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Association

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PhD
*Board
Chairperson*

Alan P. Spielman
*President and
CEO*

September 15, 2010

The Honorable Hilda L. Solis
Secretary of Labor
Attention: OCIIO-9993-IFC
200 Constitution Avenue, N.W
Washington, DC 20210

Dear Secretary Solis:

This letter comments on the Interim Final Rule with request for public comment published in the *Federal Register* on July 23rd concerning internal claims, appeals and external review processes for group health plans and health insurance issuers. These comments are offered on behalf of URAC, an independent, nonprofit organization promoting health care quality through accreditation, education and measurement programs. URAC accreditation is recognized by 43 states, the District of Columbia and four federal agencies including the Centers for Medicare and Medicaid Services.

This regulation is promulgated pursuant to the Patient Protection and Affordable Care Act (PPACA) in order to ensure that plans and issuers implement more uniform internal and external appeals processes, as well as to set a minimum standard of consumer protections for participants, beneficiaries, and enrollees. As a result of this interim final rule, patients and consumers will finally have a standardized process under which they can appeal health plan decisions, both inside the health plan and to an external Independent Review Organization (IRO), regardless of where they live or the type of health insurance coverage. Where states do not act to meet minimum standards set by the NAIC, a federally run external review program will ensure these important consumer protections are available. URAC offers the following comments regarding the Interim Final Rule.

The Interim Final Rule released by the Department of Health and Human Services, Department of Labor and Department of Treasury requires that state regulated appeal processes utilize accredited Independent Review Organizations (IROs) to review patient and consumer appeals of health plan decisions. Under technical guidance released by the Department of Labor on August 23rd directed at non-grandfathered self-insured group health plans that are subject to federal external review process requirements, such health plans are also required to utilize accredited Independent Review Organizations (IROs) for the determination of external appeals. Accrediting organizations are valued by both state and federal regulators for their ability to conduct independent and impartial reviews of organizations' internal management processes.

Specific to the interim rule, URAC offers two highly regarded accreditation programs that are directly aligned with assuring compliance with the interim rule's requirements:

1. Independent Review Organization Accreditation

URAC's IRO accreditation program provides standards that assure organizations conducting reviews and external appeals are free from conflicts of interest, establish qualifications for clinical reviewers, and address medical necessity and experimental treatment issues. URAC's

IRO standards also ensure that if a health plan's criteria are out of date the case is reviewed using current evidence-based guidelines for medical necessity, thereby protecting patient safety. In addition, URAC's IRO standards ensure that IROs conducting reviews meet mandated time periods for standard reviews, expedited reviews, and appeals processes.

URAC's IRO accreditation standards mirror those of the NAIC's Health Carrier External Review Model Act. URAC participated in the NAIC's multi-stakeholder development process for the Model Act, along with consumer groups, medical groups, and other accrediting bodies. Because URAC's IRO accreditation demonstrates compliance with the NAIC's Health Care External Review Model Act, state regulators have increasingly turned to URAC's IRO accreditation program for its valuable oversight assurance. States seeking to find URAC-accredited IROs can access lists by state on URAC's website at:

<http://www.urac.org/directory/DirectorySearch.aspx>. As of September 16, URAC's directory lists 42 organizations as having achieved IRO accreditation.

On a related note, the Department of Labor should be aware of the need to build adequate nationwide capacity in the number of accredited IROs. The Department should consider targeted outreach to potential IROs to promote awareness of the need to become accredited in order to ensure there is an adequate number of IROs across the country.

URAC supports the requirements that IROs be accredited to ensure consumers receive due process and that clinical reviews are truly independent.

2. Health Utilization Management Accreditation

The second relevant program is URAC's Health Utilization Management (HUM) accreditation program. While IRO accreditation focuses on the processes and credentials of independent organizations conducting benefits and clinical reviews, HUM accreditation ensures the health plan or third party administrator internal medical necessity reviews are in compliance with industry standards and federal regulations.

For example, URAC's HUM program ensures the following:

- Requires internal health plan processes for reviewing medical necessity appeals of denied claims are timely, evidence-based and reviewed by licensed clinical peers;
- Requires that medical necessity denials are only rendered by licensed physicians,
- Requires toll-free complaint lines be made available between 9:00 am to 5:00 pm in every time zone where reviews are conducted;
- Requires that review staff respond to requests from patients, facility personnel, attending or ordering physician or other health personnel of specific utilization management requirements and procedures;
- Requires that licensed health professionals are available to non-clinical administrative staff while performing non-clinical initial screenings;
- Maintains separate timelines for prospective, retrospective and concurrent reviews;
- Ensures treating physicians are ensured access to peer reviewers during the review process so that all clinically relevant information is taken into account during medical necessity reviews;
- Requires plans to provide patients with timely written clinical rationales when care is denied based on medical necessity and accept requests for appeals verbally and in writing from the consumer and/or treating provider

URAC's HUM guidelines also ensure that requests for expedited review of denied care are processed within timelines established by the Department of Labor.

URAC suggests that the Department of Labor explore how Health Utilization Management accreditation might be utilized as a compliance and oversight tool to further strengthen consumer protection and access to needed health care services as a mechanism to avoid inappropriate denials of medically necessary care.

URAC's overriding goal in both the IRO and HUM accreditation programs is consumer protection. In keeping with that mission, URAC separately investigates consumer complaints against accredited companies. Consumers and providers can lodge a complaint against an accredited company by visiting: <http://webapps.urac.org/complaint/>.

Thank you for your time and consideration of these comments.

Sincerely,

A handwritten signature in cursive script that reads "Alan P. Spielman".

Alan P. Spielman,
President and CEO

Attachments:

URAC Independent Review Organization Program Standards v4
URAC Health Utilization Review Standards v6

Appendix A

Overview of URAC

URAC is an independent, nonprofit organization whose mission is to promote continuous improvement in the quality and efficiency of health care management through the processes of accreditation, education and measurement. Our strategic priorities are to:

- Enhance Continuity of Care;
- Encourage Transparency: Cost & Performance/Quality Data;
- Engage Consumers in their Health Care Management;
- Enhance Operational Management Effectiveness; and
- Engender Support for Evidence-Based Decision-Making

To support these goals, our Board of Directors represents the full spectrum of stakeholders interested in our health care system, including consumers, employers, health care providers, health insurers, purchasers, workers' compensation carriers and regulators.

Incorporated in 1990, URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care determinations of medical necessity. As the health care industry evolves, URAC continues to address emerging issues: we now offer over 27 accreditation and certification programs across the health care spectrum (i.e., Case Management, Claims Processing, Consumer Education and Support, Core Organizational Quality, Credentials Verification Organization, Comprehensive Wellness Accreditation Program, Disease Management, Drug Therapy Management, Health Call Center, Health Content Provider, Health Network, Health Plan, Health Provider Credentialing, Health Utilization Management, Health Website, HIPAA Privacy, HIPAA Security, Independent Review Organization, Mail Service Pharmacy, Medicare Advantage Deeming, Pharmacy Benefit Management, Specialty Pharmacy, Workers' Compensation Utilization Management, Provider Performance Measurement and Public Reporting, Uniform External Review, Vendor Certification, and Pharmacy Benefit Management for Workers Compensation and Property and Casualty).

Many states have found URAC accreditation standards helpful in ensuring that managed care plans and other health care organizations are meeting quality benchmarks. Forty-three states and the District of Columbia currently reference one or more URAC accreditation programs in their statutes, regulations, agency publications or contracts, making URAC the most recognized national managed care accreditation body at the state level.

At the federal level, four federal agencies recognize URAC accreditation. The Centers for Medicare and Medicaid Services (CMS) recognize URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (formerly Medicare+Choice) Program; CMS' Center for Medicaid State Operations recognizes the comparability of URAC Health Plan Standards with the federal Medicaid Managed Care Regulations; the Office of Personnel Management recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program; TRICARE/Military Health System recognizes URAC Health Network, Disease Management, Health Utilization Management and Case Management Accreditations; and the Department of Veterans' Affairs recognizes URAC's Health Call Center Accreditation, URAC Independent Review Organization Accreditation, and URAC Health Utilization Management Accreditation.

URAC Standards: Establishing Quality Benchmarks

URAC accreditation serves as a symbol of excellence in the health care industry, promoting prevailing industry standards and consumer protections. In the rapidly evolving field of health care, URAC standards are developed through a dynamic process that identifies best practices and promotes high quality performance measurement. All stakeholders in the health care arena actively participate with URAC in developing these quality benchmarks through an inclusive process that incorporates an opportunity for public comment.

URAC's standards development process begins with a period of careful research, debate and discussion among stakeholders. An initial set of standards is then proposed and made available for a public comment and review. URAC's advisory committees review the submitted comments, make appropriate changes, and the draft standards are then beta tested with a discrete group of companies in order to ensure that they work in practice. After beta testing, the standards may be modified again, and then they are forwarded to URAC's Board of Directors for consideration and approval. URAC revises its standards through this process at least every three years.

URAC Accreditation Review Process

The URAC accreditation review process begins with applicants for accreditation submitting material through AccreditNet, URAC's secure online application system. When an application arrives, a reviewer is assigned to conduct an assessment of the submitted documentation for compliance with URAC standards. Any standard that appears non-compliant is noted and communicated to the client with a recommended course of action to meet the standard. Then an onsite review is conducted for each applicant.

URAC staff reviewers are clinical experts who provide application support through the entire accreditation process, including a sharing of best practices during the onsite review. The objective of the onsite review is to verify operational compliance with URAC standards. URAC reviewers, for example, interview the applicant's staff and review a statistically valid sampling of relevant documentation, including specific quality information. With respect to quality data, URAC accepts nationally recognized measures, such as HEDIS measures to evaluate plan performance and CAHPS data to evaluate consumer satisfaction. URAC may also consider other credible NQF-endorsed or CMS-recognized quality measures.

The findings from an applicant's onsite review are anonymously presented to the URAC committees that make the accreditation determinations through an Executive Summary report. Committee members include industry peers and experts such as physician providers, plan physicians, quality management professionals, information technology experts, pharmacists and security/privacy officials. Levels of accreditation are awarded in accordance with corporate policy and URAC's accreditation scoring methodology. Applicants receive an official notification letter with their accreditation status and a certificate of accreditation.

Health Utilization Management Standards, Version 6.0

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Copyright for Health Utilization Management 2008

Health Utilization Management Standards, Version 6.0, August 2008

Previous versions:

Health Utilization Management Standards, Version 5.1, April 2007
Health Utilization Management Standards, Version 5.0, January 2006
Health Utilization Management Standards, Version 4.2, April 2003
Health Utilization Management Standards, Version 4.1, July 2002
Health Utilization Management Standards, Version 4.0, November 2001
Health Utilization Management Standards, Version 3.0, June 1997
National Utilization Management Standards, 1994
National Utilization Review Standards, 1991

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Message from URAC

Dear interested party or applicant:

Quality-based operations should be the centerpiece of any company doing business in today's health care system. Quality improvement activities promote a wide range of benefits such as increasing operational efficiencies, reducing business risks and improving patient health outcomes. However, health care professionals must identify and implement a quality improvement methodology that really works for their particular business model and health care setting.

Through its modular approach to accreditation, URAC works with the industry and other key stakeholders to benchmark URAC standards against key organizational structures and business functions. Now in its 20th year of operation, URAC offers over 20 different accreditation and certification programs and has issued more than 10,000 accreditation certificates to companies operating in all 50 states and internationally. URAC also is recognized as part of the regulatory process in three-fourths of the states and by four federal agencies.

URAC, as a nonprofit, independent accreditation agency, brings to the table a nationally-recognized accreditation process and seal of approval. URAC's success is tied in large part to the broad-based, consensus-driven process by which hundreds of volunteers help URAC draft and update its standards and also oversee the accreditation system. These volunteers represent the interests of a wide variety of stakeholders including purchasers, regulators, consumers, providers and industry representatives.

All companies that apply for URAC accreditation make improvements to their operations as a result of the review process. The desktop review of the application identifies issues early on in the process and helps focus the onsite review, which is designed to confirm compliance with the standards. During the onsite visit, accreditation reviewers exchange information with applicants in what often becomes a mutual learning experience. URAC's goal is to identify and promote best practices for each market segment that it accredits.

Receiving the accreditation certificate signifies a job well done and distinguishes the organization as having met a standard of excellence. As a result, URAC-accredited organizations join the ranks of a select community who have documented and verified their commitment to quality health care.

Please contact URAC if you would like to find out more about the accreditation process or to become involved with one of our committees, educational programs, research initiatives, or other projects. We look forward to hearing from you.



Introduction to URAC Accreditation Guides and Standards

URAC offers two references addressing standards. The *Standards* publication provides a copy of the standards produced by URAC and defined terms, which are *italicized* within the standards. It is a resource for government agencies and private entities wanting to examine the standards for their own purposes. For organizations contemplating accreditation, URAC's *Accreditation Guide* provides, in addition to the standards, information about the documentation to submit as evidence for meeting the intent of the standards as well as the types of materials and activities URAC's accreditation reviewers will be examining during an onsite visit. Both the Accreditation Standards and Guide are available through URAC's Business Development Department at (202)216-9010 or send an e-mail to BusinessDevelopment@urac.org. For detailed information about how to prepare an application for accreditation, please go to: <http://www.urac.org/healthcare/accreditation/accreditnet.aspx> for a copy of the *AccreditNet Instruction Booklet*, designed to complement the Accreditation Guide for applicant organizations.

The Accreditation Standards and Accreditation Guide are intended to provide guidance only. The URAC Accreditation Committee and Executive Committee hold the final authority to make determinations regarding interpretation and application of standards, and an applicant's compliance with standards.

The Accreditation Guide is provided to assist applicants understand the meaning or intent of the standards. That being said, it cannot cover all possible situations and subsequent interpretations that may apply. Therefore, applicants should be aware that the standards are subject to ongoing interpretation and as such, changes can be made to the Accreditation Guide.

Each company applying for accreditation should carefully review URAC's accreditation standards and the defined terms *italicized* within the standards, then use the Accreditation Guide and AccreditNet Instruction Booklet to prepare an application for submittal to URAC.

Modular Concept

URAC uses a “modular accreditation system” that is adaptable to the continuing evolution of the health care system. A module is a set of standards established for a particular health care function. The collection of standards contained within modules are unique to that health care service or function. The Core Standards incorporate the basic elements necessary to promote quality for any type of health care organization and were designed for two purposes: 1) to act as a “foundation” for function-specific accreditation programs, and 2) to act as a “stand-alone” accreditation program for companies not delivering services under one of the specific functions or modules.

Each accreditation will include Core and the module(s) covering the functions.

Core Standards + Module(s) = Specific Accreditation

Core “stand-alone” accreditation will only consist of Core Standards.

Core Standards Only = Core “Stand-Alone” Accreditation

Eligibility to apply for Core “stand-alone” accreditation is determined on the basis of how a company markets itself. If a health care organization markets any of the services addressed under one of URAC’s modules, Core “stand-alone” accreditation is not an option. An example of an organization that would be eligible for Core “stand-alone” accreditation is an organization that provides health care educational services.

For applicants, the modular system provides the flexibility to choose from a variety of accreditation programs. For example, an applicant may choose to apply for Utilization Management (UM) accreditation initially, and when up for reaccreditation, add the Case Management (CM) module.

Core with Single-Module Application (Example: Core & UM only)

Core with Multi-Module Application (Example: Core & UM + CM)

With several choices available, an applicant can tailor the accreditation to its current needs and business goals. If you are not sure what modules would best fit your organization, URAC’s Business Development Department can be reached at BusinessDevelopment@urac.org or at (202) 216-9010 to answer questions, provide pricing information and help organizations decide the best course of action.

Compliance with State and Federal Law

The Accreditation Guide provides information on URAC’s expectations regarding compliance with each standard. Some standards require applicants to attest to compliance with specific state regulations regarding operational policy and procedure. Prior to submitting an application the applicant should conduct a review of its legal obligations, including those addressed in the standards. Although it is not indicated for each standard, URAC expects that the applicant will be in compliance with all applicable state and federal laws that pertain to relevant operations. State and federal laws supersede URAC Standards if the laws or regulations are more rigorous than URAC Standards. Conversely, an applicant must comply with URAC Standards if the standards are more stringent. If an applicant is required by law to carry out its business in a manner not consistent with URAC Standards, then the applicant may request a variance from a URAC Standard. A copy of the relevant statute or regulation must accompany the request submitted for that standard in the application.

Standards and Interpretation

The standards are grouped together into modules, with each module representing various health care functions. Individually, the standards address the structures and processes that need to be in place for performing the function to be accredited according to national standards. For the most part, an applicant is expected to be in compliance with all applicable standards at the time of application for accreditation.

In the *Accreditation Standards*, you will find:

- * **Definitions.** All italicized terms found in the standards are defined in this section.
- * **Standards with assigned Weights.** Standard elements include assigned weights for scoring. If an element in and of itself does not contain enough information to evaluate compliance without the following sub-element, then it is noted as "Not Weighted."

In the *Accreditation Guide*, you will find:

- * **Definitions.** All italicized terms found in the standards are defined in this section.
- * **Standards with assigned Weights and Interpretive Information for each Standard.**
- * **Points to Remember and Scope of Standards.** These bullet points identify important issues to consider when documenting your organization's compliance with the standard. In some cases, additional details are provided that will help your compliance efforts and in other cases, these details will alert you to potential pitfalls.
- * **Evidence for Meeting the Standards: Desktop Materials and Onsite Review Materials and Activities.**
- * **Bright Ideas.** This section is not used for every standard and contains common industry practices that may be helpful to the applicant organization. (Note: adoption of a "bright idea" is not required for compliance with a standard, nor does adoption of the "bright idea" guarantee compliance with that standard.)
- * **Related Standards.** This section is not used for every standard, but helps to identify relationships between standards that are not always obvious and helpful to know about.



Scoring Methodology

Policy Regarding “Not Applicable” Elements and Standards

If a weighted standard element or an entire standard is determined to be *not applicable*, then they are not included in the scoring calculations (i.e., deducted from the denominator). This includes the rare instance when a “variance” is granted by the requisite URAC committee. As a result, applicants are not penalized when a standard element or standard is not applicable.

If a mandatory standard element is determined to be *not applicable*, then it does not count against the applicant when determining an accreditation category; however, applicant organizations must have a policy that meets the intent of a mandatory standard element even if it is not currently being implemented. The only exception to this policy is the collection of mandatory standard elements in Core that apply to delegation where if an applicant organization is not delegating, then documentation on delegation for these standards is *not required* even though some of the standard elements are mandatory (e.g., Core 8(b), Core 8(h) and Core 9(b) in version 3.0 of Core).

An applicant may choose not to meet any or all leading indicator standard elements (i.e., leading indicators are *optional*); therefore, a leading indicator standard element, which is not weighted, cannot be made *not applicable*. Not all accreditation standard sets have leading indicators.

Standard Element Weights

URAC’s Scoring System has six (6) distinct categories of standard elements:

- Weight = 1: Emerging Practice
 - Weight = 2: Basic Infrastructure
 - Weight = 3: Promotes Quality
 - Weight = 4: Key Stakeholder Right / Empowers Consumers
 - Mandatory = M: Non-weighted, mandatory element with a direct or significant impact on consumer safety and welfare
- o **All mandatory elements must be met at 100% compliance in order to achieve a Full accreditation**
 - o If determined to be not applicable, applicant must have a policy and procedure in place that meets the intent of the element should the organization need to implement it in the future
 - Leading Indicator = L: Non-weighted, *optional* element highlighting effective practices not yet widely adopted in health care
 - o Potential forecast of where the health care industry may be heading

- o Provides a way for an organization to distinguish itself from other accredited companies
- o **Leading indicators are not reported to URAC’s Accreditation or Executive Committees and do not influence an applicant’s final accreditation score or category**
- o Cannot be designated “not applicable” given that they are *optional*
- o Before URAC will acknowledge that an applicant has met a leading indicator:
 - Full accreditation must be achieved, and
 - Element must be met at 100% compliance
 - Initially URAC will list leading indicators in the Accreditation Summary Report (ASR)
- o Other types of marketing exposure may be considered in the future (e.g., Website, conferences, etc.)

Definitions for the standard element categories are listed on the following pages. As you analyze the standard elements to assign a weight, keep in mind the following:

- Standards are no longer weighted, but standard *elements* are. Elements are the components of a standard that are evaluated through the accreditation review process.
- Standard elements are no longer designated as “primary” or “secondary.”

Computing an Accreditation Score

- Scoring an Element
- o Element weight x Compliance
- Scoring a Standard
- o Total points achieved ÷ Total points possible
- Scoring a Module

o Total points achieved ÷ Total number of standards

- Scoring a multi-Module accreditation

o (Core score x .30) + (Module score x .70)

- Scoring a multi-Site accreditation

o Lowest site score determines the application score

Determining an Accreditation Category

- If one Mandatory standard element is not met Conditional
- If two Mandatory standard elements are not met Corrective Action
- If three Mandatory standard elements are not met Denial
- If all Mandatory standard elements are met:

≥ 94 points/100 and complies 100% on at least one “Leading Indicator” standard Include compliance with Leading Indicator(s) on the Accreditation Summary Report (ASR)

≥ 94 points/100 Full Accreditation

≥ 90, but < 94 points/100 Conditional Accreditation

≥ 85, but < 90 points/100 Corrective Action

< 85 points/100 Denial

Rating Compliance with a Standard Element

Standard elements are individually rated at 100% (full compliance), 50% (partial compliance) or 0% (no compliance) as follows:

For elements that require a file/record audit, the audit must reveal:

% Compliance with Element

100% Compliance (Full Compliance) = Audit score \geq 80%;

Note: A mandatory element must be met at 100% compliance with an audit score of \geq 90%; if not, then the mandatory element is considered *not met*. Credentials verification must be met at 100%. Applicants must meet all applicable mandatory elements in order to achieve Full accreditation.

Note: A leading indicator element must be met at 100% compliance; if not, then the leading indicator is considered *not met*. Applicants do not have to meet leading indicators since these types of elements are *optional*, acting as “extra credit.”

Note: A minimum of 30 files will be pulled for file review, but if the applicant does not have 30 files, then all files will be reviewed. For initial accreditation, the file selection date range will begin from the date that the application was submitted for accreditation up to the date of the onsite. For reaccreditation reviews, files will be pulled from the time period since the last URAC accreditation onsite visit.

- 50% Compliance = Audit score \geq 65%, but $<$ 80%, or for contracts the audit score is $<$ 80%, but the applicant has an internally approved, compliant contract template.
- 0% Compliance = Audit score $<$ 65%, or for contracts the applicant does not have an internally approved, standards-compliant contract in place.

For elements that do not require a file/record audit:

% Compliance with Element

100% Compliance (Full Compliance) = Element documented pursuant to the standard element and upon verification is found to be fully implemented.

Note: A mandatory element must be met at 100% compliance; if not, then mandatory element is considered *not met*. Applicants must meet all applicable mandatory elements in order to achieve Full accreditation.

Note: A leading indicator element must be met at 100% compliance; if not, then the leading indicator is considered *not met*. Applicants do not have to meet leading indicators since these types of elements are *optional*, acting as “extra credit.”

- A standard element is implemented, where *at least one* of the following onsite activities is verified:

- o Staff is observed conducting the procedure correctly; or
- o Staff verbalizes the procedure correctly; or
- o Documented examples of implementation are surveyed; or
- o Documentation of oversight is reviewed; or
- o Management attests to its implementation and provides supporting documentation (i.e., sign-in sheets showing staff training session occurred, CV of newly hired medical director, sample of revised and distributed documentation such as a provider directory, notification letters, etc.)

- 50% Compliance (Partial Compliance) = Element documented pursuant to the standard element, but not consistently or completely implemented.
- One or more incidences of non-compliance in implementation will lower the compliance rating to 50%. This would include:

- o Errors implementing work processes during on-site observation by the URAC Reviewer.
- o Mistakes during interviews. If staff catches the error – misspoke – and corrects it, then this will not count as evidence of non-compliance.
- o Reports with data or analysis demonstrating non-compliance (e.g., not meeting timelines, wrong staff conducted the procedure, provider listed in a directory prior to credentialing, etc.)
- o Meeting minutes revealing decisions contrary to meeting the intent of the standards or lacking documentation indicating that a key activity did not take place (e.g., vote to eliminate provider appeal mechanism, minutes do not reflect review and update of the quality management program, etc.)

0% Compliance (No Compliance) = No evidence or incomplete evidence of compliance with the standard element in documentation or, regardless of documentation, applicant has not implemented the structures or processes needed to comply with the standard element. No compliance is exemplified when *any one* of the following statements is true.

The standard element is:

- Not addressed in documentation,
- Only partially addressed in documentation,
- Addressed in documentation, but does not meet the intent of the standard element,

- Not implemented, which *does not* include situations where:
 - o The organization did not have the opportunity to implement. An example of this would be where an organization has an appeal process in place, but is either not contracted to do appeals or simply has not had an appeal of the type addressed by the standard.
 - o The organization has been in business < six (6) months and is therefore eligible for a provisional accreditation.
 - Implemented in a non-compliant manner, or
 - Implemented, but one or more staff shows a pattern (≥ 4 occurrences) of non-compliance with an element over a period of time (within six (6) consecutive months), regardless of any warnings, corrective action taken (including training or procedural changes), or relative improvement over time.

Scoring a Weighted Standard Element

To score a weighted standard element (“element”),

- Multiply the element weight by the compliance factor achieved (e.g., 0 for *no compliance*, .50 for *partial compliance* or 1.0 for *full compliance*).

Calculation for Standard Element Score

(Compliance factor) \times (Weight of standard element) = Score for an Element

Scoring a Standard

To score a standard with weighted elements,

- Sum the score achieved for each element.
 - Divide by the number of points possible (sum of the element weights) for the entire standard.
- o Weights for the elements determined to be not applicable are not included in the denominator and as such do not count against the applicant.
- Multiply by 100; this provides a percentage score for the standard.

Calculation for Standard Score

$[(\text{Sum of all applicable element scores}) \div (\text{Total possible points for the standard})] \times 100 = \text{Standard Score}$

Calculating a Final Total Accreditation Score for Core-only Applications and Accreditations that do not include Core

To calculate a final score for Core-only and non-Core Module Applications,

- Sum the scores for each standard.
 - Divide by the total number of applicable standards.
- o Standards determined to be not applicable are not included in the denominator and as such do not count against the applicant.

Calculation for Core and non-Core Module Score

$$[(\text{Sum of all applicable standard scores}) \div (\text{Total number of applicable standards})] = \text{Module Score} = \text{Final Total Score (round to nearest tenth)}$$

Note: For purposes of calculating an accreditation score, the number of standards possible is the total count of standards that have at least one weighted element; standards that do not have any weighted elements (i.e., only mandatory and/or leading indicator elements) are not included in the count since they do not contribute a standard score towards the module score. It is not logical to include standards in the denominator when it has no points to contribute to the score and to include such a standard in the denominator would unfairly penalize the applicant.

Note: If all weighted elements in a standard are determined to be not applicable, then the standard does not count towards the total number of applicable standards for purposes of scoring a module. To count them would unfairly penalize the applicant and is contrary to the URAC policy on standards determined to be not applicable.

Calculating a Final Total Accreditation Score for Multi-Module Accreditations

To calculate a final total accreditation score for multi-module accreditations, which includes:

- Core + a single Module (e.g., Health UM, IRO, CES, etc.)
- Core + multiple Modules (e.g., Health Plan, Health Network, etc.)

For Core:

- Sum all of the Core standard scores.
- Divide by the total number of applicable standards.
 - ◆ Standards determined to be not applicable are removed from the denominator and as such do not count against the applicant.

- Multiply the Core score by .30 since Core is 30% of the final score for multi-module accreditations that include Core.

For non-Core module score:

- Sum all of the standard scores from all of the non-Core modules.
- Divide by the total number of applicable standards.
 - ◆ Standards determined to be not applicable are removed from the denominator and as such do not count against the applicant.
- Multiply the non-Core score by .70 since the non-Core modules collectively contribute to 70% of the final score.
- Sum the percentage score for Core and the modules; a perfect score would be 100%.

Final Total Score

$(\text{Core score} \times .30) + (\text{non-Core score} \times .70) = \text{Final Total Score for One or Multiple Sites (round to nearest tenth)}$

Final Total Score if all Sites achieve a Full (≥ 94)

$(\text{Sum of all Full onsite scores}) \div (\text{Number of sites that had an onsite review}) = \text{Final Full Accreditation Score (round to nearest tenth)}$

Note:

- Each site that has an onsite review receives its own score; however, the lowest of these scores determines the score for the overall application.
- If all sites receiving an onsite review achieve a Full, the average score for these sites is the final score for the application. (See calculation above.)
- If there is a trend of three (3) or more sites that achieve less than a Full accreditation, then the URAC Reviewer has the discretion to visit all of the sites in the application.

Determining How Many Mandatory Elements are Met and Not Met

Mandatory elements are non-weighted elements and all applicable mandatory elements must be met at 100% compliance in order for an applicant to achieve Full accreditation.

- Mandatory elements that are determined to be not applicable are subtracted from the total count of mandatory elements and do not count against an applicant.

- Mandatory elements with a compliance level less than 100% (e.g., partial compliance [.5] and no compliance [0]) are considered *not met* and count against an applicant when determining an accreditation level. (See “Determining an Accreditation Level.”)



Definitions for Health Accreditation Standards

(NOTE: Defined terms appear in italics throughout the standards).

Being familiar with these definitions is critically important to accurate understanding of URAC Standards. In the Standards, defined terms are *italicized*. Readers are encouraged to refer to the definitions section each time they encounter an italicized term until they feel they have committed the meaning of that term to memory.

Abandonment Rate: The percentage of calls offered into a communications network or telephone system -- i.e., automatic call distribution (ACD) system of a call center -- that are terminated by the persons originating the call before answer by a *staff* person.

Interpretive note for term "Abandonment Rate": Abandonment rate is measured as the percentage of calls that disconnect after 30 seconds when an individual (live person) would have answered the call. For example, if there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended. (On ACD reports, monitor calls that "drop" after 30 seconds.)

Access: The *consumer's* or *client's* ability to obtain services in a timely manner.

Interpretive Note: The measures of *access* for *consumers* are determined by components such as the *availability* of services, their acceptability to the *consumer*, *consumer* wait time, and the hours of operation.

The measures of *access* for *clients* are determined by components such as turn-around time and other metrics as they may be defined in written business agreements, etc.

Adverse Benefit Determination: A decision by the *Organization* to deny or reduce a benefit for some or all of the lines of a *claim* (other than the application of a deductible or other cost-sharing).

Adverse Event: An occurrence that is inconsistent with or contrary to the expected outcomes of the *Organization's* functions.

Advisory Board of Osteopathic Specialists (ABOS): American Osteopathic Association (AOA) *certification* agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and pattern of training.

American Board of Medical Specialties (ABMS): Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

Appeal: A written or verbal request by a *consumer, ordering provider* or prescriber to contest an organizational determination (e.g., services have been denied, reduced, etc.).

Interpretive Note for term “Appeal”: Specific terms used to describe *appeals* vary, and are often determined by law or regulation.

Appeals Consideration: Clinical review conducted by appropriate *clinical peers*, who were not involved in *peer clinical review*, when a decision not to certify a requested admission, procedure, or service has been appealed. Sometimes referred to as “third level review.”

Assessment: A process for evaluating individual *consumers* that have been identified as eligible for a medical management program, such as *disease management* or *case management*, to identify specific needs relating to their clinical *condition* and associated co-morbidities.

Attending Physician: The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a *patient* in a hospital or other health care *facility*.

Attending Provider: The physician or other health care practitioner with primary responsibility for the care provided to a *consumer*.

Average Speed of Answer: The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a *staff* person.

Interpretive note for term "Average Speed of Answer": The speed of answer is measured starting at the point when an individual (live person) would have answered the call. For example, if there is a pre-recorded message or greeting for the caller, the time it takes to respond to the call (i.e., average speed of answer) begins after the message/greeting has ended.

Benefit Calculation: An adjustment or calculation by the *Organization* of the financial reimbursement for a *claim* under the terms of the applicable benefit plan, provisions, *criteria*, provider contracts, or state rules.

Benefits Program: An arrangement to pay for health care services provided to a *consumer*. “Benefits program” includes, but is not limited to, health and medical benefits provided through the following *organization* types:

- ◆ Health maintenance *organizations* (HMOs);
- ◆ Preferred provider *organizations* (PPOs);
- ◆ Indemnity health insurance programs;
- ◆ Self-insured plans;
- ◆ Public programs, such as Medicare and Medicaid; and
- ◆ Workers’ compensation insurance programs.

Blockage Rate: The percentage of incoming telephone calls “blocked” or not completed because switching or transmission capacity is not available as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in *callers* receiving a busy signal.

Board-certified: A *certification* – approved by the *American Board of Medical Specialties*, the American Osteopathic Association, or another *organization* as accepted by URAC – that a physician has expertise in a particular specialty or field. To the extent that future URAC standards include other *certifications*, URAC will specify further approved boards.

Interpretive Note for term “Board-certified”: URAC recognizes that ABMS- and AOA-approved board certifications may not be the only certification programs that may be acceptable for health professionals in

URAC-certified organizations. For example, non-physician professionals will have appropriate certifications that are not ABMS- or AOA-approved. Any applicant wishing to have URAC recognize another board certification program should notify URAC early in the certification process. URAC will then take this recommendation to URAC's Accreditation Committee.

The Accreditation Committee will review all requests, and will decide to approve or reject the certification. The Accreditation Committee will consider the following criteria in judging whether a certification is acceptable:

- ◆ Is the certification accepted within its target community of health professionals?
- ◆ Was the certification developed through an open, collaborative process?
- ◆ Does the certification reflect accepted standards of practice?
- ◆ Is the certification administered through an objective process open to all qualified individuals?

Caller: The consumer inquiring to obtain health care information. This may also be a representative inquiring on behalf of the consumer.

Case: A specific request for medical or clinical services referred to an organization for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not. It is a non-approval regarding medical necessity and medical appropriateness decisions for services covered under a health benefit plan's terms and conditions or for coverage decisions regarding experimental or investigational therapies that is at issue during the independent review process.

Case Involving Urgent Care: Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or

b) in the opinion of a physician with knowledge of the consumer’s medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case. (**Note:** This definition is derived from the Department of Labor’s definition of “claim involving urgent care.”)

Interpretive Note for term “Case Involving Urgent Care”:

While the URAC standards are silent on the methods by which a claim is determined to be a “case involving urgent care,” the Department of Labor claims regulation (29 C.F.R. § 2560.503-1(m)(1)) specifies that whether a claim is a “claim involving urgent care” is to be determined by an individual acting on behalf of the health benefits plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care.”

Case Management: A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs using communication and available resources to promote quality cost-effective outcomes.

Certification:

1) (UM Specific Definition) A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Interpretive Note for term “Certification”: “Determination” may vary depending on context.

2) (General Definition) A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization. To qualify under these standards, the certification program must:

- ◆ Establish standards through a recognized, validated program;
- ◆ Be research-based; and
- ◆ Be based (at least partially) on passing an examination

Claim: Any bill, claim, or proof of loss made by or on behalf of a consumer or health care provider to an Organization (or its intermediary, administrator, or representative) for which the consumer or health care provider has a contract for payment of health care services. (Note: definition based on Code of Virginia §

38.2-3407.15.)

Claimant: A person or entity who submits a claim, or on whose behalf a claim is submitted. (Includes “consumer” for URAC’s Core Standards.)

Claims Administrator: Any entity that recommends or determines to pay claims to enrollees, physicians, hospitals, or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third party administrators, or other private contractors.

Claims Processing Organization: An organization that seeks accreditation under these standards. Examples of organizations that process claims include but are not limited to:

- ◆ Health insurance companies;
- ◆ Health maintenance organizations (HMOs);
- ◆ Preferred provider organizations (PPOs);
- ◆ Third-party administrators (TPAs);
- ◆ Disability insurance carriers; and
- ◆ Workers’ compensation insurance carriers.

Interpretive Note for term “Claims Processing Organization”: Throughout this document the term “organization” refers to claims processing organization.

Clean Claim: A claim that has no material defect, impropriety, lack of any required substantiating documentation, or special circumstance(s) – such as, but not limited to, coordination of benefits, pre-existing conditions, subrogation, or suspected fraud – that prevents timely adjudication of the claim.

Clean Credentialing File: A credentialing application is considered “clean” if it meets the following criteria:

- ◆ The provider has completed all applicable sections of the credentialing application.
- ◆ Where indicated, the provider has signed, initialed and dated the credentialing application.
- ◆ All necessary supporting documentation has been submitted and is included with the credentialing application in the provider’s file.
- ◆ Credentials verification reveals that there are **no** issues to report to the credentialing committee as defined in the organization’s credentialing plan. At a minimum, URAC considers the following items

to be “issues” for any credentialing application:

- ◇ Any lapse in practice greater than six (6) months*
- ◇ Any history of malpractice claims or settlement*

- *Unless a specific reason for a laps in practice greater than six (6) months or particular history of malpractice as defined in the credentialing plan and approved by the credentialing committee *is determined not to be an issue* requiring credentialing committee review.
- *By way of example, the credentialing committee may decide that for an orthopedic surgeon or OB/GYN physician, unless malpractice claims go over a certain dollar (\$) amount, their credentialing files do not need to be reported as files with issues to the committee.
- *The medical director for credentialing must always have the authority to forward a credentialing file to the credentialing committee at his or her discretion.

5. The provider meets the credentialing criteria approved by the credentialing committee and as stated in the credentialing plan.

Client: A business or individual that purchases services from the Organization.

Interpretive Note for term “Client”: Here are some examples of client relationships:

- ◆ If a health plan provides health coverage to an employer, the employer is the client.
- ◆ If a health plan contracts for utilization management services from a utilization management organization, the health plan is the client.
- ◆ If a PPO contracts for credentialing services with a CVO, the PPO is the client.

Clinical Activities: Operational processes related to the delivery of clinical triage and health information services performed by clinical staff.

Clinical Decision Support Tools: Protocols, guidelines, or algorithms that assist in the clinical decision-making process.

Clinical Director: A health professional who: (1) is duly licensed or certified; (2) is an employee of, or party to a contract with, an organization; and (3) who is responsible for clinical oversight of the utilization management program, including the credentialing of professional staff and quality assessment and improvement functions.

Clinical Peer: A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the

same licensure category as the ordering provider.

Clinical Practice Guidelines: Systematically developed statements to assist decision-making about appropriate health care for specific clinical circumstances.

Clinical Rationale: A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review Criteria: The written screens, decision rules, medical protocols, or guidelines used by the organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

Clinical Staff: Employees or contracted consultants of the health care organization who are clinically qualified to perform clinical triage and provide health information services.

Clinical Triage: Classifying consumers in order of clinical urgency and directing them to appropriate health care resources according to clinical decision support tools.

Comparable: Data about performance is compared to an historical baseline (which may be internal) and ongoing progress is recorded in regular intervals (e.g., monthly, quarterly, or annually). External benchmarks also may be used for purposes of comparison.

Complaint: An expression of dissatisfaction by a consumer expressed verbally or in writing regarding an organization's products or services that is elevated to a complaint resolution system.

Interpretive Note for term "Complaint":

- ◆ This term is sometimes referred to as "grievance."
- ◆ This definition does not include appeals.

Concurrent Review: Utilization management conducted during a patient's hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review".

Condition: A diagnosis, clinical problem or set of indicators such as signs and symptoms that an individual *consumer* may have that define him or her as eligible and appropriate to participate in a medical management program such as a *disease management* or *case management* program.

Conflict of Interest: Any relationship or affiliation on the part of the organization or a reviewer that could compromise the independence or objectivity of the independent review process. Conflict of interest includes, but is not limited to:

- ◆ An ownership interest of greater than 5% between any affected parties;
- ◆ A material professional or business relationship;
- ◆ A direct or indirect financial incentive for a particular determination;
- ◆ Incentives to promote the use of a certain product or service;
- ◆ A known familial relationship;
- ◆ Any prior involvement in the specific case under review.

Consumer: An individual person who is the direct or indirect recipient of the services of the Organization. Depending on the context, consumers may be identified by different names, such as “member,” “enrollee,” “beneficiary,” “patient,” “injured worker,” “claimant,” etc. A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the Organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

Interpretive Note for term “Consumer”:

In the case of a consumer who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the consumer behalf may be a consumer for the purposes of these standards.

Contractor: A business entity that performs delegated functions on behalf of the Organization.

Interpretive Note for term “Contractor”:

For the purposes of these standards, the term “contractor” includes only those contractors that perform functions related to the key processes of the Organization. It is not URAC’s intent to include contractors that provide services unrelated to key processes. For example, a contractor that provides catering services would not fall within the definition of “contractor” in these standards. Conversely, a company that provides specialty physician reviewers to a UM organization would clearly fall within the definition of “contractor.”

Covered Benefits: The specific health services provided under a health benefits program, including: cost-sharing and other financial features; claims submission and reimbursement processes; requirements and processes (if any) for prior authorization or other approval of health services.

Covered Service: A health care service for which reimbursement or other remuneration is provided to a consumer or on behalf of a consumer under the terms of the consumer's benefits program.

Credentials Verification: A process of reviewing and verifying specific credentialing criteria of a practitioner.

Credentials Verification Organization (CVO): An organization that gathers data and verifies the credentials of health care practitioners.

Criteria: A broadly applicable set of standards, guidelines, or protocols used by the organization to guide the clinical processes. Criteria should be:

- ◆ Written;
- ◆ Based on professional practice;
- ◆ Literature-based;
- ◆ Applied consistently; and
- ◆ Reviewed, at a minimum, annually.

Data Integrity: The quality or condition of being accurate, complete and valid, and not altered or destroyed in an unauthorized manner.

Date of Receipt: The date on which a claim arrives at a Organization (or, for claims that arrive on a non-business day, the date of the first business day thereafter).

Delegation: The process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.

Discharge Planning: The process that assesses a patient's needs in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge or transfer from current services or level of care.

Disease Management (DM): According to the Disease Management Association of America, “Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. Disease management components include: population identification processes; evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); process and outcomes measurement, evaluation, and management; routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling.”

Disease Management Program: A program or entity that provides the scope of functions and activities necessary to provide disease management.

Electronic: Mode of electronic transmission including the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media. (Final Rule, Department of Health and Human Services, “Health Insurance Reform: Standards for Electronic Transactions,” Federal Register (Aug. 17, 2000).)

Electronic Health Record: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Electronic Medical Record: An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Engagement: Proactive outbound contact with consumers, by phone or mail, within some specified time frame of identification of eligible consumers, with tracking of interactions.

Evidence-based: Recommendations based on valid scientific outcomes research, preferably research that has been published in peer reviewed scientific journals. Evidence-based information can be used to

develop protocols, pathways, standards of care or clinical practice guidelines and related educational materials.

Evidence Based Medicine: “Evidence based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.” David L. Sackett, William M. C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, W. Scott Richardson. Evidence based medicine: what it is and what it isn't. British Medical Journal 1996; 312:71-72. Reproduced with permission from BMJ Publishing Group.

Expedited Appeal: An appeal of a non-certification of a case involving urgent care. See definition of "Case Involving Urgent Care."

Facility: An institution that provides health care services.

Facility Rendering Service: The institution or organization in or by which the requested admission, procedure, or service is provided. Such facilities may include, but are not limited to: hospitals; outpatient surgical facilities; individual practitioner offices; rehabilitation centers; residential treatment centers; skilled nursing facilities; laboratories; imaging centers; and other organizational providers of direct services to patients.

Family: Individuals whom the consumer chooses to involve in the decision-making process regarding the consumer's health care. In the case of a consumer who is unable to participate in the decision-making process, "family" shall include any individual legally authorized to make health care decisions on the consumer's behalf.

Health Assessment Tool: A data collection instrument that allows a consumer and the organization to ascertain the consumer's health status and health risks. Such tools are often administered online, although other formats are permissible. Other common terms used to describe health assessment tools are "health risk assessment" and "health survey."

Health Benefits Plan: An arrangement to pay for medical services provided to a consumer. "Health benefits plan" includes (but is not limited to):

- ◆ HMOs;

- ◆ PPOs;
- ◆ Indemnity health insurance programs;
- ◆ Self-insured plans;
- ◆ Public programs, such as Medicare and Medicaid; and
- ◆ Workers' Compensation insurance programs.

Health Care Team: The attending physician and other health care providers with primary responsibility for the care provided to a consumer.

Health Content Reviewer: An individual who holds a license or certificate as required by the appropriate jurisdiction in a health care field (where applicable), has professional experience in providing relevant direct patient care **or** has completed formal training in a health-related field.

Health Education: Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.

Health Information: Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.

Health Information Exchange: The electronic movement of health-related information among organizations according to nationally recognized standards.

Health Information Organization: An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions regarding their health.

Health Professional: An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.

Health-Related Field: A professional discipline that promotes the physical, psychosocial, or vocational well being of individual persons.

Individually Identifiable Information: Any information that can be tied to an individual consumer, as defined by applicable laws.

Independent Review: A process, independent of all affected parties, to determine if a health care service is medically necessary and medically appropriate, experimental/investigational or to address administrative/legal issues. Independent review typically (but not always) occurs after all appeal mechanisms available within the health benefits plan have been exhausted. Independent review can be voluntary or mandated by law.

Independent Reviewer: The individual (or individuals) selected by the organization to consider a case. Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 and IR 6. All reviewer(s) who are health care practitioners must have the following qualifications:

- ◆ Active licensure;
- ◆ Recent experience or familiarity with current body of knowledge and medical practice;
- ◆ At least 5 years experience providing health care;
- ◆ If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.
- ◆ If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery.

Initial Clinical Review: Clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services

that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification. Sometimes referred to as “first level review.”

Interoperability: Ability of two or more systems or components to exchange information and to use the information that has been exchanged.

Knowledge Domains – Areas of specific expertise.

License: A license or permit (or equivalent) to practice medicine or a health profession that is 1) issued by any state or jurisdiction in the United States; and 2) required for the performance of job functions.

Interpretive Note for term "License":

In this definition, the word “equivalent” includes certifications, registrations, permits, etc. Specific terms will vary by state and health profession.

Medical Director: A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and who is an employee of, or party to a contract with, an organization, and who has responsibility for clinical oversight of the organization’s utilization management, credentialing, quality management, and other clinical functions.

Medical Management – A general term encompassing activities such as utilization management, case management, and the clinical aspects of quality management.

Medication Reconciliation: The process of creating the most accurate list possible of all medications a patient is taking - including drug name, dosage, frequency, and route - and comparing that list against the physician's admission, transfer and/or discharge orders, with the goal of providing correct medications to the patient at all transition points.

Note for term "Medication Reconciliation": This definition comes from the Institute for Healthcare

Improvement (IHI), *Reconcile Medication at All Transition Points*, available through the following Web site: www.ihl.org.

Non-Certification: A determination by an organization that an admission, extension of stay, or other health care **or pharmacy** service has been reviewed and, based on the information provided does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the applicable health benefitplan.

Non-Clinical Administrative Staff: Staff who do not meet the definition of health professional (including intake personnel).

Non-Clinical Staff: Employees or contracted consultants of a health care organization who do not perform clinical assessments or provide callers with clinical advice. They may be responsible for obtaining demographic information, providing benefit information, and re-directing callers.

Off-shoring: The relocation of an organizational function to a foreign country under the same organizational control (ownership).

Note related to off-shoring: In health care management, outsourcing distinct functions to a foreign subcontractor is the more common trend. See the definition for "outsourcing."

Opt-in: Affirmative consent actively provided by a consumer to participate in an activity or function of the program, provided after the program has fully disclosed the terms and conditions of participation to the consumer.

Note for term "Opt-in": Auto enrollees are not considered "opt-in" enrollees of the program.

Opt-out: A process by which an enrolled consumer declines to participate in an activity or function of the program.

Ordering Provider: The physician or other provider who specifically prescribes the health care service

being reviewed.

Organization: A business entity that seeks accreditation under these standards.

Interpretive Note for term “Organization”: This can include a program or department and can be geographically defined.

Organizational Conflict of Interest: A conflict that affects objectivity between the organization's financial interests and the organization's obligations to the client.

Outcome: A consumer's health status following services.

Outsourcing: The delegation of services or functions from internal production to an external entity outside of the United States.

Oversight: Monitoring and evaluation of the integrity of **relevant** program processes and decisions affecting consumers.

Participant (participating): An eligible consumer or treating provider that has had one or more inbound or outbound contacts with the disease management program, and if a consumer, has not opted out of the program.

Participating Provider – A provider that has entered into an agreement with the organization to be part of a provider network.

Patient: The enrollee or covered consumer for whom a request for certification may or may not have been filed.

Interpretive Note for term “Patient”: In the case of a patient who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the patient's behalf may be a patient for the purposes of these standards.

Peer Clinical Review: Clinical review conducted by appropriate health professionals when a request for an admission, procedure, or service was not approved during initial clinical review. Sometimes referred to as “second level review.”

Peer-to-Peer Conversation: A request by telephone for additional review of a utilization management determination not to certify, performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

Personal Health Record: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

Personally-identifiable Information: Any information that can be tied to an individual identifier.

Performance Measures: Qualitative or quantitative quality indicators for assessing the achievement of outcomes. www.wtcc.sa.gov.au/webdata/resources/files/sp_glossary.doc

Plain Language: Communication that uses short words and sentences, common terms instead of (medical) jargon, and focuses on the essential information recipients need to understand.

Population: Depending on the model of the disease management program, the population for which it is responsible may be all of the consumers identified with the disease condition, or the population may be only those consumers identified to the disease management program by client referral or another mechanism. In some instances the disease management program may be responsible for identification of the population, and in other instances the client may conduct identification (and stratification) activities.

Potential Enrollees: Employees and eligible dependents of employer/purchasers who are offering enrollment in the organization's products as part of the employee benefits package. In the case of organizations that offer products in the individual market, potential enrollees include individuals from the general public in the geographic area where the organization offers the products.

Practitioner – An individual person who is licensed to deliver health care services without supervision.

Pre-Review Screening: Automated or semi-automated screening of requests for authorization that may include: (1) collection of structured clinical data (including diagnosis, diagnosis codes, procedures, procedure codes); (2) asking scripted clinical questions; (3) accepting responses to scripted clinical questions; and (4) taking specific action (certification and assignment of length of stay explicitly linked to each of the possible responses). It excludes: (1) applying clinical judgment or interpretation; (2) accepting

unstructured clinical information; (3) deviating from script; (4) engaging in unscripted clinical dialogue; (5) asking clinical follow-up questions; and (6) issuing non-certifications.

Primary Physician: The physician who is primarily responsible for the medical treatment and services of a consumer.

Primary Source Verification: Verification of a practitioner's credentials based upon evidence obtained from the issuing source of the credential. Also known as "Primary Source."

Principal Reason(s): A clinical or non-clinical statement describing the general reason(s) for the non-certification determination ("lack of medical necessity" is not sufficient to meet this).

Professional Competency: The ability to perform assigned professional responsibilities.

Prospective Review: Utilization management conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient procedures and services). Sometimes called "precertification review" or "prior authorization."

Protected Health Information: Individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in any medium described in the definition of electronic media at Sec. 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer. (67 Fed. Reg. at 53,267 (Aug. 14, 2002); 65 Fed. Reg. at 82,805 (Dec. 28, 2000) (to be codified at 45 C.F.R. pt. 164.501)).

Provider: A licensed health care facility, program, agency, or health professional that delivers health care services.

Provider Network – A group of providers with which the organization contracts to provide health services to consumers.

Provider-Specific Information: Information that is sufficient to allow identification of the individual provider.

Quality Improvement Project: An organization-wide initiative to measure and improve the service and/or care provided by the organization.

Quality Management (QM) program: A systematic data-driven effort to measure and improve consumer and client services and/or health care services.

Quality Review Study: A scientific and systematic measurement of the effects or results of treatment modalities or practices for a particular disease or condition. The goal of quality measurement is to improve health care services by monitoring and analyzing the data and modifying practices in response to this data.

Rationale: The reason(s) or justification(s) – commonly based on criteria – for a specific action or recommendation.

Re-assessment: Re-evaluation of an individual *consumer* participating in a medical management program, such as *disease management* or *case management*, on a specified frequency using the same or similar tools that were used in the initial assessment. Re-assessment may also include re-stratification.

Referring Entity: The organization or individual that refers a case to an organization. Referring entities may include insurance regulators, health benefits plans, consumers, and attending providers. Some states may limit by law which individuals or organizations may be a referring entity.

Regional Health Information Organization: A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

Retrospective Claim: A claim presented after services have been provided (i.e., a post-service claim) and presented for consideration under a contract or policy.

Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the patient.

Interpretive Note for term “Retrospective Review”: Retrospective medical necessity determinations are considered utilization management (and subject to these standards).

Review of Service Request: Review of information submitted to the organization for health care services that do not need medical necessity certification nor result in a non-certification decision.

Reviewer(s): The individual (or individuals) selected by the organization to consider a case. Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 and IR 6. All reviewer(s) who are health care practitioners must have the following qualifications:

- ◆ Active licensure;

- ◆ Recent experience or familiarity with current body of knowledge and medical practice;
- ◆ At least 5 years experience providing health care;
- ◆ If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.
- ◆ If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery

Second Opinion: Requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.

Secondary Source Verification or Secondary Source: Verification of a practitioner's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of licenses and certifications and data base queries).

Service Requests: Screening callers to determine the services that are necessary at the time of the call. This is usually performed by a non-clinical staff person to determine if the call is clinical and requires transfer to a clinical staff person.

Staff: The Organization's employees, including full-time employees, part-time employees, and consultants.

Standard Appeal: An appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals of expedited appeals.

Statistically valid: Based on accepted statistical principles and techniques.

Stratification: A process for sorting a population of eligible consumers into groups relating to the need for disease management interventions. Stratification and assessment are inter-related, and both provide data used to assign interventions. Stratification may use a variety of data sources, including but not limited to claims, pharmacy, laboratory, or consumer-reported data.

Structured Clinical Data: Clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation.

Therapeutic: Of or relating to the treatment of disease or disorders by remedial agents or methods.

Treating Provider: The treating provider is the individual or provider group who is primarily managing the treatment for a consumer participant in the disease management program. The treating provider is not

necessarily the consumers' primary care physician. The consumer may have a different treating provider for different conditions.

Urgent Care: See "Case Involving Urgent Care."

Utilization Management (UM): Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities. UM encompasses prospective, concurrent and retrospective review in which clinical criteria are applied to a request. UM is sometimes called "utilization review".

Worker: An ill or injured individual (or representative acting on behalf of the worker) who is eligible for workers' compensation benefits and who files for, or for whom a workers' compensation claim has been filed.

Written Agreements: A document – including an electronic document – that specifies the terms of a relationship between the Organization and a client, consumer, or contractor. This term may include a contract and any attachments or addenda.

Written Notification: Correspondence transmitted by mail, facsimile, or electronic medium.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual. (65 Fed. Reg. at 82,804 (to be codified at 45 C.F.R. pt. 164.501))

(Note: This definition is derived from the federal Health Insurance Portability and Accountability Act (HIPAA)).



Crosswalk between Core v2.1 & v3.0

Crosswalk between Core v2.1 & v3.0					
std #	std #		std #	std #	
version	version		version	version	
3.0	2.1	Notes	2.1	3.0	Notes
1	1		1	1	
2	2		2	2	
3	3		3	3	
4	19		4	25	
5	12		5	26	
6	15		6	30	
7	16		7	27	
8	17		8	28	
9	18		9	29	
10	21	Old 21(a), (c) & (d) in new Core 10	10	31	
11	14		11	32	
12	24	Client satisfaction brought from Core 24	12	5	
13	13(a) & (d)	New: Interoperability [Leading Indicator]	13	13, 14 & 15	
14	Core 13(c)	Comes from Core 13(c) in v2.1	14	11	
15	Core 13(b)	Comes from Core 13(b) in v2.1	15	6	
16	23		16	7	
17	29		17	8	
18	30		18	9	
19	31		19	4	
20	32		20	33	
21	33		21	10 & 34	
22	Core 35 (stem)	Comes from stem of Core 35 in v2.1	22	38	
23	34		23	16	
24	35		24	39	Consumer Satisfaction
25	4		25	34	

26	5		26	35	
27	7		27	35	
28	8		28	35	
29	9		29	17	
30	6		30	18	
31	10		31	19	
32	11		32	20	
33	20		33	21	
34	25		34	23	
35	26, 27 & 28		35	24	
36	new std	External Coordination	---	36	
37	Core 21(e)	Comes from Core 21(e) in v2.1	---	40	
38	22				
39	24	Consumer satisfaction			
40	new std	Health Literacy			



Applicability of Core Organizational Quality Standards, Version 3.0

Applicability of Core Organizational Quality Standards, version 3.0

For the URAC Core Organizational Quality Standards version 3.0 (Core), the standards have been reorganized to ease the application process. Standards listed first apply to all health care organizations. These standards are followed by those where the applicant organization must have credentialed licensed or certified clinical staff in order to conduct the function covered by the accreditation. The last sections of Core apply to those organizations that interact directly with health care consumers on an ongoing basis in order to provide health care management support services directly to the consumer. This was done to address the fact that many of the organizations which URAC accredits under the Core standards do not interact directly with consumers, but instead are business partners or vendors to organizations that do.

The following sections of standards address infrastructure and human resources and are applicable to all organizations applying for accreditation or certification including stand-alone Core applicants, though some standards may be determined to be not applicable. For example, the delegation standards would not apply if an organization does not delegate.

- **Organizational Structure**
- **Policies and Procedures**
- **Regulatory Compliance**
- **Inter-Departmental Coordination**
- **Oversight of Delegated Functions**
- **Marketing and Sales Communications**
- **Business Relationships**
- **Information Management**
- **Quality Management**
- **Staff Qualifications**
- **Staff Management**

The Clinical Staff Credentialing and Oversight Role section covers clinical oversight and are applicable to organizations applying for accreditations that require licensed or certified clinical staff in order to perform the function covered by the accreditation. These standards may not apply to certain stand-alone Core applicants.

Lastly, the Core sections on Health Care System Coordination and Consumer Protection and Empowerment are applicable to organizations that are involved with care coordination and interact with consumers. These accreditation products cover functions that require an organization to interact with consumers on an ongoing basis in order to provide health care management services directly to the consumer.

The table below is color coded to show which standards are applicable under the various types of URAC accreditation products.

Blue: Standards apply regardless of accreditation, though it may be determined that some standards are not applicable (“N/A”) for a given organization.

Purple: Standards are applicable if the accreditation requires an organization to have licensed or certified clinical staff. (Note that these standards may or may not apply to an organization applying only for Core accreditation.)

Black: Standards are applicable for accreditations that require an organization to have licensed or certified clinical staff that interfaces with consumers on an ongoing basis in order to provide health care management support services directly to the consumer. (Note that these standards may or may not apply to an organization applying only for Core accreditation.)

Core Organizational Quality Standards, version 3.0	
<ul style="list-style-type: none"> • Organizational Structure 1-Organizational Structure 2-Organization Documents • Policies and Procedures 3-Policy and Procedure Maintenance, Review and Approval • Regulatory Compliance 4-Regulatory Compliance • Inter-Departmental Coordination 5-Inter-Departmental Coordination • Oversight of Delegated Functions 6-Delegation Review Criteria 7-Delegation Review 8-Delegation Contracts 9-Delegation Oversight • Marketing and Sales Communications 	<ul style="list-style-type: none"> • Quality Management 17-Quality Management Program 18-Quality Management Program Resources 19-Quality Management Program Requirements 20-Quality Management Committee 21-Quality Management Documentation 22-Quality Improvement Projects 23-Quality Improvement Project Requirements 24-Quality Improvement Projects: Consumer Organizations • Staff Qualifications 25-Job Descriptions 26-Staff Qualifications • Staff Management 27-Staff Training Program 28-Staff Operational Tools and Support 29-Staff Assessment Program

10-Review of Marketing and Sales Materials

- **Business Relationships**

11-Written Business Agreements

12-Client Satisfaction

- **Information Management**

13-Information Management

14-Business Continuity

15-Information Confidentiality and Security

16-Confidentiality of Individually-Identifiable
Health Information

- **Clinical Staff Credentialing and Oversight Role**

30-Clinical Staff Credentialing

31-Senior Clinical Staff Requirements

32-Senior Clinical Staff Responsibilities

33-Financial Incentive Policy

34-Access to Services

35-Consumer Complaint Process

- **Health Care System Coordination**

36-Coordination with External Entities

- **Consumer Protection and Empowerment**

37-Consumer Rights and Responsibilities

38-Consumer Safety Mechanism

39-Consumer Satisfaction

40-Health Literacy



CORE, Version 3.0

Organizational Structure

CORE - 1 - Organizational Structure

The *organization* has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the *organization*. (2)

CORE - 2 - Organization Documents

Organization's documents address: (No Weight)

- (a) Mission statement; (2)
- (b) Organizational framework for program; (2)
- (c) The population served; **and** (2)
- (d) Organizational oversight and reporting requirements of the program. (2)

Policies and Procedures

CORE - 3 - Policy and Procedure Maintenance, Review and Approval

The *organization*: (No Weight)

- (a) Maintains and complies with written policies and documented procedures that govern core business processes of its operations related to the scope of the accreditation; (Mandatory)
- (b) Maintains the ability to produce a master list of all such policies and procedures; (2)
- (c) Reviews written policies and documented procedures no less than annually and revises as necessary; (3)
- (d) Includes the following on the master list or on all written policies and documented procedures: (No Weight)
 - (i) Effective dates, review dates, including the date of the most recent revision;
and (2)

- (ii) Identification of approval authority. (2)

Regulatory Compliance

CORE - 4 - Regulatory Compliance

The *organization* implements a regulatory compliance program that: (No Weight)

- (a) Tracks applicable laws and regulations in the jurisdictions where the *organization* conducts business; (Mandatory)
- (b) Ensures the *organization's* compliance with applicable laws and regulations; **and** (Mandatory)
- (c) Responds promptly to detected problems and takes corrective action as needed. (4)

Inter-Departmental Coordination

CORE - 5 - Inter-Departmental Coordination

The *organization* establishes and implements mechanisms to promote collaboration, coordination and communication across disciplines and departments within the *organization*, with emphasis on integrating administrative activities, quality improvement, and where present, clinical operations. (3)

Oversight of Delegated Functions

CORE - 6 - Delegation Review Criteria

The *organization* establishes and implements criteria and processes for an assessment prior to the *delegation* of functions. (3)

CORE - 7 - Delegation Review

Prior to *delegating* functions to another entity, the *organization*: (No Weight)

- (a) Establishes and implements a process to conduct a review of the potential contractor's written policies and documented procedures and capacity to perform delegated functions; **and** (3)
- (b) Outlines and follows criteria and processes for approving *contractors*. (3)

CORE - 8 - Delegation Contracts

The *organization* enters into *written agreements* with *contractors* that: (No Weight)

- (a) Specify those responsibilities *delegated* to the *contractor* and those retained by the *organization*; (2)
- (b) Require that services be performed in accordance with the *organization's* requirements and URAC standards; (Mandatory)
- (c) Require notification to the *organization* of any material change in the *contractor's* ability to perform *delegated* functions; (4)
- (d) Specify that the *organization* may conduct surveys of the *contractor*, as needed; (2)
- (e) Require that the *contractor* submit periodic reports to the *organization* regarding the performance of its *delegated* responsibilities; (3)
- (f) Specify recourse and/or sanctions if the *contractor* does not make corrections to identified problems within a specified period; (2)
- (g) Specify the circumstances under which activities may be further *delegated* by the *contractor*, including any requirements for obtaining permission from the *organization* before any further *delegation*; **and** (4)
- (h) Specify that, if the *contractor* further *delegates* organizational functions, those functions shall be subject to the terms of the *written agreement* between the *contractor* and the *organization* and in accordance with URAC standards. (Mandatory)

CORE - 9 - Delegation Oversight

The *organization* establishes and implements an oversight mechanism for delegated functions within the scope of accreditation that includes: (No Weight)

- (a) A periodic review (no less than annually) of the *contractor's* written policies and documented procedures and documentation of quality activities for related delegated functions; (2)
- (b) A process to verify (no less than annually) the *contractor's* compliance with contractual requirements and written policies and documented procedures; **and** (Mandatory)

(c) A mechanism to monitor financial incentives to ensure that quality of care or service is not compromised. (3)

Marketing and Sales Communications

CORE - 10 - Review of Marketing and Sales Materials

The *organization* follows marketing and sales practices that include:

(No Weight)

(a) Mechanisms to clearly and accurately communicate information about services inclusive of delegated activities; (3)

(b) A formal process of inter-departmental review of marketing and sales materials before dissemination to safeguard against misrepresentations about the *organization's* services; (3)

(c) Monitoring of existing materials for accuracy; **and** (3)

(d) Responds promptly to detected problems and corrective action as needed. (4)

Business Relationships

CORE - 11 - Written Business Agreements

The *organization* maintains signed *written agreements* with all *clients* describing the scope of the business arrangement. (2)

CORE - 12 - Client Satisfaction

The *organization* implements a mechanism to collect or obtain information about *client* satisfaction with services provided by the *organization*. (3)

Information Management

CORE - 13 - Information Management

The *organization* implements information system(s) (*electronic* and paper) to collect, maintain and analyze information necessary for organizational management that: (No Weight)

- (a) Provides for *data integrity*; (Mandatory)
- (b) Includes a plan for storage, maintenance and destruction; **and** (2)
- (c) Includes a plan for *interoperability*: (No Weight)
 - (i) Between internal information systems; **and** (Leading Indicator)
 - (ii) With external entity information systems. (Leading Indicator)

CORE - 14 - Business Continuity

The *organization* implements a business continuity plan for program operations, including information system(s) (*electronic* and paper) that: (No Weight)

- (a) Identifies which systems and processes must be maintained and the effect an outage would have on the *organization's* program; (3)
- (b) Identifies how business continuity is maintained given various lengths of time information systems are not functioning or accessible; (3)
- (c) Is tested at least every two years; **and** (3)
- (d) Responds promptly to detected problems and takes corrective action as needed. (3)

CORE - 15 - Information Confidentiality and Security

The *organization* provides for data confidentiality and security of its information system(s) (*electronic* and paper) by implementing written policies and/or documented procedures that address: (No Weight)

- (a) Assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of information systems; (3)
- (b) Prevention of confidentiality and security breaches; **and** (Mandatory)

(c) Detection, containment and correction of confidentiality and security violations. (Mandatory)

CORE - 16 - Confidentiality of Individually-Identifiable Health Information

The *organization* implements written policies and/or documented procedures to protect the confidentiality of *individually-identifiable health information* that:

(No Weight)

- (a) Identifies how *individually-identifiable health information* will be used; (Mandatory)
- (b) Specifies that *individually-identifiable health information* is used only for purposes necessary for conducting the business of the organization, including evaluation activities; (Mandatory)
- (c) Addresses who will have access to *individually-identifiable health information* collected by the *organization*; (Mandatory)
- (d) Addresses oral, written or *electronic* communication and records that are transmitted or stored; (Mandatory)
- (e) Address the responsibility of *organization* employees, committee members and board members to preserve the confidentiality of *individually-identifiable health information*; **and** (Mandatory)
- (f) Requires employees, committee members and board members of the *organization* to sign a statement that they understand their responsibility to preserve confidentiality. (Mandatory)

Quality Management

CORE - 17 - Quality Management Program

The *organization* maintains a *quality management program* that promotes objective and systematic measurement, monitoring and evaluation of services and implements quality improvement activities based upon the findings. (Mandatory)

CORE - 18 - Quality Management Program Resources

The *organization* employs *staff* and/or provides the resources necessary to support the day-to-day operations of the *quality management program*. (3)

CORE - 19 - Quality Management Program Requirements

The *organization* has a written description for its *quality management program* that:

(No Weight)

- (a) Is approved by the *organization's* appropriate oversight authority; (2)
- (b) Defines the scope, objectives, activities, and structure of the *quality management program*; (2)
- (c) Is reviewed and updated by the Quality Management Committee at least annually; (2)
- (d) Defines the roles and responsibilities of the Quality Management Committee; **and** (2)
- (e) Designates a member of senior management with the authority and responsibility for the overall operation of the *quality management program* and who serves on the Quality Management Committee. (3)

CORE - 20 - Quality Management Committee

The *organization* has a quality management committee that:

(No Weight)

- (a) Is granted authority for quality management by the *organization's* oversight authority; (3)
- (b) Provides ongoing reporting to the *organization's* oversight authority; (3)
- (c) Meets at least quarterly; (3)
- (d) Maintains approved records of all committee meetings; (2)
- (e) If applicable, includes at least one participating provider or receives input from participating providers; (4)
- (f) Provides guidance to *staff* on quality management priorities and projects; (3)
- (g) Approves the *quality improvement projects* to undertake; (3)
- (h) Monitors progress in meeting quality improvement goals; **and** (3)

- (i) Evaluates the effectiveness of the *quality management program* at least annually. (3)

CORE - 21 - Quality Management Documentation

The *organization*, as part of its *quality management program*, provides written documentation of: (No Weight)

- (a) Objectives and approaches utilized in the quality management activities; (3)
- (b) Identification and tracking and trending of *performance measures* relevant to the scope of the accreditation including, but not limited to: (Mandatory)
 - (i) Access to services; (3)
 - (ii) Complaints; **and** (3)
 - (iii) Satisfaction; (3)
- (c) *Measures* that are quantifiable and used to establish acceptable levels of performance; (Mandatory)
- (d) Measuring baseline level of performance; (Mandatory)
- (e) Re-measuring level of performance at least annually; (Mandatory)
- (f) The implementation of action plans to improve or correct identified problems or meet acceptable levels of performance on measures; (Mandatory)
- (g) The mechanisms to communicate the results of such activities to relevant *staff*; **and** (3)
- (h) The mechanism to communicate the results of such activities to the quality management committee. (3)

CORE - 22 - Quality Improvement Projects

At any given time, the *organization* maintains no less than two *quality improvement projects* that address opportunities for *error* reduction or performance improvement related to the services covered by the accreditation. (Mandatory)

CORE - 23 - Quality Improvement Project Requirements

For each *quality improvement project*, the *organization* will:

(No Weight)

- (a) Establish measurable goals for quality improvement; (3)
- (b) Design and implement strategies to improve performance; (3)
- (c) Establish projected time frames for meeting goals for quality improvement; (3)
- (d) Re-measure level of performance at least annually; (3)
- (e) Document changes or improvements relative to the baseline measurement; **and** (3)
- (f) Conduct an analysis if the performance goals are not met. (3)

CORE - 24 - Quality Improvement Projects: Consumer Organizations

For an *organization* that interacts with *consumers*: (No Weight)

- (a) At least one of the two *quality improvement projects* must address consumer safety for the population served; **and** (Mandatory)
- (b) If the *quality improvement project* is clinical in nature, then the *organization* demonstrates the involvement of a senior clinical *staff* person in judgments about the use of clinical quality *measures* and clinical aspects of performance. (Mandatory)

Staff Qualifications

CORE - 25 - Job Descriptions

The *organization* has written job descriptions for *staff* that address requirements pertinent to the scope of the positions' roles and responsibilities: (No Weight)

- (a) Required education, training, and/or professional experience; (2)
- (b) Expected *professional competencies*; (2)

(c) Appropriate *licensure/certification* requirements; **and** (2)

(d) Current scope of roles and responsibilities. (2)

CORE - 26 - Staff Qualifications

Staff meets qualifications as required in written job descriptions. (3)

Staff Management

CORE - 27 - Staff Training Program

The *organization* has an ongoing training program that includes: (No Weight)

(a) Initial orientation and/or training for all *staff* before assuming assigned roles and responsibilities; (2)

(b) Training in current URAC standards as appropriate to job functions; (2)

(c) Conflict of interest; (4)

(d) Confidentiality; (Mandatory)

(e) Documentation of all training provided for *staff*; **and** (2)

(f) Ongoing training, at a minimum annually, to maintain *professional competency*. (2)

CORE - 28 - Staff Operational Tools and Support

The *organization* provides *staff* with: (No Weight)

(a) Written policies and/or documented procedures appropriate to their jobs; (2)

(b) *Clinical decision support tools* as appropriate; **and** (2)

(c) Regulatory requirements as related to their job function. (2)

CORE - 29 - Staff Assessment Program

The *organization* maintains a formal assessment program for individual *staff* members, which includes: (No Weight)

- (a) An annual performance appraisal; **and** (2)
- (b) A review of relevant documentation produced by that individual staff member. (3)

Clinical Staff Credentialing and Oversight Role

CORE - 30 - Clinical Staff Credentialing

The *organization* implements a written policy and/or documented procedure to: (No Weight)

- (a) *Primary source* verify the current *licensure* or *certification* of *staff* whose job description requires *licensure* or *certification* upon hire, and thereafter no less than every three (3) years; (Mandatory)
- (b) Require *staff* to notify the *organization* in a timely manner of an adverse change in *licensure* or *certification* status; (Mandatory)
- (c) Implement corrective action in response to adverse changes in *licensure* or *certification* status; **and** (Mandatory)
- (d) *Primary source* verify current *licensure* and *certification* upon hire, and thereafter no later than scheduled expiration. (Leading Indicator)

CORE - 31 - Senior Clinical Staff Requirements

The *organization* designates at least one senior clinical *staff* person who has: (No Weight)

- (a) Current, unrestricted clinical *license(s)* (or if the *license* is restricted, the *organization* has a process to ensure job functions do not violate the restrictions imposed by the state licensure board); (Mandatory)
- (b) Qualifications to perform clinical oversight for the services provided; (Mandatory)
- (c) Post-graduate experience in direct patient care; **and** (Mandatory)

(d) *Board certification* (if the senior clinical *staff* person is an M.D. or D.O.). (3)

CORE - 32 - Senior Clinical Staff Responsibilities

A senior clinical *staff* person's program responsibilities include: (No Weight)

- (a) Provides guidance for clinical operational aspects of the program; (3)
- (b) Is responsible for oversight of clinical decision-making aspects of the program; (Mandatory)
- (c) Has periodic consultation with practitioners in the field; **and** (3)
- (d) Ensures the organizational objective to have qualified clinicians accountable to the *organization* for decisions affecting *consumers*. (Mandatory)

CORE - 33 - Financial Incentive Policy

If the *organization* has a system for reimbursement, bonuses or incentives to *staff* or health care providers based directly on *consumer* utilization of health care services, then the *organization* implements mechanisms addressing how the *organization* will ensure that *consumer* health care is not compromised. (Mandatory)

CORE - 34 - Access to Services

The *organization* implements written policies and/or documented procedures to ensure *access* to services covered by the accreditation. (Mandatory)

CORE - 35 - Consumer Complaint Process

The *organization* maintains a formal process to address *consumer complaints* that includes: (No Weight)

- (a) A process to receive and respond in a timely manner to *complaints*; (Mandatory)
- (b) Notice (written or verbal) of final result with an explanation; (4)
- (c) Informs *consumers* of the avenues to seek further review if an additional *complaint* review process is available; (4)
- (d) Evidence of meeting the *organization's* specified time frame for resolution and response; **and** (4)

(e) Reporting analysis of the *complaints* to the quality management committee. (3)

Health Care System Coordination

CORE - 36 - Coordination with External Entities

The *organization* establishes and implements mechanisms to promote collaboration and communication with applicable external entities to coordinate health services for consumers. (1)

Consumer Protection and Empowerment

CORE - 37 - Consumer Rights and Responsibilities

The *organization* implements a mechanism for informing *consumers* of their rights and responsibilities. (4)

CORE - 38 - Consumer Safety Mechanism

The *organization* has a mechanism to respond on an urgent basis to situations that pose an immediate threat to the health and safety of *consumers*. (Mandatory)

CORE - 39 - Consumer Satisfaction

The *organization* implements a mechanism to collect or obtain information about *consumer* satisfaction with services provided by the *organization*. (3)

CORE - 40 - Health Literacy

The *organization* will implement written policies and/or documented procedures addressing *health literacy* that: (No Weight)

- (a) Require *consumer* materials to be in *plain language*; (Leading Indicator)
- (b) Assess the use of *plain language* in *consumer* documents; **and** (Leading Indicator)
- (c) Provide relevant information and guidance to *staff* that interfaces directly with, or writes content for, *consumers*. (Leading Indicator)



Health Utilization Management , Version 6.0

Review Criteria

HUM - 1 - Review Criteria Requirements

The *organization* utilizes explicit *clinical review criteria* or scripts that are: (No Weight)

- (a) Developed with involvement from appropriate *providers* with current knowledge relevant to the *criteria* or scripts under review; (3)
- (b) Based on current clinical principles and processes; (3)
- (c) Evaluated at least annually and updated if necessary by: (3)
 - (i) The *organization* itself; **and** (3)
 - (ii) Appropriate, actively practicing physicians and other *providers* with current knowledge relevant to the *criteria* or scripts under review; **and** (Mandatory)
- (d) Approved by the *medical director* (or equivalent designate) or *clinical director* (or equivalent designate). (Mandatory)

Accessibility of Review Services

HUM - 2 - Access to Review Staff

The *organization* provides *access* to its review *staff* by a toll free or collect telephone line at a minimum from 9:00 a.m. to 4:00 p.m. of each normal business day in each time zone where the *organization* conducts at least two percent of its review activities. (4)

HUM - 3 - Review Service Communication and Time Frames

The *organization* maintains processes to: (No Weight)

- (a) Receive communications from *providers* and *patients* during the business day and after business hours; (4)
- (b) Respond to communications within one business day; **and** (4)

(c) Conduct its outgoing communications related to *utilization management* during *providers'* reasonable and normal business hours, unless otherwise mutually agreed. (4)

HUM - 4 - Review Service Disclosures

The *organization*: (No Weight)

(a) Requires *utilization management staff* to identify themselves by name, title, and *organization* name; **and** (2)

(b) Upon request, verbally informs *patients; facility* personnel; the *attending physician* and other *ordering providers*; and *health professionals* of specific *utilization management* requirements and procedures. (4)

On-Site Review Services

HUM - 5 - On-Site Review Requirements

For on-site review services, the *organization*: (No Weight)

(a) Requires on-site *reviewers* to carry a picture ID with full name and the name of the *organization*; (2)

(b) Schedules reviews at least one business day in advance, unless otherwise agreed; **and** (4)

(c) Requires the on-site *reviewers* to follow reasonable hospital or facility procedures, including checking in with designated hospital or facility personnel. (4)

HUM - 6 - N/A

This standard number is reserved to synchronize with URAC's Workers' Compensation Utilization Management Standards. There is no current Standard UM 6. (No Weight)

Initial Screening

HUM - 7 - Limitations in Use of Non-Clinical Staff

For *initial screening*, the *organization* limits use of *non-clinical administrative* staff to: (No Weight)

- (a) Performance of *review of service request* for completeness of information; (2)
- (b) Collection and transfer of non-clinical data; (2)
- (c) Acquisition of *structured clinical data*; **and** (2)
- (d) Activities that do not require evaluation or interpretation of clinical information. (Mandatory)

HUM - 8 - Pre-Review Screening Staff Oversight

The *organization* ensures that *licensed health professionals* are available to *non-clinical administrative staff* while performing *initial screening*. (Mandatory)

HUM - 9 - Pre-Review Screening Non-Certifications

The *organization* does not issue *non-certifications* based on *initial screening*. (Mandatory)

Initial Clinical Review

HUM - 10 - Initial Clinical Reviewer Qualifications

Individuals who conduct *initial clinical review*: (No Weight)

- (a) Are appropriate *health professionals*; **and** (Mandatory)
- (b) Possess an active professional relevant *license*. (Mandatory)

HUM - 11 - Initial Clinical Reviewer Resources

Individuals who conduct *initial clinical review* have *access* to consultation with a:

- (3)
 - (a)

Licensed doctor of medicine or doctor of osteopathic medicine; **or**

(No Weight)

(b)

Licensed health professional in the same licensure category as the *ordering provider*; **or**

(No Weight)

(c)

Health professional with the same clinical education as the *ordering provider* in clinical specialties where *licensure* is not issued.

(No Weight)

HUM - 12 - Initial Clinical Reviewer Non-Certifications

The *organization* does not issue *non-certifications* based on *initial clinical review*. (Mandatory)

Peer Clinical Review

HUM - 13 - Peer Clinical Review Cases

The *organization* conducts *peer clinical reviews* for all *cases* where a *certification* is not issued through *initial clinical review* or *initial screening*. (Mandatory)

HUM - 14 - Peer Clinical Reviewer Qualifications

Individuals who conduct *peer clinical review*: (No Weight)

(a) Are appropriate *health professionals*; (Mandatory)

(b) Are qualified, as determined by the *medical director* or *clinical director*, to render a clinical opinion about the medical *condition*, procedures, and treatment under review; **and** (Mandatory)

(c) Hold a current and valid *license*: (Mandatory)

(i) In the same licensure category as the *ordering provider*; **or** (No Weight)

(ii) As a doctor of medicine or doctor of osteopathic medicine. (No Weight)

Peer-to-Peer Conversation

HUM - 15 - Peer-to-Peer Conversation Availability

Health professionals that conduct *peer clinical review* are available to discuss review determinations with *attending physicians* or other *ordering providers*. (4)

HUM - 16 - Peer-to-Peer Conversation Alternate

When a determination is made to issue a *non-certification* and no *peer-to-peer conversation* has occurred: (No Weight)

(a) The *organization* provides, within one business day of a request by the *attending physician* or *ordering provider*, the opportunity to discuss the *non-certification* decision: (No Weight)

(i) With the *clinical peer reviewer* making the initial determination; **or** (4)

(ii) With a different *clinical peer*, if the original *clinical peer reviewer* cannot be available within one business day); **and** (4)

(b) If a *peer-to-peer conversation* or review of additional information does not result in a *certification*, the *organization* informs the *provider* and *consumer* of the right to initiate an *appeal* and the procedure to do so. (4)

Time Frames for Initial UM Decision

HUM - 17 - Prospective Review Time Frames

For *prospective review*, the *organization* issues a determination: (No Weight)

(a) As soon as possible based on the clinical situation, but in no *case* later than 72 hours of the receipt of request for a *utilization management* determination, if it is a *case involving urgent care*; or (4)

(b) Within 15 calendar days of the receipt of request for a *utilization management* determination, if it is a non-urgent *case*. (4)

(c) For non-urgent cases this period may be extended one time by the *organization* for up to 15 calendar days: (No Weight)

(i) Provided that the *organization* determines that an extension is necessary because of matters beyond the control of the *organization*; **and** (4)

(ii) Notifies the *patient*, prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; **and** (4)

(iii) If a *patient* fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the *patient* must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information. (4)

HUM - 18 - Retrospective Review Time Frames

For *retrospective review*, the *organization* issues a determination: (No Weight)

(a) Within 30 calendar days of the receipt of request for a *utilization management* determination; **and** (3)

(b) This period may be extended one time by the *organization* for up to 15 calendar days: (No Weight)

(i) Provided that the *organization* determines that an extension is necessary because of matters beyond the control of the *organization*; **and** (4)

(ii) Notifies the *patient*, prior to the expiration of the initial 30 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; **and** (4)

(iii) If a *patient* fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the *patient* must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information. (4)

HUM - 19 - Concurrent Review Time Frames

For *concurrent review*, the *organization* adheres to the following time frames: (No Weight)

(a) For reductions or terminations in a previously approved course of treatment, the *organization* issues the determination early enough to allow the patient to request a review and receive a decision before the reduction or termination occurs; **and** (4)

(b) For requests to extend a current course of treatment, the *organization* issues the determination within: (No Weight)

(i) 24 hours of the request for a *utilization management* determination, if it is a *case involving urgent care* and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments; **or** (4)

(ii) 72 hours of the request for a *utilization management* determination, if it is a *case involving urgent care* and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments. (4)

Notice of Certification Decisions

HUM - 20 - Certification Decision Notice and Tracking

For *certifications*, the *organization*: (No Weight)

(a) Has a process for notification of the *attending physician* or other *ordering provider, facility rendering service, and patient*: (4)

(b) Includes tracking information (such as reference number) in the notice of *certification*; **and** (3)

(c) Upon request from the *attending physician* or other *ordering provider, facility rendering service, or patient*, provides *written notification* of any *certification*. (4)

HUM - 21 - Continued Certification Decision Requirements

Confirmation of *certification* for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services. (3)

Notice of Non-Certification Decisions

HUM - 22 - Written Notice of Non-Certification Decisions and Rationale

For *non-certifications*, the *organization* issues *written notification* of the *non-certification* decision to the *patient* and *attending physician* or other *ordering provider* or *facility rendering service* that includes: (No Weight)

- (a) The *principle reasons* for the determination not to certify; (4)
- (b) A statement that the *clinical rationale* used in making the *non-certification* decision will be provided, in writing, upon request; **and** (4)
- (c) Instructions for: (No Weight)
 - (i) Initiating an *appeal* of the *non-certification*; **and** (Mandatory)
 - (ii) Requesting a *clinical rationale* for the *non-certification*. (Mandatory)

HUM - 23 - Clinical Rationale for Non-Certification Requirements

Upon request from the *patient*, *attending physician*, or other *ordering provider* or *facility rendering service*, the *organization* provides specific *clinical rationale* upon which the *non-certification* was based. (4)

UM Procedures

HUM - 24 - Reversal of Certification Determinations

The *organization* does not reverse a *certification* determination unless it receives new information that is relevant to the *certification* and that was not available at the time of the original *certification*. (4)

HUM - 25 - Frequency of Continued Reviews

The *organization* ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the *patient's condition* or on necessary treatment and *discharge planning* activity (i.e., not routinely conducted on a daily basis). (4)

Information Upon Which UM is Conducted

HUM - 26 - Scope of Review Information

The *organization*, when conducting routine *prospective review*, *concurrent review*, or *retrospective review*: (No Weight)

- (a) Accepts information from any reasonably reliable source that will assist in the *certification* process; (2)
- (b) Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services. (2)
- (c) Does not routinely require hospitals, physicians, and other *providers* to numerically code diagnoses or procedures to be considered for *certification*, but may request such codes, if available; (4)
- (d) Does not routinely request copies of all medical records on all *patients* reviewed; (4)
- (e) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; **and** (4)
- (f) Administers a process to share all clinical and demographic information on individual *patients* among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or *providers*. (3)

HUM - 27 - Prospective and Concurrent Review Determinations

For *prospective review* and *concurrent review*, the *organization* bases review determinations solely on the medical information obtained by the *organization* at the time of the review determination. (4)

HUM - 28 - Retrospective Review Determinations

For *retrospective review*, the *organization* bases review determinations solely on the medical information available to the *attending physician* or *ordering provider* at the time the medical care was provided. (4)

HUM - 29 - Lack of Information Policy and Procedures

The *organization* implements policies and procedures to address situations in which it has insufficient information to conduct a review. Such policies and procedures provide for: (4)

- (a) Procedural time frames that are appropriate to the clinical circumstances of the review (i.e., prospective, concurrent, *retrospective reviews*); (4)
- (b) Resolution of cases in which the necessary information is not provided to the *organization* within specified time frames; **and** (4)
- (c) Processes by which the *organization* issues an administrative *non-certification* due to lack of information. (4)

Appeals Considerations

HUM - 30 - Non-Certification Appeals Process

The *organization* maintains a formal process to consider *appeals* of *non-certifications* that includes: (No Weight)

- (a) The availability of *standard appeal* for non-urgent cases and *expedited appeal* for cases involving *urgent care*; **and** (Mandatory)
- (b) Written policies and procedures that: (No Weight)
 - (i) Clearly describe the *appeal* process, including the right to *appeal of the patient, provider, or facility rendering service*; (Mandatory)
 - (ii) Provide for explicit time frames for each stage of the *appeal* resolution process; **and** (Mandatory)
 - (iii) Are available, upon request, to any *patient, provider, or facility rendering service*. (Mandatory)

HUM - 31 - Appeals Process

As part of the *appeals* process: (No Weight)

- (a) The *organization* provides the *patient, provider, or facility rendering service* the opportunity to submit written comments, documents, records, and other information relating to the case;

(Mandatory)

(b) Takes all such information into account during the *appeals* process without regard to whether such information was submitted or considered in the initial consideration of the case; **and** (Mandatory)

(c) In instance of a first level *appeal*, the *organization* implements the decision of the first level clinical *appeal* if it overturns the initial denial. (Mandatory)

HUM - 32 - Appeal Peer Reviewer Qualifications

Appeals considerations are conducted by *health professionals* who: (No Weight)

(a) Are *clinical peers*; (Mandatory)

(b) Hold an active, unrestricted *license* to practice medicine or a health profession; (Mandatory)

(c) Are *board-certified* (if applicable) by: (3)

(i) A specialty board approved by *the American Board of Medical Specialties* (doctors of medicine); **or** (No Weight)

(ii) The *Advisory Board of Osteopathic Specialists* from the major areas of clinical services (doctors of osteopathic medicine); (No Weight)

(d) Are in the same profession and in a similar specialty as typically manages the medical *condition*, procedure, or treatment as mutually deemed appropriate; **and** (Mandatory)

(e) Are neither the individual who made the original *non-certification*, nor the subordinate of such an individual. (Mandatory)

HUM - 33 - Expedited Appeals Process Time Frame

Expedited appeals are completed with verbal notification of determination to the requesting party within 72 hours of the request followed by a written confirmation of the notification within 3 calendar days to the *patient* and *attending physician* or other *ordering provider* or *facility rendering service*. (Mandatory)

HUM - 34 - Standard Appeals Process Time Frame

Standard appeals are completed, and *written notification* of the *appeal* decision issued, within 30 calendar days of the receipt of the request for *appeal* to the patient and *attending physician* or other *ordering provider* or *facility rendering service*.

(Mandatory)

HUM - 35 - Written Notice of Upheld Non-Certifications

For *appeals* determinations, the *organization* issues *written notification* of the adverse *appeal decision* to the *patient* and *attending physician* or other *ordering provider* or *facility rendering service* that includes: (No Weight)

- (a) The *principal reasons* for the determination to uphold the *non-certification*; (4)
- (b) A statement that the *clinical rationale* used in making the *appeal* decision will be provided, in writing, upon request; **and** (4)
- (c) Information about additional *appeal* mechanisms available, if any. (4)

HUM - 36 - Appeal Record Documentation

The *organization* maintains records for each *appeal* that includes: (No Weight)

- (a) The name of the *patient*, *provider*, and/or *facility rendering service*; (3)
- (b) Copies of all correspondence from the *patient*, *provider*, or *facility rendering service* and the *organization* regarding the *appeal*; (3)
- (c) Dates of *appeal* reviews, documentation of actions taken, and final resolution; (3)
- (d) Minutes or transcripts of *appeal* proceedings (if any); **and** (3)
- (e) Name and credentials of the *clinical peer* that meets the qualifications in Standard UM 32. (3)

Independent Review Organization Standards, Version 4.0

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Message from URAC

Dear interested party or applicant:

Quality-based operations should be the centerpiece of any company doing business in today's health care system. Quality improvement activities promote a wide range of benefits such as increasing operational efficiencies, reducing business risks and improving patient health outcomes. However, health care professionals must identify and implement a quality improvement methodology that really works for their particular business model and health care setting.

Through its modular approach to accreditation, URAC works with the industry and other key stakeholders to benchmark URAC standards against key organizational structures and business functions. Now in its 20th year of operation, URAC offers over 20 different accreditation and certification programs and has issued more than 10,000 accreditation certificates to companies operating in all 50 states and internationally. URAC also is recognized as part of the regulatory process in three-fourths of the states and by four federal agencies.

URAC, as a nonprofit, independent accreditation agency, brings to the table a nationally-recognized accreditation process and seal of approval. URAC's success is tied in large part to the broad-based, consensus-driven process by which hundreds of volunteers help URAC draft and update its standards and also oversee the accreditation system. These volunteers represent the interests of a wide variety of stakeholders including purchasers, regulators, consumers, providers and industry representatives.

All companies that apply for URAC accreditation make improvements to their operations as a result of the review process. The desktop review of the application identifies issues early on in the process and helps focus the onsite review, which is designed to confirm compliance with the standards. During the onsite visit, accreditation reviewers exchange information with applicants in what often becomes a mutual learning experience. URAC's goal is to identify and promote best practices for each market segment that it accredits.

Receiving the accreditation certificate signifies a job well done and distinguishes the organization as having met a standard of excellence. As a result, URAC-accredited organizations join the ranks of a select community who have documented and verified their commitment to quality health care.

Please contact URAC if you would like to find out more about the accreditation process or to become involved with one of our committees, educational programs, research initiatives, or other projects. We look forward to hearing from you.



Introduction to URAC Accreditation Guides and Standards

URAC offers two references addressing standards. The *Standards* publication provides a copy of the standards produced by URAC and defined terms, which are *italicized* within the standards. It is a resource for government agencies and private entities wanting to examine the standards for their own purposes. For organizations contemplating accreditation, URAC's *Accreditation Guide* provides, in addition to the standards, information about the documentation to submit as evidence for meeting the intent of the standards as well as the types of materials and activities URAC's accreditation reviewers will be examining during an onsite visit. Both the Accreditation Standards and Guide are available through URAC's Business Development Department at (202)216-9010 or send an e-mail to BusinessDevelopment@urac.org. For detailed information about how to prepare an application for accreditation, please go to: <http://www.urac.org/healthcare/accreditation/accreditnet.aspx> for a copy of the *AccreditNet Instruction Booklet*, designed to complement the Accreditation Guide for applicant organizations.

The Accreditation Standards and Accreditation Guide are intended to provide guidance only. The URAC Accreditation Committee and Executive Committee hold the final authority to make determinations regarding interpretation and application of standards, and an applicant's compliance with standards.

The Accreditation Guide is provided to assist applicants understand the meaning or intent of the standards. That being said, it cannot cover all possible situations and subsequent interpretations that may apply. Therefore, applicants should be aware that the standards are subject to ongoing interpretation and as such, changes can be made to the Accreditation Guide.

Each company applying for accreditation should carefully review URAC's accreditation standards and the defined terms *italicized* within the standards, then use the Accreditation Guide and AccreditNet Instruction Booklet to prepare an application for submittal to URAC.

Modular Concept

URAC uses a “modular accreditation system” that is adaptable to the continuing evolution of the health care system. A module is a set of standards established for a particular health care function. The collection of standards contained within modules are unique to that health care service or function. The Core Standards incorporate the basic elements necessary to promote quality for any type of health care organization and were designed for two purposes: 1) to act as a “foundation” for function-specific accreditation programs, and 2) to act as a “stand-alone” accreditation program for companies not delivering services under one of the specific functions or modules.

Each accreditation will include Core and the module(s) covering the functions.

Core Standards + Module(s) = Specific Accreditation

Core “stand-alone” accreditation will only consist of Core Standards.

Core Standards Only = Core “Stand-Alone” Accreditation

Eligibility to apply for Core “stand-alone” accreditation is determined on the basis of how a company markets itself. If a health care organization markets any of the services addressed under one of URAC’s modules, Core “stand-alone” accreditation is not an option. An example of an organization that would be eligible for Core “stand-alone” accreditation is an organization that provides health care educational services.

For applicants, the modular system provides the flexibility to choose from a variety of accreditation programs. For example, an applicant may choose to apply for Utilization Management (UM) accreditation initially, and when up for reaccreditation, add the Case Management (CM) module.

Core with Single-Module Application (Example: Core & UM only)

Core with Multi-Module Application (Example: Core & UM + CM)

With several choices available, an applicant can tailor the accreditation to its current needs and business goals. If you are not sure what modules would best fit your organization, URAC’s Business Development Department can be reached at BusinessDevelopment@urac.org or at (202) 216-9010 to answer questions, provide pricing information and help organizations decide the best course of action.

Compliance with State and Federal Law

The Accreditation Guide provides information on URAC’s expectations regarding compliance with each standard. Some standards require applicants to attest to compliance with specific state regulations regarding operational policy and procedure. Prior to submitting an application the applicant should conduct a review of its legal obligations, including those addressed in the standards. Although it is not indicated for each standard, URAC expects that the applicant will be in compliance with all applicable state and federal laws that pertain to relevant operations. State and federal laws supersede URAC Standards if the laws or regulations are more rigorous than URAC Standards. Conversely, an applicant must comply with URAC Standards if the standards are more stringent. If an applicant is required by law to carry out its business in a manner not consistent with URAC Standards, then the applicant may request a variance from a URAC Standard. A copy of the relevant statute or regulation must accompany the request submitted for that standard in the application.

Standards and Interpretation

The standards are grouped together into modules, with each module representing various health care functions. Individually, the standards address the structures and processes that need to be in place for performing the function to be accredited according to national standards. For the most part, an applicant is expected to be in compliance with all applicable standards at the time of application for accreditation.

In the *Accreditation Standards*, you will find:

- * **Definitions.** All italicized terms found in the standards are defined in this section.
- * **Standards with assigned Weights.** Standard elements include assigned weights for scoring. If an element in and of itself does not contain enough information to evaluate compliance without the following sub-element, then it is noted as "Not Weighted."

In the *Accreditation Guide*, you will find:

- * **Definitions.** All italicized terms found in the standards are defined in this section.
- * **Standards with assigned Weights and Interpretive Information for each Standard.**
- * **Points to Remember and Scope of Standards.** These bullet points identify important issues to consider when documenting your organization's compliance with the standard. In some cases, additional details are provided that will help your compliance efforts and in other cases, these details will alert you to potential pitfalls.
- * **Evidence for Meeting the Standards: Desktop Materials and Onsite Review Materials and Activities.**
- * **Bright Ideas.** This section is not used for every standard and contains common industry practices that may be helpful to the applicant organization. (Note: adoption of a "bright idea" is not required for compliance with a standard, nor does adoption of the "bright idea" guarantee compliance with that standard.)
- * **Related Standards.** This section is not used for every standard, but helps to identify relationships between standards that are not always obvious and helpful to know about.



Scoring Methodology

Policy Regarding “Not Applicable” Elements and Standards

If a weighted standard element or an entire standard is determined to be *not applicable*, then they are not included in the scoring calculations (i.e., deducted from the denominator). This includes the rare instance when a “variance” is granted by the requisite URAC committee. As a result, applicants are not penalized when a standard element or standard is not applicable.

If a mandatory standard element is determined to be *not applicable*, then it does not count against the applicant when determining an accreditation category; however, applicant organizations must have a policy that meets the intent of a mandatory standard element even if it is not currently being implemented. The only exception to this policy is the collection of mandatory standard elements in Core that apply to delegation where if an applicant organization is not delegating, then documentation on delegation for these standards is *not required* even though some of the standard elements are mandatory (e.g., Core 8(b), Core 8(h) and Core 9(b) in version 3.0 of Core).

An applicant may choose not to meet any or all leading indicator standard elements (i.e., leading indicators are *optional*); therefore, a leading indicator standard element, which is not weighted, cannot be made *not applicable*. Not all accreditation standard sets have leading indicators.

Standard Element Weights

URAC’s Scoring System has six (6) distinct categories of standard elements:

- Weight = 1: Emerging Practice
 - Weight = 2: Basic Infrastructure
 - Weight = 3: Promotes Quality
 - Weight = 4: Key Stakeholder Right / Empowers Consumers
 - Mandatory = M: Non-weighted, mandatory element with a direct or significant impact on consumer safety and welfare
- o **All mandatory elements must be met at 100% compliance in order to achieve a Full accreditation**
 - o If determined to be not applicable, applicant must have a policy and procedure in place that meets the intent of the element should the organization need to implement it in the future
 - Leading Indicator = L: Non-weighted, *optional* element highlighting effective practices not yet widely adopted in health care
 - o Potential forecast of where the health care industry may be heading

- o Provides a way for an organization to distinguish itself from other accredited companies
- o **Leading indicators are not reported to URAC’s Accreditation or Executive Committees and do not influence an applicant’s final accreditation score or category**
- o Cannot be designated “not applicable” given that they are *optional*
- o Before URAC will acknowledge that an applicant has met a leading indicator:
 - Full accreditation must be achieved, and
 - Element must be met at 100% compliance
 - Initially URAC will list leading indicators in the Accreditation Summary Report (ASR)
- o Other types of marketing exposure may be considered in the future (e.g., Website, conferences, etc.)

Definitions for the standard element categories are listed on the following pages. As you analyze the standard elements to assign a weight, keep in mind the following:

- Standards are no longer weighted, but standard *elements* are. Elements are the components of a standard that are evaluated through the accreditation review process.
- Standard elements are no longer designated as “primary” or “secondary.”

Computing an Accreditation Score

- Scoring an Element
- o Element weight x Compliance
- Scoring a Standard
- o Total points achieved ÷ Total points possible
- Scoring a Module

o Total points achieved ÷ Total number of standards

- Scoring a multi-Module accreditation

o (Core score x .30) + (Module score x .70)

- Scoring a multi-Site accreditation

o Lowest site score determines the application score

Determining an Accreditation Category

- If one Mandatory standard element is not met Conditional
- If two Mandatory standard elements are not met Corrective Action
- If three Mandatory standard elements are not met Denial
- If all Mandatory standard elements are met:

≥ 94 points/100 and complies 100% on at least one “Leading Indicator” standard Include compliance with Leading Indicator(s) on the Accreditation Summary Report (ASR)

≥ 94 points/100 Full Accreditation

≥ 90, but < 94 points/100 Conditional Accreditation

≥ 85, but < 90 points/100 Corrective Action

< 85 points/100 Denial

Rating Compliance with a Standard Element

Standard elements are individually rated at 100% (full compliance), 50% (partial compliance) or 0% (no compliance) as follows:

For elements that require a file/record audit, the audit must reveal:

% Compliance with Element

100% Compliance (Full Compliance) = Audit score \geq 80%;

Note: A mandatory element must be met at 100% compliance with an audit score of \geq 90%; if not, then the mandatory element is considered *not met*. Credentials verification must be met at 100%. Applicants must meet all applicable mandatory elements in order to achieve Full accreditation.

Note: A leading indicator element must be met at 100% compliance; if not, then the leading indicator is considered *not met*. Applicants do not have to meet leading indicators since these types of elements are *optional*, acting as “extra credit.”

Note: A minimum of 30 files will be pulled for file review, but if the applicant does not have 30 files, then all files will be reviewed. For initial accreditation, the file selection date range will begin from the date that the application was submitted for accreditation up to the date of the onsite. For reaccreditation reviews, files will be pulled from the time period since the last URAC accreditation onsite visit.

- 50% Compliance = Audit score \geq 65%, but $<$ 80%, or for contracts the audit score is $<$ 80%, but the applicant has an internally approved, compliant contract template.
- 0% Compliance = Audit score $<$ 65%, or for contracts the applicant does not have an internally approved, standards-compliant contract in place.

For elements that do not require a file/record audit:

% Compliance with Element

100% Compliance (Full Compliance) = Element documented pursuant to the standard element and upon verification is found to be fully implemented.

Note: A mandatory element must be met at 100% compliance; if not, then mandatory element is considered *not met*. Applicants must meet all applicable mandatory elements in order to achieve Full accreditation.

Note: A leading indicator element must be met at 100% compliance; if not, then the leading indicator is considered *not met*. Applicants do not have to meet leading indicators since these types of elements are *optional*, acting as “extra credit.”

- A standard element is implemented, where *at least one* of the following onsite activities is verified:

- o Staff is observed conducting the procedure correctly; or
- o Staff verbalizes the procedure correctly; or
- o Documented examples of implementation are surveyed; or
- o Documentation of oversight is reviewed; or
- o Management attests to its implementation and provides supporting documentation (i.e., sign-in sheets showing staff training session occurred, CV of newly hired medical director, sample of revised and distributed documentation such as a provider directory, notification letters, etc.)

- 50% Compliance (Partial Compliance) = Element documented pursuant to the standard element, but not consistently or completely implemented.
- One or more incidences of non-compliance in implementation will lower the compliance rating to 50%. This would include:

- o Errors implementing work processes during on-site observation by the URAC Reviewer.
- o Mistakes during interviews. If staff catches the error – misspoke – and corrects it, then this will not count as evidence of non-compliance.
- o Reports with data or analysis demonstrating non-compliance (e.g., not meeting timelines, wrong staff conducted the procedure, provider listed in a directory prior to credentialing, etc.)
- o Meeting minutes revealing decisions contrary to meeting the intent of the standards or lacking documentation indicating that a key activity did not take place (e.g., vote to eliminate provider appeal mechanism, minutes do not reflect review and update of the quality management program, etc.)

0% Compliance (No Compliance) = No evidence or incomplete evidence of compliance with the standard element in documentation or, regardless of documentation, applicant has not implemented the structures or processes needed to comply with the standard element. No compliance is exemplified when *any one* of the following statements is true.

The standard element is:

- Not addressed in documentation,
- Only partially addressed in documentation,
- Addressed in documentation, but does not meet the intent of the standard element,

- Not implemented, which *does not* include situations where:
 - o The organization did not have the opportunity to implement. An example of this would be where an organization has an appeal process in place, but is either not contracted to do appeals or simply has not had an appeal of the type addressed by the standard.
 - o The organization has been in business < six (6) months and is therefore eligible for a provisional accreditation.
 - Implemented in a non-compliant manner, or
 - Implemented, but one or more staff shows a pattern (≥ 4 occurrences) of non-compliance with an element over a period of time (within six (6) consecutive months), regardless of any warnings, corrective action taken (including training or procedural changes), or relative improvement over time.

Scoring a Weighted Standard Element

To score a weighted standard element (“element”),

- Multiply the element weight by the compliance factor achieved (e.g., 0 for *no compliance*, .50 for *partial compliance* or 1.0 for *full compliance*).

Calculation for Standard Element Score

(Compliance factor) \times (Weight of standard element) = Score for an Element

Scoring a Standard

To score a standard with weighted elements,

- Sum the score achieved for each element.
 - Divide by the number of points possible (sum of the element weights) for the entire standard.
- o Weights for the elements determined to be not applicable are not included in the denominator and as such do not count against the applicant.
- Multiply by 100; this provides a percentage score for the standard.

Calculation for Standard Score

[(Sum of all applicable element scores) \div (Total possible points for the standard)] \times 100 = Standard Score

Calculating a Final Total Accreditation Score for Core-only Applications and Accreditations that do not include Core

To calculate a final score for Core-only and non-Core Module Applications,

- Sum the scores for each standard.
 - Divide by the total number of applicable standards.
- o Standards determined to be not applicable are not included in the denominator and as such do not count against the applicant.

Calculation for Core and non-Core Module Score

$$[(\text{Sum of all applicable standard scores}) \div (\text{Total number of applicable standards})] = \text{Module Score} = \text{Final Total Score (round to nearest tenth)}$$

Note: For purposes of calculating an accreditation score, the number of standards possible is the total count of standards that have at least one weighted element; standards that do not have any weighted elements (i.e., only mandatory and/or leading indicator elements) are not included in the count since they do not contribute a standard score towards the module score. It is not logical to include standards in the denominator when it has no points to contribute to the score and to include such a standard in the denominator would unfairly penalize the applicant.

Note: If all weighted elements in a standard are determined to be not applicable, then the standard does not count towards the total number of applicable standards for purposes of scoring a module. To count them would unfairly penalize the applicant and is contrary to the URAC policy on standards determined to be not applicable.

Calculating a Final Total Accreditation Score for Multi-Module Accreditations

To calculate a final total accreditation score for multi-module accreditations, which includes:

- Core + a single Module (e.g., Health UM, IRO, CES, etc.)
- Core + multiple Modules (e.g., Health Plan, Health Network, etc.)

For Core:

- Sum all of the Core standard scores.
- Divide by the total number of applicable standards.
 - ◆ Standards determined to be not applicable are removed from the denominator and as such do not count against the applicant.

- Multiply the Core score by .30 since Core is 30% of the final score for multi-module accreditations that include Core.

For non-Core module score:

- Sum all of the standard scores from all of the non-Core modules.
- Divide by the total number of applicable standards.
 - ◆ Standards determined to be not applicable are removed from the denominator and as such do not count against the applicant.
- Multiply the non-Core score by .70 since the non-Core modules collectively contribute to 70% of the final score.
- Sum the percentage score for Core and the modules; a perfect score would be 100%.

Final Total Score

$(\text{Core score} \times .30) + (\text{non-Core score} \times .70) = \text{Final Total Score for One or Multiple Sites (round to nearest tenth)}$

Final Total Score if all Sites achieve a Full (≥ 94)

$(\text{Sum of all Full onsite scores}) \div (\text{Number of sites that had an onsite review}) = \text{Final Full Accreditation Score (round to nearest tenth)}$

Note:

- Each site that has an onsite review receives its own score; however, the lowest of these scores determines the score for the overall application.
- If all sites receiving an onsite review achieve a Full, the average score for these sites is the final score for the application. (See calculation above.)
- If there is a trend of three (3) or more sites that achieve less than a Full accreditation, then the URAC Reviewer has the discretion to visit all of the sites in the application.

Determining How Many Mandatory Elements are Met and Not Met

Mandatory elements are non-weighted elements and all applicable mandatory elements must be met at 100% compliance in order for an applicant to achieve Full accreditation.

- Mandatory elements that are determined to be not applicable are subtracted from the total count of mandatory elements and do not count against an applicant.

- Mandatory elements with a compliance level less than 100% (e.g., partial compliance [.5] and no compliance [0]) are considered *not met* and count against an applicant when determining an accreditation level. (See “Determining an Accreditation Level.”)



Definitions for Health Accreditation Standards

(NOTE: Defined terms appear in italics throughout the standards).

Being familiar with these definitions is critically important to accurate understanding of URAC Standards. In the Standards, defined terms are *italicized*. Readers are encouraged to refer to the definitions section each time they encounter an italicized term until they feel they have committed the meaning of that term to memory.

Abandonment Rate: The percentage of calls offered into a communications network or telephone system -- i.e., automatic call distribution (ACD) system of a call center -- that are terminated by the persons originating the call before answer by a *staff* person.

Interpretive note for term "Abandonment Rate": Abandonment rate is measured as the percentage of calls that disconnect after 30 seconds when an individual (live person) would have answered the call. For example, if there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended. (On ACD reports, monitor calls that "drop" after 30 seconds.)

Access: The *consumer's* or *client's* ability to obtain services in a timely manner.

Interpretive Note: The measures of *access* for *consumers* are determined by components such as the *availability* of services, their acceptability to the *consumer*, *consumer* wait time, and the hours of operation.

The measures of *access* for *clients* are determined by components such as turn-around time and other metrics as they may be defined in written business agreements, etc.

Adverse Benefit Determination: A decision by the *Organization* to deny or reduce a benefit for some or all of the lines of a *claim* (other than the application of a deductible or other cost-sharing).

Adverse Event: An occurrence that is inconsistent with or contrary to the expected outcomes of the *Organization's* functions.

Advisory Board of Osteopathic Specialists (ABOS): American Osteopathic Association (AOA) *certification* agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and pattern of training.

American Board of Medical Specialties (ABMS): Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

Appeal: A written or verbal request by a *consumer, ordering provider* or prescriber to contest an organizational determination (e.g., services have been denied, reduced, etc.).

Interpretive Note for term “Appeal”: Specific terms used to describe *appeals* vary, and are often determined by law or regulation.

Appeals Consideration: Clinical review conducted by appropriate *clinical peers*, who were not involved in *peer clinical review*, when a decision not to certify a requested admission, procedure, or service has been appealed. Sometimes referred to as “third level review.”

Assessment: A process for evaluating individual *consumers* that have been identified as eligible for a medical management program, such as *disease management* or *case management*, to identify specific needs relating to their clinical *condition* and associated co-morbidities.

Attending Physician: The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a *patient* in a hospital or other health care *facility*.

Attending Provider: The physician or other health care practitioner with primary responsibility for the care provided to a *consumer*.

Average Speed of Answer: The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a *staff* person.

Interpretive note for term "Average Speed of Answer": The speed of answer is measured starting at the point when an individual (live person) would have answered the call. For example, if there is a pre-recorded message or greeting for the caller, the time it takes to respond to the call (i.e., average speed of answer) begins after the message/greeting has ended.

Benefit Calculation: An adjustment or calculation by the *Organization* of the financial reimbursement for a *claim* under the terms of the applicable benefit plan, provisions, *criteria*, provider contracts, or state rules.

Benefits Program: An arrangement to pay for health care services provided to a *consumer*. “Benefits program” includes, but is not limited to, health and medical benefits provided through the following *organization* types:

- ◆ Health maintenance *organizations* (HMOs);
- ◆ Preferred provider *organizations* (PPOs);
- ◆ Indemnity health insurance programs;
- ◆ Self-insured plans;
- ◆ Public programs, such as Medicare and Medicaid; and
- ◆ Workers’ compensation insurance programs.

Blockage Rate: The percentage of incoming telephone calls “blocked” or not completed because switching or transmission capacity is not available as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in *callers* receiving a busy signal.

Board-certified: A *certification* – approved by the *American Board of Medical Specialties*, the American Osteopathic Association, or another *organization* as accepted by URAC – that a physician has expertise in a particular specialty or field. To the extent that future URAC standards include other *certifications*, URAC will specify further approved boards.

Interpretive Note for term “Board-certified”: URAC recognizes that ABMS- and AOA-approved board certifications may not be the only certification programs that may be acceptable for health professionals in

URAC-certified organizations. For example, non-physician professionals will have appropriate certifications that are not ABMS- or AOA-approved. Any applicant wishing to have URAC recognize another board certification program should notify URAC early in the certification process. URAC will then take this recommendation to URAC's Accreditation Committee.

The Accreditation Committee will review all requests, and will decide to approve or reject the certification. The Accreditation Committee will consider the following criteria in judging whether a certification is acceptable:

- ◆ Is the certification accepted within its target community of health professionals?
- ◆ Was the certification developed through an open, collaborative process?
- ◆ Does the certification reflect accepted standards of practice?
- ◆ Is the certification administered through an objective process open to all qualified individuals?

Caller: The consumer inquiring to obtain health care information. This may also be a representative inquiring on behalf of the consumer.

Case: A specific request for medical or clinical services referred to an organization for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not. It is a non-approval regarding medical necessity and medical appropriateness decisions for services covered under a health benefit plan's terms and conditions or for coverage decisions regarding experimental or investigational therapies that is at issue during the independent review process.

Case Involving Urgent Care: Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or

b) in the opinion of a physician with knowledge of the consumer’s medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case. (**Note:** This definition is derived from the Department of Labor’s definition of “claim involving urgent care.”)

Interpretive Note for term “Case Involving Urgent Care”:

While the URAC standards are silent on the methods by which a claim is determined to be a “case involving urgent care,” the Department of Labor claims regulation (29 C.F.R. § 2560.503-1(m)(1)) specifies that whether a claim is a “claim involving urgent care” is to be determined by an individual acting on behalf of the health benefits plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care.”

Case Management: A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs using communication and available resources to promote quality cost-effective outcomes.

Certification:

1) (UM Specific Definition) A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Interpretive Note for term “Certification”: “Determination” may vary depending on context.

2) (General Definition) A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization. To qualify under these standards, the certification program must:

- ◆ Establish standards through a recognized, validated program;
- ◆ Be research-based; and
- ◆ Be based (at least partially) on passing an examination

Claim: Any bill, claim, or proof of loss made by or on behalf of a consumer or health care provider to an Organization (or its intermediary, administrator, or representative) for which the consumer or health care provider has a contract for payment of health care services. (Note: definition based on Code of Virginia §

38.2-3407.15.)

Claimant: A person or entity who submits a claim, or on whose behalf a claim is submitted. (Includes “consumer” for URAC’s Core Standards.)

Claims Administrator: Any entity that recommends or determines to pay claims to enrollees, physicians, hospitals, or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third party administrators, or other private contractors.

Claims Processing Organization: An organization that seeks accreditation under these standards. Examples of organizations that process claims include but are not limited to:

- ◆ Health insurance companies;
- ◆ Health maintenance organizations (HMOs);
- ◆ Preferred provider organizations (PPOs);
- ◆ Third-party administrators (TPAs);
- ◆ Disability insurance carriers; and
- ◆ Workers’ compensation insurance carriers.

Interpretive Note for term “Claims Processing Organization”: Throughout this document the term “organization” refers to claims processing organization.

Clean Claim: A claim that has no material defect, impropriety, lack of any required substantiating documentation, or special circumstance(s) – such as, but not limited to, coordination of benefits, pre-existing conditions, subrogation, or suspected fraud – that prevents timely adjudication of the claim.

Clean Credentialing File: A credentialing application is considered “clean” if it meets the following criteria:

- ◆ The provider has completed all applicable sections of the credentialing application.
- ◆ Where indicated, the provider has signed, initialed and dated the credentialing application.
- ◆ All necessary supporting documentation has been submitted and is included with the credentialing application in the provider’s file.
- ◆ Credentials verification reveals that there are **no** issues to report to the credentialing committee as defined in the organization’s credentialing plan. At a minimum, URAC considers the following items

to be “issues” for any credentialing application:

- ◇ Any lapse in practice greater than six (6) months*
- ◇ Any history of malpractice claims or settlement*

- *Unless a specific reason for a lapse in practice greater than six (6) months or particular history of malpractice as defined in the credentialing plan and approved by the credentialing committee *is determined not to be an issue* requiring credentialing committee review.
- *By way of example, the credentialing committee may decide that for an orthopedic surgeon or OB/GYN physician, unless malpractice claims go over a certain dollar (\$) amount, their credentialing files do not need to be reported as files with issues to the committee.
- *The medical director for credentialing must always have the authority to forward a credentialing file to the credentialing committee at his or her discretion.

5. The provider meets the credentialing criteria approved by the credentialing committee and as stated in the credentialing plan.

Client: A business or individual that purchases services from the Organization.

Interpretive Note for term “Client”: Here are some examples of client relationships:

- ◆ If a health plan provides health coverage to an employer, the employer is the client.
- ◆ If a health plan contracts for utilization management services from a utilization management organization, the health plan is the client.
- ◆ If a PPO contracts for credentialing services with a CVO, the PPO is the client.

Clinical Activities: Operational processes related to the delivery of clinical triage and health information services performed by clinical staff.

Clinical Decision Support Tools: Protocols, guidelines, or algorithms that assist in the clinical decision-making process.

Clinical Director: A health professional who: (1) is duly licensed or certified; (2) is an employee of, or party to a contract with, an organization; and (3) who is responsible for clinical oversight of the utilization management program, including the credentialing of professional staff and quality assessment and improvement functions.

Clinical Peer: A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the

same licensure category as the ordering provider.

Clinical Practice Guidelines: Systematically developed statements to assist decision-making about appropriate health care for specific clinical circumstances.

Clinical Rationale: A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review Criteria: The written screens, decision rules, medical protocols, or guidelines used by the organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

Clinical Staff: Employees or contracted consultants of the health care organization who are clinically qualified to perform clinical triage and provide health information services.

Clinical Triage: Classifying consumers in order of clinical urgency and directing them to appropriate health care resources according to clinical decision support tools.

Comparable: Data about performance is compared to an historical baseline (which may be internal) and ongoing progress is recorded in regular intervals (e.g., monthly, quarterly, or annually). External benchmarks also may be used for purposes of comparison.

Complaint: An expression of dissatisfaction by a consumer expressed verbally or in writing regarding an organization's products or services that is elevated to a complaint resolution system.

Interpretive Note for term "Complaint":

- ◆ This term is sometimes referred to as "grievance."
- ◆ This definition does not include appeals.

Concurrent Review: Utilization management conducted during a patient's hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review".

Condition: A diagnosis, clinical problem or set of indicators such as signs and symptoms that an individual *consumer* may have that define him or her as eligible and appropriate to participate in a medical management program such as a *disease management* or *case management* program.

Conflict of Interest: Any relationship or affiliation on the part of the organization or a reviewer that could compromise the independence or objectivity of the independent review process. Conflict of interest includes, but is not limited to:

- ◆ An ownership interest of greater than 5% between any affected parties;
- ◆ A material professional or business relationship;
- ◆ A direct or indirect financial incentive for a particular determination;
- ◆ Incentives to promote the use of a certain product or service;
- ◆ A known familial relationship;
- ◆ Any prior involvement in the specific case under review.

Consumer: An individual person who is the direct or indirect recipient of the services of the Organization. Depending on the context, consumers may be identified by different names, such as “member,” “enrollee,” “beneficiary,” “patient,” “injured worker,” “claimant,” etc. A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the Organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

Interpretive Note for term “Consumer”:

In the case of a consumer who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the consumer behalf may be a consumer for the purposes of these standards.

Contractor: A business entity that performs delegated functions on behalf of the Organization.

Interpretive Note for term “Contractor”:

For the purposes of these standards, the term “contractor” includes only those contractors that perform functions related to the key processes of the Organization. It is not URAC’s intent to include contractors that provide services unrelated to key processes. For example, a contractor that provides catering services would not fall within the definition of “contractor” in these standards. Conversely, a company that provides specialty physician reviewers to a UM organization would clearly fall within the definition of “contractor.”

Covered Benefits: The specific health services provided under a health benefits program, including: cost-sharing and other financial features; claims submission and reimbursement processes; requirements and processes (if any) for prior authorization or other approval of health services.

Covered Service: A health care service for which reimbursement or other remuneration is provided to a consumer or on behalf of a consumer under the terms of the consumer's benefits program.

Credentials Verification: A process of reviewing and verifying specific credentialing criteria of a practitioner.

Credentials Verification Organization (CVO): An organization that gathers data and verifies the credentials of health care practitioners.

Criteria: A broadly applicable set of standards, guidelines, or protocols used by the organization to guide the clinical processes. Criteria should be:

- ◆ Written;
- ◆ Based on professional practice;
- ◆ Literature-based;
- ◆ Applied consistently; and
- ◆ Reviewed, at a minimum, annually.

Data Integrity: The quality or condition of being accurate, complete and valid, and not altered or destroyed in an unauthorized manner.

Date of Receipt: The date on which a claim arrives at a Organization (or, for claims that arrive on a non-business day, the date of the first business day thereafter).

Delegation: The process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.

Discharge Planning: The process that assesses a patient's needs in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge or transfer from current services or level of care.

Disease Management (DM): According to the Disease Management Association of America, “Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. Disease management components include: population identification processes; evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); process and outcomes measurement, evaluation, and management; routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling.”

Disease Management Program: A program or entity that provides the scope of functions and activities necessary to provide disease management.

Electronic: Mode of electronic transmission including the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media. (Final Rule, Department of Health and Human Services, “Health Insurance Reform: Standards for Electronic Transactions,” Federal Register (Aug. 17, 2000).)

Electronic Health Record: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Electronic Medical Record: An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Engagement: Proactive outbound contact with consumers, by phone or mail, within some specified time frame of identification of eligible consumers, with tracking of interactions.

Evidence-based: Recommendations based on valid scientific outcomes research, preferably research that has been published in peer reviewed scientific journals. Evidence-based information can be used to

develop protocols, pathways, standards of care or clinical practice guidelines and related educational materials.

Evidence Based Medicine: “Evidence based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.” David L. Sackett, William M. C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, W. Scott Richardson. Evidence based medicine: what it is and what it isn't. British Medical Journal 1996; 312:71-72. Reproduced with permission from BMJ Publishing Group.

Expedited Appeal: An appeal of a non-certification of a case involving urgent care. See definition of "Case Involving Urgent Care."

Facility: An institution that provides health care services.

Facility Rendering Service: The institution or organization in or by which the requested admission, procedure, or service is provided. Such facilities may include, but are not limited to: hospitals; outpatient surgical facilities; individual practitioner offices; rehabilitation centers; residential treatment centers; skilled nursing facilities; laboratories; imaging centers; and other organizational providers of direct services to patients.

Family: Individuals whom the consumer chooses to involve in the decision-making process regarding the consumer's health care. In the case of a consumer who is unable to participate in the decision-making process, "family" shall include any individual legally authorized to make health care decisions on the consumer's behalf.

Health Assessment Tool: A data collection instrument that allows a consumer and the organization to ascertain the consumer's health status and health risks. Such tools are often administered online, although other formats are permissible. Other common terms used to describe health assessment tools are "health risk assessment" and "health survey."

Health Benefits Plan: An arrangement to pay for medical services provided to a consumer. "Health benefits plan" includes (but is not limited to):

- ◆ HMOs;

- ◆ PPOs;
- ◆ Indemnity health insurance programs;
- ◆ Self-insured plans;
- ◆ Public programs, such as Medicare and Medicaid; and
- ◆ Workers' Compensation insurance programs.

Health Care Team: The attending physician and other health care providers with primary responsibility for the care provided to a consumer.

Health Content Reviewer: An individual who holds a license or certificate as required by the appropriate jurisdiction in a health care field (where applicable), has professional experience in providing relevant direct patient care **or** has completed formal training in a health-related field.

Health Education: Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.

Health Information: Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.

Health Information Exchange: The electronic movement of health-related information among organizations according to nationally recognized standards.

Health Information Organization: An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions regarding their health.

Health Professional: An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.

Health-Related Field: A professional discipline that promotes the physical, psychosocial, or vocational well being of individual persons.

Individually Identifiable Information: Any information that can be tied to an individual consumer, as defined by applicable laws.

Independent Review: A process, independent of all affected parties, to determine if a health care service is medically necessary and medically appropriate, experimental/investigational or to address administrative/legal issues. Independent review typically (but not always) occurs after all appeal mechanisms available within the health benefits plan have been exhausted. Independent review can be voluntary or mandated by law.

Independent Reviewer: The individual (or individuals) selected by the organization to consider a case. Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 and IR 6. All reviewer(s) who are health care practitioners must have the following qualifications:

- ◆ Active licensure;
- ◆ Recent experience or familiarity with current body of knowledge and medical practice;
- ◆ At least 5 years experience providing health care;
- ◆ If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.
- ◆ If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery.

Initial Clinical Review: Clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services

that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification. Sometimes referred to as “first level review.”

Interoperability: Ability of two or more systems or components to exchange information and to use the information that has been exchanged.

Knowledge Domains – Areas of specific expertise.

License: A license or permit (or equivalent) to practice medicine or a health profession that is 1) issued by any state or jurisdiction in the United States; and 2) required for the performance of job functions.

Interpretive Note for term "License":

In this definition, the word “equivalent” includes certifications, registrations, permits, etc. Specific terms will vary by state and health profession.

Medical Director: A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and who is an employee of, or party to a contract with, an organization, and who has responsibility for clinical oversight of the organization’s utilization management, credentialing, quality management, and other clinical functions.

Medical Management – A general term encompassing activities such as utilization management, case management, and the clinical aspects of quality management.

Medication Reconciliation: The process of creating the most accurate list possible of all medications a patient is taking - including drug name, dosage, frequency, and route - and comparing that list against the physician's admission, transfer and/or discharge orders, with the goal of providing correct medications to the patient at all transition points.

Note for term "Medication Reconciliation": This definition comes from the Institute for Healthcare

Improvement (IHI), *Reconcile Medication at All Transition Points*, available through the following Web site: www.ihl.org.

Non-Certification: A determination by an organization that an admission, extension of stay, or other health care **or pharmacy** service has been reviewed and, based on the information provided does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the applicable health benefitplan.

Non-Clinical Administrative Staff: Staff who do not meet the definition of health professional (including intake personnel).

Non-Clinical Staff: Employees or contracted consultants of a health care organization who do not perform clinical assessments or provide callers with clinical advice. They may be responsible for obtaining demographic information, providing benefit information, and re-directing callers.

Off-shoring: The relocation of an organizational function to a foreign country under the same organizational control (ownership).

Note related to off-shoring: In health care management, outsourcing distinct functions to a foreign subcontractor is the more common trend. See the definition for "outsourcing."

Opt-in: Affirmative consent actively provided by a consumer to participate in an activity or function of the program, provided after the program has fully disclosed the terms and conditions of participation to the consumer.

Note for term "Opt-in": Auto enrollees are not considered "opt-in" enrollees of the program.

Opt-out: A process by which an enrolled consumer declines to participate in an activity or function of the program.

Ordering Provider: The physician or other provider who specifically prescribes the health care service

being reviewed.

Organization: A business entity that seeks accreditation under these standards.

Interpretive Note for term “Organization”: This can include a program or department and can be geographically defined.

Organizational Conflict of Interest: A conflict that affects objectivity between the organization's financial interests and the organization's obligations to the client.

Outcome: A consumer's health status following services.

Outsourcing: The delegation of services or functions from internal production to an external entity outside of the United States.

Oversight: Monitoring and evaluation of the integrity of **relevant** program processes and decisions affecting consumers.

Participant (participating): An eligible consumer or treating provider that has had one or more inbound or outbound contacts with the disease management program, and if a consumer, has not opted out of the program.

Participating Provider – A provider that has entered into an agreement with the organization to be part of a provider network.

Patient: The enrollee or covered consumer for whom a request for certification may or may not have been filed.

Interpretive Note for term “Patient”: In the case of a patient who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the patient's behalf may be a patient for the purposes of these standards.

Peer Clinical Review: Clinical review conducted by appropriate health professionals when a request for an admission, procedure, or service was not approved during initial clinical review. Sometimes referred to as “second level review.”

Peer-to-Peer Conversation: A request by telephone for additional review of a utilization management determination not to certify, performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

Personal Health Record: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

Personally-identifiable Information: Any information that can be tied to an individual identifier.

Performance Measures: Qualitative or quantitative quality indicators for assessing the achievement of outcomes. www.wtcc.sa.gov.au/webdata/resources/files/sp_glossary.doc

Plain Language: Communication that uses short words and sentences, common terms instead of (medical) jargon, and focuses on the essential information recipients need to understand.

Population: Depending on the model of the disease management program, the population for which it is responsible may be all of the consumers identified with the disease condition, or the population may be only those consumers identified to the disease management program by client referral or another mechanism. In some instances the disease management program may be responsible for identification of the population, and in other instances the client may conduct identification (and stratification) activities.

Potential Enrollees: Employees and eligible dependents of employer/purchasers who are offering enrollment in the organization's products as part of the employee benefits package. In the case of organizations that offer products in the individual market, potential enrollees include individuals from the general public in the geographic area where the organization offers the products.

Practitioner – An individual person who is licensed to deliver health care services without supervision.

Pre-Review Screening: Automated or semi-automated screening of requests for authorization that may include: (1) collection of structured clinical data (including diagnosis, diagnosis codes, procedures, procedure codes); (2) asking scripted clinical questions; (3) accepting responses to scripted clinical questions; and (4) taking specific action (certification and assignment of length of stay explicitly linked to each of the possible responses). It excludes: (1) applying clinical judgment or interpretation; (2) accepting

unstructured clinical information; (3) deviating from script; (4) engaging in unscripted clinical dialogue; (5) asking clinical follow-up questions; and (6) issuing non-certifications.

Primary Physician: The physician who is primarily responsible for the medical treatment and services of a consumer.

Primary Source Verification: Verification of a practitioner's credentials based upon evidence obtained from the issuing source of the credential. Also known as "Primary Source."

Principal Reason(s): A clinical or non-clinical statement describing the general reason(s) for the non-certification determination ("lack of medical necessity" is not sufficient to meet this).

Professional Competency: The ability to perform assigned professional responsibilities.

Prospective Review: Utilization management conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient procedures and services). Sometimes called "precertification review" or "prior authorization."

Protected Health Information: Individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in any medium described in the definition of electronic media at Sec. 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer. (67 Fed. Reg. at 53,267 (Aug. 14, 2002); 65 Fed. Reg. at 82,805 (Dec. 28, 2000) (to be codified at 45 C.F.R. pt. 164.501)).

Provider: A licensed health care facility, program, agency, or health professional that delivers health care services.

Provider Network – A group of providers with which the organization contracts to provide health services to consumers.

Provider-Specific Information: Information that is sufficient to allow identification of the individual provider.

Quality Improvement Project: An organization-wide initiative to measure and improve the service and/or care provided by the organization.

Quality Management (QM) program: A systematic data-driven effort to measure and improve consumer and client services and/or health care services.

Quality Review Study: A scientific and systematic measurement of the effects or results of treatment modalities or practices for a particular disease or condition. The goal of quality measurement is to improve health care services by monitoring and analyzing the data and modifying practices in response to this data.

Rationale: The reason(s) or justification(s) – commonly based on criteria – for a specific action or recommendation.

Re-assessment: Re-evaluation of an individual *consumer* participating in a medical management program, such as *disease management* or *case management*, on a specified frequency using the same or similar tools that were used in the initial assessment. Re-assessment may also include re-stratification.

Referring Entity: The organization or individual that refers a case to an organization. Referring entities may include insurance regulators, health benefits plans, consumers, and attending providers. Some states may limit by law which individuals or organizations may be a referring entity.

Regional Health Information Organization: A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

Retrospective Claim: A claim presented after services have been provided (i.e., a post-service claim) and presented for consideration under a contract or policy.

Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the patient.

Interpretive Note for term “Retrospective Review”: Retrospective medical necessity determinations are considered utilization management (and subject to these standards).

Review of Service Request: Review of information submitted to the organization for health care services that do not need medical necessity certification nor result in a non-certification decision.

Reviewer(s): The individual (or individuals) selected by the organization to consider a case. Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 and IR 6. All reviewer(s) who are health care practitioners must have the following qualifications:

- ◆ Active licensure;

- ◆ Recent experience or familiarity with current body of knowledge and medical practice;
- ◆ At least 5 years experience providing health care;
- ◆ If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.
- ◆ If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery

Second Opinion: Requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.

Secondary Source Verification or Secondary Source: Verification of a practitioner's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of licenses and certifications and data base queries).

Service Requests: Screening callers to determine the services that are necessary at the time of the call. This is usually performed by a non-clinical staff person to determine if the call is clinical and requires transfer to a clinical staff person.

Staff: The Organization's employees, including full-time employees, part-time employees, and consultants.

Standard Appeal: An appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals of expedited appeals.

Statistically valid: Based on accepted statistical principles and techniques.

Stratification: A process for sorting a population of eligible consumers into groups relating to the need for disease management interventions. Stratification and assessment are inter-related, and both provide data used to assign interventions. Stratification may use a variety of data sources, including but not limited to claims, pharmacy, laboratory, or consumer-reported data.

Structured Clinical Data: Clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation.

Therapeutic: Of or relating to the treatment of disease or disorders by remedial agents or methods.

Treating Provider: The treating provider is the individual or provider group who is primarily managing the treatment for a consumer participant in the disease management program. The treating provider is not

necessarily the consumers' primary care physician. The consumer may have a different treating provider for different conditions.

Urgent Care: See "Case Involving Urgent Care."

Utilization Management (UM): Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities. UM encompasses prospective, concurrent and retrospective review in which clinical criteria are applied to a request. UM is sometimes called "utilization review".

Worker: An ill or injured individual (or representative acting on behalf of the worker) who is eligible for workers' compensation benefits and who files for, or for whom a workers' compensation claim has been filed.

Written Agreements: A document – including an electronic document – that specifies the terms of a relationship between the Organization and a client, consumer, or contractor. This term may include a contract and any attachments or addenda.

Written Notification: Correspondence transmitted by mail, facsimile, or electronic medium.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual. (65 Fed. Reg. at 82,804 (to be codified at 45 C.F.R. pt. 164.501))

(Note: This definition is derived from the federal Health Insurance Portability and Accountability Act (HIPAA)).



Crosswalk between Core v2.1 & v3.0

Crosswalk between Core v2.1 & v3.0					
std #	std #		std #	std #	
version	version		version	version	
3.0	2.1	Notes	2.1	3.0	Notes
1	1		1	1	
2	2		2	2	
3	3		3	3	
4	19		4	25	
5	12		5	26	
6	15		6	30	
7	16		7	27	
8	17		8	28	
9	18		9	29	
10	21	Old 21(a), (c) & (d) in new Core 10	10	31	
11	14		11	32	
12	24	Client satisfaction brought from Core 24	12	5	
13	13(a) & (d)	New: Interoperability [Leading Indicator]	13	13, 14 & 15	
14	Core 13(c)	Comes from Core 13(c) in v2.1	14	11	
15	Core 13(b)	Comes from Core 13(b) in v2.1	15	6	
16	23		16	7	
17	29		17	8	
18	30		18	9	
19	31		19	4	
20	32		20	33	
21	33		21	10 & 34	
22	Core 35 (stem)	Comes from stem of Core 35 in v2.1	22	38	
23	34		23	16	
24	35		24	39	Consumer Satisfaction
25	4		25	34	

26	5		26	35	
27	7		27	35	
28	8		28	35	
29	9		29	17	
30	6		30	18	
31	10		31	19	
32	11		32	20	
33	20		33	21	
34	25		34	23	
35	26, 27 & 28		35	24	
36	new std	External Coordination	---	36	
37	Core 21(e)	Comes from Core 21(e) in v2.1	---	40	
38	22				
39	24	Consumer satisfaction			
40	new std	Health Literacy			



Applicability of Core Organizational Quality Standards, Version 3.0

Applicability of Core Organizational Quality Standards, version 3.0

For the URAC Core Organizational Quality Standards version 3.0 (Core), the standards have been reorganized to ease the application process. Standards listed first apply to all health care organizations. These standards are followed by those where the applicant organization must have credentialed licensed or certified clinical staff in order to conduct the function covered by the accreditation. The last sections of Core apply to those organizations that interact directly with health care consumers on an ongoing basis in order to provide health care management support services directly to the consumer. This was done to address the fact that many of the organizations which URAC accredits under the Core standards do not interact directly with consumers, but instead are business partners or vendors to organizations that do.

The following sections of standards address infrastructure and human resources and are applicable to all organizations applying for accreditation or certification including stand-alone Core applicants, though some standards may be determined to be not applicable. For example, the delegation standards would not apply if an organization does not delegate.

- **Organizational Structure**
- **Policies and Procedures**
- **Regulatory Compliance**
- **Inter-Departmental Coordination**
- **Oversight of Delegated Functions**
- **Marketing and Sales Communications**
- **Business Relationships**
- **Information Management**
- **Quality Management**
- **Staff Qualifications**
- **Staff Management**

The Clinical Staff Credentialing and Oversight Role section covers clinical oversight and are applicable to organizations applying for accreditations that require licensed or certified clinical staff in order to perform the function covered by the accreditation. These standards may not apply to certain stand-alone Core applicants.

Lastly, the Core sections on Health Care System Coordination and Consumer Protection and Empowerment are applicable to organizations that are involved with care coordination and interact with consumers. These accreditation products cover functions that require an organization to interact with consumers on an ongoing basis in order to provide health care management services directly to the consumer.

The table below is color coded to show which standards are applicable under the various types of URAC accreditation products.

Blue: Standards apply regardless of accreditation, though it may be determined that some standards are not applicable (“N/A”) for a given organization.

Purple: Standards are applicable if the accreditation requires an organization to have licensed or certified clinical staff. (Note that these standards may or may not apply to an organization applying only for Core accreditation.)

Black: Standards are applicable for accreditations that require an organization to have licensed or certified clinical staff that interfaces with consumers on an ongoing basis in order to provide health care management support services directly to the consumer. (Note that these standards may or may not apply to an organization applying only for Core accreditation.)

Core Organizational Quality Standards, version 3.0	
<ul style="list-style-type: none"> • Organizational Structure 1-Organizational Structure 2-Organization Documents • Policies and Procedures 3-Policy and Procedure Maintenance, Review and Approval • Regulatory Compliance 4-Regulatory Compliance • Inter-Departmental Coordination 5-Inter-Departmental Coordination • Oversight of Delegated Functions 6-Delegation Review Criteria 7-Delegation Review 8-Delegation Contracts 9-Delegation Oversight • Marketing and Sales Communications 	<ul style="list-style-type: none"> • Quality Management 17-Quality Management Program 18-Quality Management Program Resources 19-Quality Management Program Requirements 20-Quality Management Committee 21-Quality Management Documentation 22-Quality Improvement Projects 23-Quality Improvement Project Requirements 24-Quality Improvement Projects: Consumer Organizations • Staff Qualifications 25-Job Descriptions 26-Staff Qualifications • Staff Management 27-Staff Training Program 28-Staff Operational Tools and Support 29-Staff Assessment Program

10-Review of Marketing and Sales Materials

- **Business Relationships**

11-Written Business Agreements

12-Client Satisfaction

- **Information Management**

13-Information Management

14-Business Continuity

15-Information Confidentiality and Security

16-Confidentiality of Individually-Identifiable
Health Information

- **Clinical Staff Credentialing and Oversight Role**

30-Clinical Staff Credentialing

31-Senior Clinical Staff Requirements

32-Senior Clinical Staff Responsibilities

33-Financial Incentive Policy

34-Access to Services

35-Consumer Complaint Process

- **Health Care System Coordination**

36-Coordination with External Entities

- **Consumer Protection and Empowerment**

37-Consumer Rights and Responsibilities

38-Consumer Safety Mechanism

39-Consumer Satisfaction

40-Health Literacy



Table of Applicable Core Standards v3.0



CORE, Version 3.0

Organizational Structure

CORE - 1 - Organizational Structure

The *organization* has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the *organization*. (2)

CORE - 2 - Organization Documents

Organization's documents address: (No Weight)

- (a) Mission statement; (2)
- (b) Organizational framework for program; (2)
- (c) The population served; **and** (2)
- (d) Organizational oversight and reporting requirements of the program. (2)

Policies and Procedures

CORE - 3 - Policy and Procedure Maintenance, Review and Approval

The *organization*: (No Weight)

- (a) Maintains and complies with written policies and documented procedures that govern core business processes of its operations related to the scope of the accreditation; (Mandatory)
- (b) Maintains the ability to produce a master list of all such policies and procedures; (2)
- (c) Reviews written policies and documented procedures no less than annually and revises as necessary; (3)
- (d) Includes the following on the master list or on all written policies and documented procedures: (No Weight)
 - (i) Effective dates, review dates, including the date of the most recent revision;
and (2)

- (ii) Identification of approval authority. (2)

Regulatory Compliance

CORE - 4 - Regulatory Compliance

The *organization* implements a regulatory compliance program that: (No Weight)

- (a) Tracks applicable laws and regulations in the jurisdictions where the *organization* conducts business; (Mandatory)
- (b) Ensures the *organization's* compliance with applicable laws and regulations; **and** (Mandatory)
- (c) Responds promptly to detected problems and takes corrective action as needed. (4)

Inter-Departmental Coordination

CORE - 5 - Inter-Departmental Coordination

The *organization* establishes and implements mechanisms to promote collaboration, coordination and communication across disciplines and departments within the *organization*, with emphasis on integrating administrative activities, quality improvement, and where present, clinical operations. (3)

Oversight of Delegated Functions

CORE - 6 - Delegation Review Criteria

The *organization* establishes and implements criteria and processes for an assessment prior to the *delegation* of functions. (3)

CORE - 7 - Delegation Review

Prior to *delegating* functions to another entity, the *organization*: (No Weight)

- (a) Establishes and implements a process to conduct a review of the potential contractor's written policies and documented procedures and capacity to perform delegated functions; **and** (3)
- (b) Outlines and follows criteria and processes for approving *contractors*. (3)

CORE - 8 - Delegation Contracts

The *organization* enters into *written agreements* with *contractors* that: (No Weight)

- (a) Specify those responsibilities *delegated* to the *contractor* and those retained by the *organization*; (2)
- (b) Require that services be performed in accordance with the *organization's* requirements and URAC standards; (Mandatory)
- (c) Require notification to the *organization* of any material change in the *contractor's* ability to perform *delegated* functions; (4)
- (d) Specify that the *organization* may conduct surveys of the *contractor*, as needed; (2)
- (e) Require that the *contractor* submit periodic reports to the *organization* regarding the performance of its *delegated* responsibilities; (3)
- (f) Specify recourse and/or sanctions if the *contractor* does not make corrections to identified problems within a specified period; (2)
- (g) Specify the circumstances under which activities may be further *delegated* by the *contractor*, including any requirements for obtaining permission from the *organization* before any further *delegation*; **and** (4)
- (h) Specify that, if the *contractor* further *delegates* organizational functions, those functions shall be subject to the terms of the *written agreement* between the *contractor* and the *organization* and in accordance with URAC standards. (Mandatory)

CORE - 9 - Delegation Oversight

The *organization* establishes and implements an oversight mechanism for delegated functions within the scope of accreditation that includes: (No Weight)

- (a) A periodic review (no less than annually) of the *contractor's* written policies and documented procedures and documentation of quality activities for related delegated functions; (2)
- (b) A process to verify (no less than annually) the *contractor's* compliance with contractual requirements and written policies and documented procedures; **and** (Mandatory)

(c) A mechanism to monitor financial incentives to ensure that quality of care or service is not compromised. (3)

Marketing and Sales Communications

CORE - 10 - Review of Marketing and Sales Materials

The *organization* follows marketing and sales practices that include:

(No Weight)

(a) Mechanisms to clearly and accurately communicate information about services inclusive of delegated activities; (3)

(b) A formal process of inter-departmental review of marketing and sales materials before dissemination to safeguard against misrepresentations about the *organization's* services; (3)

(c) Monitoring of existing materials for accuracy; **and** (3)

(d) Responds promptly to detected problems and corrective action as needed. (4)

Business Relationships

CORE - 11 - Written Business Agreements

The *organization* maintains signed *written agreements* with all *clients* describing the scope of the business arrangement. (2)

CORE - 12 - Client Satisfaction

The *organization* implements a mechanism to collect or obtain information about *client* satisfaction with services provided by the *organization*. (3)

Information Management

CORE - 13 - Information Management

The *organization* implements information system(s) (*electronic* and paper) to collect, maintain and analyze information necessary for organizational management that: (No Weight)

- (a) Provides for *data integrity*; (Mandatory)
- (b) Includes a plan for storage, maintenance and destruction; **and** (2)
- (c) Includes a plan for *interoperability*: (No Weight)
 - (i) Between internal information systems; **and** (Leading Indicator)
 - (ii) With external entity information systems. (Leading Indicator)

CORE - 14 - Business Continuity

The *organization* implements a business continuity plan for program operations, including information system(s) (*electronic* and paper) that: (No Weight)

- (a) Identifies which systems and processes must be maintained and the effect an outage would have on the *organization's* program; (3)
- (b) Identifies how business continuity is maintained given various lengths of time information systems are not functioning or accessible; (3)
- (c) Is tested at least every two years; **and** (3)
- (d) Responds promptly to detected problems and takes corrective action as needed. (3)

CORE - 15 - Information Confidentiality and Security

The *organization* provides for data confidentiality and security of its information system(s) (*electronic* and paper) by implementing written policies and/or documented procedures that address: (No Weight)

- (a) Assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of information systems; (3)
- (b) Prevention of confidentiality and security breaches; **and** (Mandatory)

(c) Detection, containment and correction of confidentiality and security violations. (Mandatory)

CORE - 16 - Confidentiality of Individually-Identifiable Health Information

The *organization* implements written policies and/or documented procedures to protect the confidentiality of *individually-identifiable health information* that:

(No Weight)

- (a) Identifies how *individually-identifiable health information* will be used; (Mandatory)
- (b) Specifies that *individually-identifiable health information* is used only for purposes necessary for conducting the business of the organization, including evaluation activities; (Mandatory)
- (c) Addresses who will have access to *individually-identifiable health information* collected by the *organization*; (Mandatory)
- (d) Addresses oral, written or *electronic* communication and records that are transmitted or stored; (Mandatory)
- (e) Address the responsibility of *organization* employees, committee members and board members to preserve the confidentiality of *individually-identifiable health information*; **and** (Mandatory)
- (f) Requires employees, committee members and board members of the *organization* to sign a statement that they understand their responsibility to preserve confidentiality. (Mandatory)

Quality Management

CORE - 17 - Quality Management Program

The *organization* maintains a *quality management program* that promotes objective and systematic measurement, monitoring and evaluation of services and implements quality improvement activities based upon the findings. (Mandatory)

CORE - 18 - Quality Management Program Resources

The *organization* employs *staff* and/or provides the resources necessary to support the day-to-day operations of the *quality management program*. (3)

CORE - 19 - Quality Management Program Requirements

The *organization* has a written description for its *quality management program* that:

(No Weight)

- (a) Is approved by the *organization's* appropriate oversight authority; (2)
- (b) Defines the scope, objectives, activities, and structure of the *quality management program*; (2)
- (c) Is reviewed and updated by the Quality Management Committee at least annually; (2)
- (d) Defines the roles and responsibilities of the Quality Management Committee; **and** (2)
- (e) Designates a member of senior management with the authority and responsibility for the overall operation of the *quality management program* and who serves on the Quality Management Committee. (3)

CORE - 20 - Quality Management Committee

The *organization* has a quality management committee that:

(No Weight)

- (a) Is granted authority for quality management by the *organization's* oversight authority; (3)
- (b) Provides ongoing reporting to the *organization's* oversight authority; (3)
- (c) Meets at least quarterly; (3)
- (d) Maintains approved records of all committee meetings; (2)
- (e) If applicable, includes at least one participating provider or receives input from participating providers; (4)
- (f) Provides guidance to *staff* on quality management priorities and projects; (3)
- (g) Approves the *quality improvement projects* to undertake; (3)
- (h) Monitors progress in meeting quality improvement goals; **and** (3)

- (i) Evaluates the effectiveness of the *quality management program* at least annually. (3)

CORE - 21 - Quality Management Documentation

The *organization*, as part of its *quality management program*, provides written documentation of: (No Weight)

- (a) Objectives and approaches utilized in the quality management activities; (3)
- (b) Identification and tracking and trending of *performance measures* relevant to the scope of the accreditation including, but not limited to: (Mandatory)
 - (i) Access to services; (3)
 - (ii) Complaints; **and** (3)
 - (iii) Satisfaction; (3)
- (c) *Measures* that are quantifiable and used to establish acceptable levels of performance; (Mandatory)
- (d) Measuring baseline level of performance; (Mandatory)
- (e) Re-measuring level of performance at least annually; (Mandatory)
- (f) The implementation of action plans to improve or correct identified problems or meet acceptable levels of performance on measures; (Mandatory)
- (g) The mechanisms to communicate the results of such activities to relevant *staff*; **and** (3)
- (h) The mechanism to communicate the results of such activities to the quality management committee. (3)

CORE - 22 - Quality Improvement Projects

At any given time, the *organization* maintains no less than two *quality improvement projects* that address opportunities for *error* reduction or performance improvement related to the services covered by the accreditation. (Mandatory)

CORE - 23 - Quality Improvement Project Requirements

For each *quality improvement project*, the *organization* will:

(No Weight)

- (a) Establish measurable goals for quality improvement; (3)
- (b) Design and implement strategies to improve performance; (3)
- (c) Establish projected time frames for meeting goals for quality improvement; (3)
- (d) Re-measure level of performance at least annually; (3)
- (e) Document changes or improvements relative to the baseline measurement; **and** (3)
- (f) Conduct an analysis if the performance goals are not met. (3)

CORE - 24 - Quality Improvement Projects: Consumer Organizations

For an *organization* that interacts with *consumers*: (No Weight)

- (a) At least one of the two *quality improvement projects* must address consumer safety for the population served; **and** (Mandatory)
- (b) If the *quality improvement project* is clinical in nature, then the *organization* demonstrates the involvement of a senior clinical *staff* person in judgments about the use of clinical quality *measures* and clinical aspects of performance. (Mandatory)

Staff Qualifications

CORE - 25 - Job Descriptions

The *organization* has written job descriptions for *staff* that address requirements pertinent to the scope of the positions' roles and responsibilities: (No Weight)

- (a) Required education, training, and/or professional experience; (2)
- (b) Expected *professional competencies*; (2)

(c) Appropriate *licensure/certification* requirements; **and** (2)

(d) Current scope of roles and responsibilities. (2)

CORE - 26 - Staff Qualifications

Staff meets qualifications as required in written job descriptions. (3)

Staff Management

CORE - 27 - Staff Training Program

The *organization* has an ongoing training program that includes: (No Weight)

(a) Initial orientation and/or training for all *staff* before assuming assigned roles and responsibilities; (2)

(b) Training in current URAC standards as appropriate to job functions; (2)

(c) Conflict of interest; (4)

(d) Confidentiality; (Mandatory)

(e) Documentation of all training provided for *staff*; **and** (2)

(f) Ongoing training, at a minimum annually, to maintain *professional competency*. (2)

CORE - 28 - Staff Operational Tools and Support

The *organization* provides *staff* with: (No Weight)

(a) Written policies and/or documented procedures appropriate to their jobs; (2)

(b) *Clinical decision support tools* as appropriate; **and** (2)

(c) Regulatory requirements as related to their job function. (2)

CORE - 29 - Staff Assessment Program

The *organization* maintains a formal assessment program for individual *staff* members, which includes: (No Weight)

- (a) An annual performance appraisal; **and** (2)
- (b) A review of relevant documentation produced by that individual staff member. (3)

Clinical Staff Credentialing and Oversight Role

CORE - 30 - Clinical Staff Credentialing

The *organization* implements a written policy and/or documented procedure to: (No Weight)

- (a) *Primary source* verify the current *licensure* or *certification* of *staff* whose job description requires *licensure* or *certification* upon hire, and thereafter no less than every three (3) years; (Mandatory)
- (b) Require *staff* to notify the *organization* in a timely manner of an adverse change in *licensure* or *certification* status; (Mandatory)
- (c) Implement corrective action in response to adverse changes in *licensure* or *certification* status; **and** (Mandatory)
- (d) *Primary source* verify current *licensure* and *certification* upon hire, and thereafter no later than scheduled expiration. (Leading Indicator)

CORE - 31 - Senior Clinical Staff Requirements

The *organization* designates at least one senior clinical *staff* person who has: (No Weight)

- (a) Current, unrestricted clinical *license(s)* (or if the *license* is restricted, the *organization* has a process to ensure job functions do not violate the restrictions imposed by the state licensure board); (Mandatory)
- (b) Qualifications to perform clinical oversight for the services provided; (Mandatory)
- (c) Post-graduate experience in direct patient care; **and** (Mandatory)

(d) *Board certification* (if the senior clinical *staff* person is an M.D. or D.O.). (3)

CORE - 32 - Senior Clinical Staff Responsibilities

A senior clinical *staff* person's program responsibilities include: (No Weight)

- (a) Provides guidance for clinical operational aspects of the program; (3)
- (b) Is responsible for oversight of clinical decision-making aspects of the program; (Mandatory)
- (c) Has periodic consultation with practitioners in the field; **and** (3)
- (d) Ensures the organizational objective to have qualified clinicians accountable to the *organization* for decisions affecting *consumers*. (Mandatory)

CORE - 33 - Financial Incentive Policy

If the *organization* has a system for reimbursement, bonuses or incentives to *staff* or health care providers based directly on *consumer* utilization of health care services, then the *organization* implements mechanisms addressing how the *organization* will ensure that *consumer* health care is not compromised. (Mandatory)

CORE - 34 - Access to Services

The *organization* implements written policies and/or documented procedures to ensure *access* to services covered by the accreditation. (Mandatory)

CORE - 35 - Consumer Complaint Process

The *organization* maintains a formal process to address *consumer complaints* that includes: (No Weight)

- (a) A process to receive and respond in a timely manner to *complaints*; (Mandatory)
- (b) Notice (written or verbal) of final result with an explanation; (4)
- (c) Informs *consumers* of the avenues to seek further review if an additional *complaint* review process is available; (4)
- (d) Evidence of meeting the *organization's* specified time frame for resolution and response; **and** (4)

(e) Reporting analysis of the *complaints* to the quality management committee. (3)

Health Care System Coordination

CORE - 36 - Coordination with External Entities

The *organization* establishes and implements mechanisms to promote collaboration and communication with applicable external entities to coordinate health services for consumers. (1)

Consumer Protection and Empowerment

CORE - 37 - Consumer Rights and Responsibilities

The *organization* implements a mechanism for informing *consumers* of their rights and responsibilities. (4)

CORE - 38 - Consumer Safety Mechanism

The *organization* has a mechanism to respond on an urgent basis to situations that pose an immediate threat to the health and safety of *consumers*. (Mandatory)

CORE - 39 - Consumer Satisfaction

The *organization* implements a mechanism to collect or obtain information about *consumer* satisfaction with services provided by the *organization*. (3)

CORE - 40 - Health Literacy

The *organization* will implement written policies and/or documented procedures addressing *health literacy* that: (No Weight)

- (a) Require *consumer* materials to be in *plain language*; (Leading Indicator)
- (b) Assess the use of *plain language* in *consumer* documents; **and** (Leading Indicator)
- (c) Provide relevant information and guidance to *staff* that interfaces directly with, or writes content for, *consumers*. (Leading Indicator)



Independent Review Organization, Version 4.0

Organizational Structure

IR - 1 - Initial Case Review

Upon receipt of a *case* from a *referring entity*, the *organization* conducts a review of the *case* to determine: (No Weight)

- (a) If any organizational *conflict of interest* exists; (Mandatory)
- (b) Whether the *case* relates to medical necessity and medical appropriateness; experimental or investigational treatment; administrative issue or a combination of both; (3)
- (c) The specific question or issue to be resolved by the *independent review* process; **and** (3)
- (d) Whether the *case* merits standard review or expedited review. (3)

IR - 2 - Conflict of Interest Process

If an organizational *conflict of interest* does exist (see IR 1(a)), the *organization* returns the *case* to the *referring entity*, unless, after full disclosure of the *conflict of interest*, the *organization* obtains written consent to conduct the *independent review* from the *consumer*, *health benefits plan*, and the *referring entity*. (Mandatory)

IR - 3 - Reviewer Conflict of Interest Assessment

For each *case*, the *organization* verifies that the *reviewer(s)* does not: (No Weight)

- (a) Have a material professional, familial, or financial *conflict of interest* regarding any of the following: (No Weight)
 - (i) The *referring entity*; (4)
 - (ii) The *health benefits plan*; (4)
 - (iii) The *consumer*; (4)
 - (iv) The *attending provider* or any other health care provider previously involved in the *case*; (4)

- (v) The facility at which the recommended treatment would be provided; **or** (4)
- (vi) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the *consumer*; (4)
- (b) Accept compensation for *independent review* activities that is dependent in any way on the specific outcome of the *case*; **or** (4)
- (c) Have involvement with the *case* prior to its referral to *independent review*. (4)

IR - 4 - Reviewer Credentialing

The *organization* establishes and implements selection criteria for *reviewers*, and implements a program to verify current unrestricted credentials (prior to assignment of any reviews), and re-verify at least every three years, the qualifications of all *reviewers*. At a minimum, such a program shall address: (4)

- (a) Verification of professional credentials, including: (Mandatory)
 - (i) Current *licensure*; (Mandatory)
 - (ii) Current *board certification*, if applicable; (Mandatory)
 - (iii) History of sanctions and/or disciplinary actions; **and** (Mandatory)
 - (iv) Professional experience; (Mandatory)
- (b) Potential *conflicts of interest*; (Mandatory)

IR - 5 - File Documentation

For each *case*, the *organization*: (No Weight)

- (a) Maintains a file that includes: (No Weight)
 - (i) The name, credentials, and specialty of the *reviewer(s)*; (2)
 - (ii) Medical evidence and information considered during the review; (2)
 - (iii) References to any applicable medical literature/research data or national clinical criteria upon which the *organization's* determination was

based; (2)

(iv) Documentation of all correspondence and communication between the *organization*, the *reviewer(s)*, and any other party regarding the *case*, including a copy of the final determination letter; **and** (3)

(v) The *organization's* determination regarding the issues listed in Standard IR 1; (2)

(b) Maintains a file that includes, if received: (No Weight)

(i) All documentation related to the *case* provided by the *referring entity*; (2)

(ii) Copies of all relevant documents from the *health benefits plan*; (2)

(iii) Any applicable state-mandated review criteria or standards; (3)

(iv) A copy of prior determination letters if available; **and** (2)

(v) For expedited reviews, after hours contact information for the *referring entity*. (2)

IR - 6 - IRO Log

The *organization* maintains a log of all *independent review case* files and is able to report, at a minimum, the following information for each *case*: (No Weight)

(a) The date the *organization* received the request to conduct an independent review from the referring entity; (2)

(b) The date upon which the *organization* received the initial information packet from the referring entity; (2)

(c) The date by which the *organization* must receive additional information from the referring entity, *consumer*, or *attending provider*. (2)

(d) A description of the issue to be resolved; (2)

(e) The name of the *referring entity*; (2)

- (f) Whether the case was expedited or not; (2)
- (g) The *organization's* determination regarding the *case*; (2)
- (h) The date the *organization's* determination was issued; **and** (2)
- (i) The date the *organization's* determination was sent to the appropriate parties (see IR 15). (2)

IR - 7 - Telephone Access

The *organization* provides free telephone access for, at a minimum, *consumers* and *attending providers* that: (No Weight)

- (a) Operates at a minimum from 9:00 a.m. until 4:00 p.m. of each business day in each time zone where the services under review were performed; (2)
- (b) Includes written procedures for: (No Weight)
 - (i) Receiving all after-hours requests; **and** (2)
 - (ii) Acting on expedited *cases*. (3)

Independent Review Process

IR - 8 - Reviewer Qualifications

The *organization* establishes and implements criteria for the number and qualification of *reviewers*. At a minimum, such criteria will specify that, for each *case*, there is a *reviewer* who: (3)

- (a) Has active licensure; (Mandatory)
- (b) If an M.D. or D.O., has board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association; (4)
- (c) If a D.P.M., has board certification by the American Board of Podiatric Surgery; (4)
- (d) Is a *clinical peer* of the *attending provider*; (Mandatory)
- (e) Has a scope of *licensure* and professional experience that encompasses the health service, treatment or issue under review; (Mandatory)

(f) Has at least five years experience providing clinical health care; **and** (3)

(g) Has the ability to evaluate alternatives to the proposed treatment. (3)

IR - 9 - Reviewer Case Selection

For each case, the *organization*: (No Weight)

(a) Selects the *reviewer(s)* (with qualifications noted in IR 8), with responsibility for considering the case and rendering a determination; **and** (Mandatory)

(b) Provides to each *reviewer* a file that includes all information necessary to consider the *case*. (2)

IR - 10 - Medical Necessity/Appropriateness Case Processing

When processing a *case* regarding medical necessity and appropriateness, the *organization* and its *reviewer(s)* consider information pertinent to the *case* that will include the following when provided to the *organization*, unless otherwise prohibited by state or federal regulation: (No Weight)

(a) The *consumer's* medical records; (Mandatory)

(b) The *attending provider's* recommendation; (Mandatory)

(c) The terms of coverage under the *consumer's health benefits plan*; (3)

(d) Information accumulated regarding the case prior to its referral to *independent review*, including rationale for prior review determinations; (3)

(e) Information submitted to the *organization* by the *referring entity, consumer, or attending provider*; (Mandatory)

(f) Clinical review criteria and/or medical policy developed and used by the *health benefits plan*; **and** (3)

(g) As appropriate, clinical practice guidelines and criteria that are evidence-based or practice guidelines or criteria from the state or federal government or nationally recognized entities or societies that have been developed by a peer review or consensus process. (3)

IR - 11 - Experimental/Investigational Case Processing

When processing a *case* regarding the experimental or investigational nature of a proposed treatment, the *organization* and its *reviewer(s)* consider: (No Weight)

- (a) All the information listed in standards IR 10(a) through IR 10(g); **and** (4)
- (b) Existing medical research and peer-reviewed literature regarding the proposed treatment with respect to effectiveness and efficacy. (3)

IR - 12 - Administrative/Legal Case Processing

When processing a *case* regarding administrative or legal issues, the *organization* and its *reviewer(s)* consider all information necessary to render a decision, such as the applicable *health benefits plan* contract; other relevant *health benefits plan* materials and documents; and applicable state and federal law. (4)

IR - 13 - Additional Information Processing

The *organization* implements mechanisms to request and accept any additional information that may assist in rendering a determination. If additional information is provided by the *consumer* or *attending provider*, the *organization* provides a copy to the *health benefits plan* to provide the *health benefits plan* the opportunity to reverse the decision that is the subject of the *independent review*. Once the *health benefits plan* issues a reversal in writing, the *independent review* process is terminated. (4)

IR - 14 - Multiple Reviewer Cases

In *cases* where more than one *reviewer* is used, the *organization*: (No Weight)

- (a) If requested by a *reviewer*, provides an opportunity for the *reviewers* to discuss the *case* with one another; **and** (3)
- (b) Accepts the decision of the majority of *reviewers*. (3)

IR - 15 - Decision Notice

Within two business days of rendering a determination, the *organization* sends to the *referring entity* a notice of the determination that includes: (No Weight)

- (a) The question/issue referred to *independent review*; (4)

(b) A description of the qualifications of the *reviewer(s)*; **and** (4)

(c) A clinical rationale or explanation for the determination, including references to supporting evidence. (Mandatory)

IR - 16 - Decision Time Frames

The *organization* adheres to the following time frames for completing standard reviews: (No Weight)

(a) Within a median duration of 5 business days for *cases* where the timeline is not regulated by state or federal regulation; (4)

(b) In no case longer than 20 business days unless otherwise defined by state or federal regulation; **and** (4)

(c) The time frame starts upon receipt of all of the information that has been forwarded to the *organization*, including any additional information that may be submitted by the covered person and/or the referring entity. (3)

IR - 17 - Expedited Review Process

The *organization* provides for an expedited review process that: (No Weight)

(a) Is available in *cases* for which the time frame for completion of a standard *independent review* would seriously jeopardize: (No Weight)

(i) The life or health of the *consumer*; **or** (Mandatory)

(ii) The *consumer's* ability to regain maximum function; **and** (Mandatory)

(b) Adheres to the following time frames for completion and notification unless otherwise defined by state or federal regulation: (No Weight)

(i) As quickly as possible given the circumstances and the *consumer's* health condition; **and** (Mandatory)

(ii) In no case longer than 72 hours from receipt of the initial information packet from the referring entity (except that the *organization* may extend the time frame for an additional 24 hours if such an extension is necessary to collect additional information); **and** (Mandatory)

(c) Upon completion, immediately provides notice of the determination to the *referring entity*. (4)