis,
- Service and billing integrity reviews

III. Utilization Management Plan Components:

A. General Overview of Utilization Management Activities

Utilization management processes for mental health services are based on three determinations.

1. Eligibility determination

The eligibility/coverage determination decision is the result of integrating eligibility criteria and clinical needs with insurance benefits that may be present. Eligibility determinations occur at initial entry into an episode of care, and on an ongoing basis during an episode of care. Initial eligibility for outpatient services is determined through the Access screening process that occurs as the individual/family requests services to determine the likelihood of a mental illness, substance use disorder, or developmental disability. The screening process shall be used to determine the coverage eligibility that qualifies individuals for services and authorize their initial entry into the publically funded mental health system for a clinical assessment. Ongoing eligibility is determined by provider clinical reviews, (routine outpatient services) residential review committee reviews, (specialized residential services) and/or UM continued stay reviews (inpatient services). Ongoing eligibility reviews shall be used to determine the coverage eligibility that continues to qualify the individual for ongoing services.

2. Level of care determination

Clinicians use the NorthCare Benefit Plan (see attachment 2) to guide the service selection process. The NorthCare Benefit Plan is a utilization management tool designed to assist providers with service planning and development. Level of care determination is established following initial entry into an episode of care, and re-evaluated periodically during an episode of care where there is a significant change in the individual's condition. The level of care determination is based on information gathered during the person-centered planning process and on clinical and demographic information documented in the medical record. Level of care determinations incorporates three factors: 1) diagnosis, 2) duration of the condition, and 3) the impact of the condition on the individual's ability to function. Generally, as the individual's "mental health condition" increases in severity, complexity, and/or duration, the expected types, amounts, and duration of services will also increase. Each level of care is specifically tailored to match the expected types and amounts of service(s) deemed medically necessary for a particular "mental health condition". The level of care assignment provides the initial framework for the service selection process.

3. Service selection determination

Determining what public mental health services and supports an individual is eligible for involves intricate clinical considerations that can be difficult to interpret and apply. This intricacy stems from the fact that PIHPs and CMHSPs manage complex benefit plans that have variant eligibility criteria, target service populations, coverage eligibility qualifications and legal and funding constraints. While the individual's assigned level of care *guides* the service selection process, authorization for covered services and supports must occur in accordance with the eligibility guidelines specified in the Medicaid Provider Manual, and/or MDCH contracts as applicable to the specific health care benefit plan coverage for which the individual is eligible. The Medicaid Provider Manual provides definitions of each Medicaid-covered service and includes descriptions of program/service-specific eligibility criteria, and additional criteria as defined by the individual's specialty benefit plan coverage. All services authorized must be:

- a) Identified using the person centered planning process and,
- b) Medically necessary as defined in the Michigan Medicaid Provider Manual and,

- c) Consistent with the service definition, and other criteria as described in the Medicaid Provider Manual and,
- d) Deemed effective for a given condition based on professionally and scientifically recognized and accepted standards of care and,
- e) Specified in the individual plan of service, which includes the expected date each service is to commence and specifies the amount, scope and duration and who will provide each service.

B. Utilization Review Activities

Utilization review involves a performance analysis of how the managed provider network services are used. The review of service utilization consists of multiple tools, including, but not limited to: ongoing concurrent reviews of all requests for selected services; retrospective reviews of high-volume services, high-cost cases, prolonged program lengths of stay, or random samples of all cases; special/targeted; analysis of grievances and appeals; and ongoing monitoring, and analysis of provider network service utilization trends. Proper program review will reveal patterns in over-utilization, under-utilization, and inappropriate utilization of services across the provider network's service continuum.

1. Concurrent Review

The purpose of concurrent review is to allow for the examination of requested services at the time of the request. Concurrent reviews occur whenever services are requested: i.e., at the initial request for treatment, and at each subsequent request for ongoing authorizations of treatment and services. These reviews occur on initial access to inpatient psychiatric services and initial access to non-emergent/non-urgent outpatient mental health services. Concurrent reviews also occur following entry to care at various points during an episode of inpatient and outpatient treatment. Responsibility for carrying out these activities is described in the Delegated/Non-Delegated Utilization Management Functions below.

2. Retrospective Review

The purpose of the retrospective review is to examine various aspects of previously provided services. The purpose of these reviews is to furnish information about the quality of eligibility determinations and service authorization decisions, and various other aspects associated with the services provided to consumers. Ultimately, this information is used to evaluate the quality and appropriateness of services the organization is contracted to deliver. Open and closed cases may be identified for retrospective review through numerous mechanisms. Retrospective reviews include:

- a) Over-utilization and under-utilization of services,
- b) Selected utilization patterns based on specific review criteria;
- c) Evaluate consistent use of medical necessity including:
 - Criteria used,
 - Information sources,
 - Review process used to approve the provision of services.
- d) Review of initial and ongoing eligibility determinations and initial and continued service authorization decisions.

The Utilization Management Committee will review aggregate data on retrospective reviews. Summary reports provided by NorthCare will be reviewed by the UM committee.

These reports are defined in the schedule of monitoring activities section. Summaries of these reports will be provided to the Performance Monitoring Committee at least quarterly.

3. Prospective Review

The purpose of prospective review is to analyze data and apply it to strategic planning activities. Prospective reviews include analysis of penetration rates, evaluating provider capacity, assessing service volume and cost, or other demand management activities. Prospective review is conducted by the Utilization Management Committee by reviewing the findings of concurrent and retrospective reviews and assessing the implications on the entire region. Review findings allow leaders to make informed judgments about processes, define opportunities for improvement, and determine whether existing services are meeting contractual obligations. Summaries of these reports will be provided to the PMC at least quarterly.

4. Special Studies

Special studies may be conducted each year, or as appropriately indicated by data, to research and evaluate the impact of various clinical operations, conditions, or situations on the frequency, types and quality of services rendered. These studies focus on various patterns of utilization, outcomes for certain treatments, or any other emerging issues that impact quality care. The Utilization Management Committee will participate with the PIHP Quality Improvement Committee and Practices Improvement Leadership Team, or others in defining these targeted studies. Organizational leaders, Managers and/or providers may submit issues of concern to Utilization Management Committee members for consideration. For example, a manager who identifies a concern with a certain diagnostic group or treatment approach may make a request for a more formal assessment regarding the concern. Utilization Management Committee members, after reviewing the request, may then implement a directed study. Findings are disseminated to providers who then may recommend a modification in procedures.

5. Grievance and Appeals

Grievances and appeals are often a reaction to proper utilization management of services and are an important measure of a provider's ability to engage consumers in treatment and work with them to ameliorate their presenting problems. At each denial, reduction, or restriction of care, consumers are provided an opportunity to grieve or appeal decisions. Grievances and appeals information is collected from each Board and maintained in a database. This allows information regarding trends around types of complaints, complaints about particular facilities or providers, and the outcomes of the situations. Specifically the number of grievances and appeals, and the number of upheld and overturned decisions will be aggregated, and reported to the appropriate oversight committee. Information gained may be used for system improvements, provider network development, and the credentialing of providers.

6. Aggregate Data Ad-Hoc Reports

Aggregate ad-hoc utilization management reports are generated as needed to identify and analyze trends as determined by the specific need/purpose. Data are gathered from a variety of sources including findings from concurrent and retrospective reviews, special studies, grievance and appeals. Data may be reported and organized regionally, by Board, program, service provider, primary clinician, level of care, payer, age group, diagnostic group, and other categories or combinations of categories to include service types, treatment settings, intensities and modes. Aggregate review findings are compiled into

reports for the purpose of formulating recommendations regarding overall regional operations. Level of Care reports profiling service utilization, clinical attributes, or demographic data are examples of aggregate data reports. The PMC may direct that specific data analysis and resultant reports be completed and presented.

C. Delegated/Non-Delegated Utilization Management Functions

The following describes the UM functions that have been delegated to the CMHSPs, those retained by NorthCare (not delegated to the CMHSPs), and those which are the responsibility of NorthCare and the CMHSPs as stipulated in the written delegation agreement.

1. Services Authorized by the CMHSPs exclusively

Initial access to inpatient psychiatric services. This includes authorization of the day of admission, and the days immediately following admission, (Initial Authorization Period) Authorization for initial entry into inpatient psychiatric treatment is carried out by the local CMHSP inpatient preadmission screening process. This includes all acute care inpatient psychiatric admissions and those provided in a State facility.

2. Services Authorized by NorthCare exclusively

Initial access to outpatient mental health services. This includes all non-emergent/non-urgent outpatient services and supports. Authorization for initial entry into the publically-funded outpatient mental health system is the responsibility of NorthCare Access.

3. Services authorized by either NorthCare or the CMHSP(s)

a) Initial authorization of services after Access. This includes the authorization of services provided immediately following the initial eligibility determination assessment. Responsibility for this aspect of the authorization process may be a function of the PIHP or the CMHSP, as stipulated in the written delegation agreement.

b) Continued authorization of outpatient services. This includes the authorization of services provided following the expiration of the preliminary IPOS, and all subsequent continued authorization of services. Responsibility for this aspect of the authorization process may be a function of NorthCare or the CMHSP, as stipulated in the written delegation agreement.

IV. Intra-Agency Interface

Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Many of the NorthCare Utilization Management functions overlap or are reliant on coordination with, Quality Assessment & Performance Improvement, Provider Relations, Practices Improvement Leadership Team, claims/Reimbursement, Management of Information Services and other service management functions. Successful interface among the various functions of the PIHP is essential for effective and efficient management of resources, identification of gaps in service delivery and resolution of over- and under-utilization of services and resources. Interface between Utilization Management and other PIHP functions occurs through exchange of data, information and reports,

joint participation in a variety of committees and collaboration in planning, projects and operational initiatives.

V. Schedule of Monitoring Activities

Although the UM plan identifies specific review activities, it should be noted that all consumer services, and episodes of care are subject to review. Examined data will include consumer QI/demographic and encounter data, clinical documentation supporting service authorization decisions, level of care assignments, service activity logs, claims data, grievance/appeal/denial logs, person-centered planning activities, admission and discharge data, and results of other NorthCare/CMHSP committee monitoring activities and external audits.

ACCESS TO SERVICES	
Routine/non-emergent	Monitoring Frequency
Total Access screenings completed	Monthly
Total eligible following Access screening	Monthly
Total denials following Access screening	Monthly
Disposition at CMHSP following Access screening admission	Monthly
Penetration rates by CMHSP (by disability designation/age group)	Monthly
Emergent	Monitoring Frequency
Total inpatient preadmission screenings completed	Monthly
Total admissions to inpatient	Monthly
Total denials to inpatient	Monthly

SERVICE UTILIZATION TRENDS	
Outpatient	Monitoring Frequency
Retention rates by CMHSP (LOS following CMHSP admission)	Monthly
High volume services by LOC, primary clinician & CMHSP	Monthly
High cost cases by LOC, primary clinician & CMHSP	Monthly
Over/under service utilization thresholds by service type & LOC & CMHSP	Monthly
Inpatient	Monitoring Frequency
Inpatient LOS by hospital & CMHSP	Monthly
Inpatient cost/episode of care by hospital & CMHSP	Monthly

TARGETED SERVICE UTILIZATION	
	Monitoring Frequency
Specialized Residential LOS & Cost/Episode	Monthly
HSW enrollee monthly service utilization by CMHSP	Monthly
Selected B3 utilization by LOC, provider & CMHSP	Monthly

-Attachment 1-

DEFINITIONS

ABUSE – Excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss. Examples include:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicare

ACTION– A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Note: The term "action" is also referred to as an "adverse action".

ADMISSION REVIEW – A review and determination of the medical necessity and appropriateness of an individual's entry to a specific level of care (LOC).

APPEAL – Request for a review of an "action" as defined above.

APPELLANT – An individual or appeal representative who is requesting an appeal of an action.

CONCURRENT REVIEW – Review activities that take place during the course of a consumer's treatment for the purpose of determining if continued treatment is medically necessary.

CONTINUED STAY REVIEW – A review conducted after admission and during an episode of care to determine the medical necessity and appropriateness of continuing the current level of care (LOC).

CREDENTIALS – Documented evidence of licensure, education, training, experience, or other qualifications.

DELEGATION – A formal process by which an organization designates the authority to perform certain functions on its behalf to a third party via contract or mutual written agreement. Examples of delegated functions mandated by provisions of the Balanced Budget Act include: service

authorization, credentialing & privileging, utilization management, and quality improvement. Although an organization may delegate the authority to perform a function to a third party, it cannot delegate the responsibility for assuring that the function is performed appropriately. That responsibility remains with the organization.

EFFECTIVENESS – The degree to which the desired or projected outcome is achieved for the individual.

EFFICIENCY – The relationship between outcomes (results of care) and the resources used to deliver care.

ELIGIBILITY – The determination that an individual meets the requirements to receive health care benefits as defined by the payer.

ENCOUNTER – A contact (typically face to face) between a consumer and a health care provider during which health care services are provided and documented in the individual's health record.

EXPEDITED APPEAL – An appeal of an adverse determination (denial) for inpatient services or continued stay for hospitalization. Because of the immediacy of the condition, the time frames for appeal and resolution are shorter than the standard appeal process.

FRAUD – An intentional act of deception, misrepresentation or concealment in order to gain something of value. Examples include:

- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Deliberately misrepresenting services, resulting in unnecessary costs to the Medicaid program, improper payments to providers or overpayments

INDICATOR – A defined, measurable variable used to monitor the quality or appropriateness of an important aspect of consumer care or service. Indicators can be activities, events, occurrences, or outcomes for which data can be collected to allow comparison with a threshold, a benchmark or prior performance. A measure used to determine, over time, an organization's performance of functions, processes, and outcomes.

INDIVIDUAL PLAN OF SERVICE (IPOS) – The document that identifies the needs and goals of the individual beneficiary and the medical necessity, amount, duration, and scope of the services and supports to be provided.

LENGTH OF STAY (LOS) – Is a term commonly used to measure the duration of a single episode of care. Care may be in an inpatient, residential or outpatient treatment setting or program. A popular statistic associated with length of stay is the average length of stay (ALOS), calculated by dividing the sum of days in an episode of care by the number of consumers admitted with the same diagnosis-related group classification.

LEVEL OF CARE (LOC) – A designation given to a standardized package of services designed specifically to match the expected type, amount, and duration of supports/services for a particular mental health condition.

MEDICAID FAIR HEARING – A federally required process that ensures Medicaid-eligible individuals are not denied access to medically necessary services.

MEDICALLY NECESSARY/MEDICAL NECESSITY: A determination that a specific service is medically (clinically) appropriate, necessary to meet an individual's needs, consistent with the person's diagnosis, symptomology, and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of service. See Medicaid Provider Manual for the complete definition.

MENTAL HEALTH CONDITION – The term used to describe an individual with a mental illness, serious emotional disturbance, developmental disability, or co-occurring substance use disorder.

MONITORING ACTIVITIES – Reviews that are repeated periodically during the normal course of operations. Monitoring activities may occur to ensure corrective actions are undertaken or when no specific problems have been identified but are conducted to confirm ongoing compliance.

NORM – Means a pattern of performance in the delivery of health care services that is typical for a specified group. Also means numerical or statistical measures of average observed performance in the delivery of health care services.

OUTCOME – The result of actions on people, systems, and communities.

OUTLIER – An observation in a distribution that falls significantly outside the range of most of the data.

OVERUTILIZATION – Unnecessary or excessive rendering of services by providers. Provision of services that are not clearly indicated or provision of services that is inconsistent with sound fiscal, business, or clinical/medical practices. Overutilization of services results in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

PEER REVIEW – Evaluation or review of the performance of colleagues by professionals with similar types and degrees of expertise (e.g. the evaluation of one physician's practice by another physician).

PENETRATION RATE – Medicaid recipients use of mental health services from the public mental health system. It is a measure of the percent of Medicaid eligible individuals for which a CMHSP was paid within a quarter who received at least one CMHSP managed Medicaid service. Information about penetration rates is required by Centers for Medicare and Medicaid Services (CMS).

PREADMISSION REVIEW – Means review prior to an individual's admission to a hospital to determine, for payment purposes, the reasonableness, medical necessity and appropriateness of placement at an acute level of care.

PRIOR AUTHORIZATION – The process of obtaining coverage approval for a service/support, item or medication prior to being provided/supplied. Without such prior authorization, the service/support, item or medication is not covered or is reimbursed.

PROFILE – Means aggregated data compiled in formats that display patterns of health care services over a defined period of time.

PROFILE ANALYSIS – Means review and examination of profiles to identify and consider patterns of health care services.

PROSPECTIVE REVIEW – Pre-admission review for appropriateness of admission to service prior to receiving services.

PROVIDER – A practitioner, group practice, program or facility credentialed within a recognized health care discipline and involved in providing the services of that discipline to individuals.

PROVIDER NETWORK – Entities from which administrative functions and/or direct clinical services are purchased. The Provider Network includes the affiliate CMHSPs of a PIHP, substance abuse coordinating agencies (CAs) that manage Medicaid services, Managed Comprehensive Provider Networks (MCPNs) and all other entities that meet the definition of prime subcontractor.

PROVIDER PROFILING – An essential mechanism by which organizations use aggregate data and information about providers in their networks to assess various attributes about the care provided. The collection of data associated with profiling allows the PIHP/CMHSP to assess performance of clinicians, programs and services. The intent of such a process is to identify opportunities for improvement and support activities that allow services to be provided in a more efficient and effective manner. Profiling covers multiple areas such as:

- Competency of providers to provide care.
- Accessibility to services.
- Safety of the environment in which services are provided.
- Continuity of care.
- Effectiveness and efficiency of treatment.
- Satisfaction of individuals and family members with services.

QUALIFIED MENTAL HEALTH PROFESSIONAL – An individual who has specialized training or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QMHP prior to January 1, 2008.

QUALITY – A judgment related to the degree of excellence achieved through the provision of service. The most fundamental evaluation of quality is how well the individual achieves their desired outcomes from participating in the service.

QUALITY IMPROVEMENT (QI) – A systematic approach to the continuous study and improvement of the processes within an organization providing health care services.

QUALITY MANAGEMENT (QM) – A program developed and implemented by the CMHSP by which organizational performance and services are assessed and evaluated to ensure the existence of those structures and processes necessary for the achievement of consumer outcomes and continuous quality improvement.

RECIDIVISM – The frequency of the same individual returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.

RECOVERY – The ability to live well irrespective of an individual's experience of a disorder. Development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness.

REFERRAL – The sending of an individual:

- from one clinician to another clinician or specialist,
- from one setting or service to another setting or service; or
- by one physician (the referring physician) to another physician (or some other resource) either for consultation or care.

RETROSPECTIVE REVIEW – Review following service provision to assess the appropriateness, necessity, quality, and reasonableness of health care services provided. These reviews may be conducted on a case-by-case or aggregate basis.

SCREENING – Brief assessment to determine initial eligibility for and urgency of care/treatment to be provided. This can be by telephone or face-to-face.

SERVICE AUTHORIZATION REQUEST – Means a Medicaid recipients request for the provision of a service.

SERVICE PACKAGE (SP) – A standardized set of services that are available to an individual authorized to receive them. See also LEVEL OF CARE.

UNDERUTILIZATION – Failure to provide appropriate and/or medically necessary services, or provision of a lower quantity or level of services than recommended or than is usually considered sufficient or needed.

UTILIZATION – The extent to which individuals use health care services and expressed as patterns or rates of use. Utilization rates are established to help in comprehensive health planning, budget review, and cost containment. Utilization can be expressed in a variety of ways:

- Patterns or rates of use of a single service or type of service, e.g. hospital care, physician visits, prescription drugs.
- The extent to which individuals (or members of a covered group) use a program or obtain a particular service, or a category of procedures, over a given period of time. Usually expressed as the number of services (by reporting unit, e.g. units or encounters) used per year or per numbers of persons eligible for services.

UTILIZATION MANAGEMENT – According to the Utilization Review Accreditation Commission, utilization management is "the evaluation of the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the applicable health benefits plan." Utilization management describes proactive procedures—discharge

planning, concurrent planning, precertification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or consumer.

UTILIZATION MANAGEMENT COMMITTEE – A standing committee that consists of individuals representing the PIHP, CMHSP including utilization and quality management staff, clinical management staff, and others as indicated. Members meet periodically to evaluate and monitor service utilization patterns and trends and clinical practices; provide information for agency resource planning and allocation decisions; and ensure ongoing improvement in the utilization management process. Committee functions also include ensuring that resources are channeled to the services that are needed by individuals and that a balance between crisis and routine services is achieved.

UTILIZATION MANAGEMENT GUIDELINES – Descriptions of evidence-based clinical practices that are configured into levels of care (LOC) which describe the type, amount and duration of services for each level of care and also provide admission, continued stay and discharge criteria for all services and levels of care for the mental health service system. They are functionally integrated into the treatment planning process.

UTILIZATION MANAGEMENT PROGRAM PLAN – A plan describing the PIHPs Utilization Management Program. The plan must be written and include at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services. The program must have mechanisms to identify and correct under-utilization as well as over-utilization as well as procedures that address prospective (preauthorization), concurrent and retrospective review activities.

UTILIZATION REVIEW – Utilization review portrays the review of cases after healthcare services are conducted. A formal review of client utilization of health care services to assess efficiency, and/or appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis. Utilization review may be accomplished by a peer review group or a public agency. Utilization review (UR) is part of the utilization management process.

UTILIZATION REVIEW – Activities to determine whether healthcare services are reasonable and medically necessary and are furnished at the appropriate level of care.

WASTE: Refers to the misuse of resources (not resulting from criminally negligent actions). See also over-utilization.