



MEDICAL MANAGEMENT UTILIZATION REVIEW CRITERIA

During the review and case management process, Medical and Behavioral Care Management clinical staff use criteria developed and approved by the CMO Medical Management Committee and the Behavioral Care Utilization Management/Quality Improvement Committee to assist in the determination of clinical appropriateness. The guidelines used include, but are not limited to:

- InterQual ISD A-P
- InterQual Acute Rehabilitation
- InterQual Skilled Nursing Facility
- Guidelines developed by the American Society of Addictive Medicine (ASAM)
- Guidelines developed by the American Psychiatric Association (APA)
- Medicare coverage guidelines
- Managed Care Organization guidelines for benefit interpretation

These guidelines are applied taking into consideration the needs of the individual patients and characteristics of the local delivery system, and with the advice of practicing physicians who are members of the MIPA Quality Improvement/Medical Management Committee.

Clinical criteria used in the clinical review process of a particular case will be shared with the involved provider and with the member/member's designee upon request. Any participating provider may request to review the entire Medical Management criteria set used in the clinical review process. Providers may schedule an appointment to conduct such a review by contacting the Medical Management Director either in writing or by telephone. Instructions can also be provided by obtaining a reference copy of the criteria used.

STATEMENT REGARDING APPROPRIATE SERVICE AND COVERAGE FOR IPA MEMBERS

CMO is dedicated to ensuring the delivery of appropriate care to IPA members. This statement affirms CMO's policy regarding utilization management- UM decision making when conducted by MIPA providers and CMO staff.

1. All UM decisions are based on the members' eligibility, the benefits covered under the members' certificate of coverage and the appropriateness of care and service.
2. CMO does not specifically reward UM decision makers for issuing denials of coverage or service and encourages the use of medically necessary and appropriate care and services to prevent and/or treat medical conditions.
3. CMO does not compensate UM decision makers for non-certification of service or offer incentives to encourage non-certification or underutilization of health care services.