

## **Case Management and Utilization Review**

### Oversight:

The Quality Assurance, Utilization Management, Pharmacy & Therapeutics (QAUMPT) Committee is tasked with defining formulary coverage and clinical guidelines, coverage policies, and formulary decisions for the Medicare population. The Committee is an advisory body for quality, utilization, pharmacy, therapeutics, and performance improvement activities under the directive authority of the Chief Medical Officer (CMO). The Chief Medical Officer collaborates with and receives input and recommendations from the committee regarding quality and performance improvement activities. Committee members are selected to comprise a representation of network physicians by specialty types, geographic region, and organizations, such as Independent Practice Associations, Medical Homes, and Federally Qualified Health Clinics.

### Resources:

Resources used for making utilization decisions and developing criteria may include:

- Evidence-based websites such as American College of Radiology (ACR) appropriateness Criteria
- AIM Diagnostic Imaging Utilization Management  
<http://www.AimSpecialtyHealth.com/clinical-guidelines/agreementAccess>
- Medicare criteria and guidelines (always used as a first resource if available):  
<http://www.CMS.gov/Medicare-Coverage-Database/>
  - Medicare's National database.  
<https://www.NoridianMedicare.com/>
  - Oregon's Medicare carrier's database.
- Milliman criteria:  
<http://Careweb.CareGuidelines.com/ed16/>
  - This resource is used for diagnostic requests and acute inpatient requests.
- Hayes Health Technology Website:  
<https://www.HayesInc.com/>
  - This reference is used for new and evolving technology.
- Nationally recognized utilization management criteria and established practice guidelines
- In-network and out-of-network physician specialty consultants.
- Members of the QAUMPTcommittee or outside consultants.
- Other Commercial health plan criteria

The Medical Services team reviews requests for services. The Medical Services team consists of health service representatives, nurse case managers, member support specialists, and medical directors. Requests are prioritized based on the date received, urgency status, and type of request. Consideration is also given to plan benefits and the needs of individual members. The attending physician and/or the primary care physician are

consulted during the review process as appropriate and as needed. Clinical staff conducts medical review under the direction of the medical directors. With all approval and denial decisions, letters are issued to providers and members.

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