Independent Review Organization: Comprehensive Review (Internal & External Review) Standards, Version 5.0

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Message from URAC

<u>NOTE:</u> This document was composed in American-standard English. Readers accustomed to British-standard English spelling and terminology should be mindful of the differences.

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 24th year of operation, URAC offers over 25 different accreditation and certification programs and has issued more than 10,000 accreditation certificates to companies operating in all 50 states and internationally. URAC is also recognized as part of the regulatory process in five federal agencies, 47 states, and the District of Columbia.

URAC, as a nonprofit, independent accreditation agency, provides a nationally- and internationally-recognized accreditation process and seal of approval. URAC's success is tied in large part to the broad-based, consensus-driven approach by which hundreds of volunteers assist with drafting and updating URAC's standards, measures and surveys. 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 streamlines 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 https://accreditnet.urac.org/Resources for a copy of the AccreditNet Application 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 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.

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.

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
    - All mandatory elements must be met at 100% compliance in order to achieve a Full accreditation
    - 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
    - Potential forecast of where the health care industry may be heading
    - Provides a way for an organization to distinguish itself from other accredited companies
    - **Leading indicators are not reported to URAC's Accreditation or Executive Committees and do not influence an applicant's final accreditation score or category**
    - Cannot be designated "not applicable" given that they are optional
    - 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)
    - Other types of marketing exposure may be considered in the future (e.g., Website, conferences, etc.)

Scoring Methodology

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
  - Element weight x Compliance
- Scoring a Standard
  - Total points achieved ÷ Total points possible
- Scoring a Module
  - Total points achieved ÷ Total number of standards
- Scoring a multi-Module accreditation
  - (Core score x .30) + (Module score x .70)
- Scoring a multi-Site accreditation
  - 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 ≥ 80%;
- **Note**: A mandatory element must be met at 100% compliance with an audit score of ≥ 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."

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- **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 ≥ 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:
        - Staff is observed conducting the procedure correctly; or
        - Staff verbalizes the procedure correctly; or
        - Documented examples of implementation are surveyed; or
        - Documentation of oversight is reviewed; or
        - 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:
        - Errors implementing work processes during onsite observation by the URAC Reviewer.
        - Mistakes during interviews. If staff catches the error – misspoke – and corrects it, then this will not count as evidence of non-compliance.
        - 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.)
        - 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

Scoring Methodology

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:
  - 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.
  - 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) × (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.
  - 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) ÷ (Total possible points for the standard)] × 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.
    - Standards determined to be not applicable are not included in the denominator and as such do not count against the applicant.

Scoring Methodology

- Calculation for Core and non-Core Module Score
  - [(Sum of all applicable standard scores) ÷ (Total number of applicable standards)] = Module Score = 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

  - (Core score × .30) + (non-Core score × .70) = Final Total Score for One or Multiple Sites (round to nearest tenth)

- Final Total Score if all Sites achieve a Full (≥ 94)
  - (Sum of all Full onsite scores) ÷ (Number of sites that had an onsite
  - review) = 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.”)

Glossary for Health Accreditation Standards

Reviewing these definitions and becoming familiar with them is critically important to an accurate understanding of URAC's health accreditation standards. Readers are encouraged to refer to the glossary section each time they encounter an unfamiliar *italicized* term, which will help to clarify the intent of the standards.

Note: Defined terms appear in *italics* throughout the standards.

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:** 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.

Accessible/Accessibility: Easy to obtain for the *consumer*; in the context of written materials, capable of being read with comprehension (e.g. educational materials are developed so that the target population will have the ability to understand the materials provided by the organization, such as through the process of generating and distributing multi-lingual or reading-level appropriate editions.

- **Interpretive Note:** See definition of "access". 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.

Adverse benefit determination: A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in a health benefit plan or insurance coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

Adverse benefit determination includes a rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. The regulations restricting rescissions generally define a rescission as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

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

Glossary for Health Accreditation Standards

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.

Annually (or "yearly"): Occurs every 12 months to the month (not the day of the month). In other words, it is a month/year to month/year requirement.

Appeal: A written or verbal request by a prescriber, ordering provider, or consumer to contest an organizational determination, such as, services have been denied, reduced, etc.

- **Interpretive Note:** Specific terms used to describe appeals vary, and are often determined by law or regulation. URAC's drug management standards apply to first-level appeal.

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."

Appropriate utilization: appropriate care at the appropriate setting

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.

Automated review: A computerized process whereby a validated algorithm is used for drug management.

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**: 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.

Behavioral Health/Behavioral Health Care: An umbrella term that includes mental health and substance abuse. Services are provided by those who are licensed by the state and whose professional activities address a client's behavioral issues. Licensed mental health practitioners include psychologists, psychiatrists, social workers, psychiatric nurse practitioners, marriage and family counselors, professional clinical counselors, licensed drug/alcohol abuse counselors and mental health professionals. (Behavioral Healthcare: The Practical Resource for the Field's Leaders - www.behavioral.net/ME2/Default.asp).

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.

Glossary for Health Accreditation Standards

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:** 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- of 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.

Care Coordination: Care Coordination is the deliberate organization of patient care activities among two or more participants (including the patient and/or the family) to facilitate the appropriate delivery of health care services. Organizing care involves marshaling personnel and other resources to carry out all required patient care activities, which is often managed by the exchange of information among participants responsible for different aspects of the care.
Caregiver: A caregiver includes family member(s), personal caregiver, significant other, or friend who cares for the *consumer*.

Source: http://www.ntocc.org

Care Transitions/Transitions of Care: refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. For example, in the course of an acute exacerbation of an illness, a patient might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she would receive care from a visiting nurse. Each of these shifts from care providers and settings is defined as a care transition."

Source: http://www.ntocc.org

Glossary for Health Accreditation Standards

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:** 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.

Case Management Plan of Care (also known "case management plan"): A comprehensive plan that includes a statement of problems/needs determined upon assessment; strategies to address the problems/needs; and measurable goals to demonstrate resolution based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client.

Source: Case Management Society of America (CMSA.org)

Case Management Process: The manner in which case management functions are performed, including: assessment, problem identification, outcome identification, planning, monitoring, and evaluating.

Source: Case Management Society of America (CMSA.org)

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**: "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.

Glossary for Health Accreditation Standards

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**: Throughout this document the term "organization" refers to claims processing organization.

CLAS standards (National Standards for Culturally and Linguistically Appropriate Services in Health Care): The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

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 application (also known as a "clean credentialing file"): A credentialing application or file is considered "clean" if it meets the criteria listed below; however, the medical or clinical director for credentialing must always have the authority to forward a credentialing file to the credentialing committee at his or her discretion.

- 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 support documentation has been submitted and is included with the credentialing application in the provider's file.
- The provider meets the credentialing criteria as stated in the credentialing plan, which is approved by the credentialing committee.
    - Credentials verification reveals that the provider meets credentialing criteria and there are no issues to report to the credentialing committee as defined in the organization's 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 sells health coverage to an employer, the employer is the client.
- If a health plan sells health coverage directly to consumers, the consumer 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.

Glossary for Health Accreditation Standards

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.

Clinically Integrated Network (CIN): An active and ongoing program to evaluate and modify practice patterns by the clinically integrated providers and create a high degree of interdependence and cooperation among the clinically integrated providers to control costs and ensure quality.

URAC Clinically Integrated Networks Advisory Committee, 2012

Clinically Integrated Provider: An independent provider that has entered into an agreement with the organization to be part of a clinically integrated network among otherwise independent and competing providers. May include physicians and other health care team members and facilities providing direct care services.

URAC Clinically Integrated Networks Advisory Committee, 2012

Clinical Oversight Body: A body comprised of discipline specific experts such as physicians, pharmacists, *providers*, and content experts who may include non-physician *providers* such as certified health educators, respiratory therapists, nutritionists, nurses, mental *health professionals* or other specialists.

- **Interpretive note for CIN**: A clinical oversight body within a CIN is physician led and comprised of clinically integrated providers. The charter of this body defined by the CIN centers on providing clinical oversight and guidance to CIN programs impacting patient care delivery.

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/Protocols: Systematically developed, documented protocols used to assist decision-making about appropriate health care for specific clinical circumstances. Clinical practice guidelines are based on a standard assessment of the body of scientific evidence, whenever such evidence exists. If guidelines are not evidence-based, then the process for coming to a consensus needs to address the absence or paucity of high quality, scientific evidence and the systematic way in which a consensus was reached in order to establish the guidelines.

- **Interpretive note for CIN:** The identification of benchmarks protocols – to which clinically integrated providers aspire and against which their performance is measured - requires active involvement of physicians.

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.

Glossary for Health Accreditation Standards

Clinical Social Work: Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.

Source: NASW, 1986. www.socialworkers.org

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**: 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**: 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.

Glossary for Health Accreditation Standards

***Consumer* activation (also known as "*patient* activation")**: An individual's motivation to engage in adaptive health behavior that may, in turn, lead to improved health outcomes.

The motivation to take actions representing adaptive health behaviors emerges from the influence of psychological factors and personal competencies, which include an individual's understanding of his/her role in managing his/her own health care, as well as the knowledge, skill, preferences and confidence for managing his/her own health/health care.

Source: Based on a definition from Hibbard JH, Stockard J, Mahoney ER, et al. Development of the patient activation measure (PAM): conceptualizing and measuring activation in patients and consumers. Health Serv Res 2004; 39:1005-26.

Consumer-Centered (also known as patient-centered care): Providing care that is respectful of and responsive to individual patient or consumer preferences, needs, and values, and ensuring that patient or consumer values guide all clinical decisions.

Source: (Adapted from IOM 2001, Crossing the Quality Chasm)

"Consumer or patient and family-centered care" means planning, delivering, and evaluating health care through consumer or patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices. It also incorporates the participant's knowledge, values, beliefs and cultural background into care planning and delivery. Consumer or patient and family-centered care applies to consumers or patients of all ages. (Adapted from MN HCH Rule)

***Consumer* engagement (also known as "*patient* engagement")**: Actions individuals must take to obtain the greatest benefit from the health care services available to them. These actions fall within the category of adaptive health behaviors.

Consumer or patient engagement is a collaborative process in which enrolled individuals are working or have worked directly with licensed or certified clinical staff in a chronic disease management or health improvement/wellness program. Individuals are interacting with health professionals in reference to their health improvement plan with "bidirectional interaction" meaning an exchange between health professionals and the enrolled individual in both directions, regardless of modality for communication (e.g., telephone, e-mail, texting, online tools, and virtual coaching tools, etc.) Adaptive health behaviors include the use of patient education and virtual behavior change tools provided by health professionals and incorporated into the health improvement plan.

Source: Based on definitions from the Center for Advancing Health. Center for Advancing Health (2010). A new definition of patient engagement: What is engagement and why is it important? Center for Advancing Health, Washington D.C. www.chah.org.

Consumer Experience (also known as "experience of care"): Good *consumer* experience of care is an outcome unto itself; research demonstrates that *consumer*s prioritize communication and other aspects of the provider-*consumer* relationship as key elements of quality. Good *consumer* experience has a well-documented relationship to clinical quality, *consumer* engagement, adherence, and outcomes.

Source: RWJ Foundation 2012

- **Interpretive Note**: The CAHPS Clinician and Group Survey provides a nationally standardized, validated tool to measure consumers' experiences in primary care practices. This survey asks consumers to assess their experiences in areas that research has shown consumers value, including ease of scheduling appointments, availability of information, communication with clinicians, responsiveness of clinic staff, and coordination between care providers.

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

- **Interpretive Note**: 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."

Glossary for Health Accreditation Standards

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 Person: Means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. For Workers' Compensation, this would include the injured worker.

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.

Cultural Competence: Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.

Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

Culture: "The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture" (Katz, Michael. Personal communication, November 1998).

Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

Culturally and Linguistically Appropriate Services: Health care services that are respectful of and responsive to cultural and linguistic needs.

Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

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Cultural and Linguistic Competence: "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities" (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center).

Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

Cultural Sensitivity: The ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic or cultural heritage

Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

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

Data Liquidity: data that is no longer confined to databases or data silos in health systems so that it flows to where it is needed and when it is needed.

Adapted from: Paul K. Courtney, M.S
Cancer J. 2011 ; 17(4): 219–221
doi:10.1097/PPO.0b013e3182270c83

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

Decision support tools: A paper or electronic aid, or both, to help people make informed decisions by providing and managing information and presenting the trade-offs involved in various possible choices by arraying comparative information. The various types of aids used in health care include protocols, guidelines, or algorithms that assist in the clinical decision-making process.

Source: Carlisle, E. et al. "Empirical Studies of Decision Aids for Consumers," Santa Monica: The RAND Corporation, 2003. As cited in: Shaller Consulting, "Consumers in HealthCare: Creating Decision-Support Tools That Work" California HealthCare Foundation, June 2006. Also see http://www.chcf.org/publications/2006/06/consumers-in-health-care-creating-decisionsupport-tools-that-work

Delegation (includes delegate/delegated): 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 affect an appropriate and timely discharge or transfer from current services or level of care.

Discrimination: The unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex.

Glossary for Health Accreditation Standards

Disease Management: 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.

Downstream Risk: Acceptance of financial insurance risk and accountability for health services utilization and quality of care outcomes by a provider service organization from a health plan or employer / plan sponsor for the provision or arrangement of health care services.

Adapted from: US Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation,
June , 1997
aspe.hhs.gov/health/pso-6.htm

Drug Management: Evaluation of patients’ drug profiles related to covered benefits, clinical appropriateness and safety for patients’ use of medications.

Drug Utilization Management & Drug Utilization Review: Evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, products, and facilities under the provisions of the applicable health benefits plan; sometimes called “drug review.”

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 (EHR): 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 (EMR): 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.

Eligible population (same as) eligible consumers - Eligible population (also “eligible consumers”): The pool of consumers who are entitled or qualified to receive program services and interventions.

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.

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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."

Exploratory Performance Measures: A measure designated as “Exploratory” means that URAC will include measures with specifications that are considered “experimental” within the industry. These measures are “on the cutting edge” of the performance measurement know-how and need further refinement and evaluation before becoming a requirement of a program.

External review: A review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State or Federal external review process.

Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

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.

Final external review decision: A final external review decision means a determination by an independent review organization at the conclusion of an external review.

Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

Final internal adverse benefit determination: An adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal review (appeals) process or upon exhaustion of the internal appeals process.

Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

Governing Body: a group of people appointed or elected to supervise and regulate a field of activity or institution.

Source: Adapted from the Encarta English Dictionary

Group health plan: An entity providing health insurance coverage, including insured and self-insured group health plans.

Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

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Health benefit plan: A policy, contract, certificate or agreement offered or issued by a health issuer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Source: 2008 NAIC Health Carrier Uniform External Review Model Act

Health content: Health information that is intended to provide general, user non-specific information or advice about maintaining health or the treatment of an acute or chronic illness, health condition, or disease state.

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 Information Technology: The technology to create, transmit, store and manage individuals' health data.

URAC Clinically Integrated Networks Advisory Committee, 2012

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.

Health Risk Assessment Process: A process of collecting and interpreting health data and risk factors, gathered from the *health risk assessment tool* and other sources about the *target population*, to evaluate potential *participants* for inclusion in the *wellness program*.

- **Note:** The term "health risk assessment" and its corresponding acronym "HRA" are not the only terms that define an acceptable assessment process.

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Health Risk Assessment Tool (HRAT): A health risk assessment tool is a systematic approach to collecting information from individuals that identifies risk factors, which can be determined through biometric and other methods, and provides individualized feedback, such as through a health risk score, to increase overall awareness of risk. Definition adopted from the Centers for Medicare and Medicaid Services – CMS).

Healthy Behavior A specific action, taken at the individual level, associated with improved health outcomes and the reduction of *risk factors*. Healthy behavior may include:

- Seeking appropriate health care or tests (e.g., getting a cholesterol screening)
- • Avoiding risky behavior (e.g., quitting smoking)
- • Engaging in lifestyle changes (e.g., getting more exercise)

Glossary for Health Accreditation Standards

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

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).

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: See definition for "Reviewer."

Information System: Any written, electronic, or graphical method of communicating information. The basis of an information system is the sharing and processing of information and ideas. Computers and telecommunication technologies have become essential information system components.

Barron's Business Dictionary

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."

Initial Screening (formerly "pre-review screening" and "scripted clinical 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; (6) issuing non-certifications; and (7) verification of insurance coverage or eligibility.

Inreach: use of *consumer* interactions inside the primary care / medical home setting to discover gaps in care and identify opportunities for and act on *consumer* targeted interventions promoting preventive care

Adapted from Yabroff KR, et al. J Am Med Womens Assoc. 2001 Fall;56(4):166-73, 188.

Internal review: Review, including appeal review, by an insurance issuer or group health plan or their designee (i.e., such as a TPA) of an adverse benefit determination.

Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

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

Glossary for Health Accreditation Standards

Key work processes: An organization's most important internal value creation processes that produce customer/ student/ stakeholder/ market value.
Source: Baldrige Glossary for Business, Government (Public Sector) and other Nonprofit (2009).

Knowledge Domains: Areas of specific expertise.

Licensure/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**: In this definition, the word "equivalent" includes certifications, registrations, permits, etc. Specific terms will vary by state and health profession.

Mandatory Performance Measures: A measure classified as "Mandatory" means that URAC will designate a set of unique measures with their specifications that have undergone URAC's evaluation and vetting process and that have been approved by the URAC Board of Directors. These measures must be reported to URAC on an annual basis or more frequent as specified by URAC to maintain accreditation status.

Measure: A valid and reliable indicator that can be used to monitor and evaluate the quality of important governance, management, clinical and support functions that affect patient outcomes (The Joint Commission, 2008, p. 129). Includes patient perspective of care, clinical quality and patient outcomes.

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.

Medical or Scientific Evidence: means evidence found in the following sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;
- The following standard reference compendia:
    - The American Hospital Formulary Service–Drug Information;
    - Drug Facts and Comparisons;
    - The American Dental Association Accepted Dental Therapeutics; and
    - The United States Pharmacopoeia–Drug Information;
- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
    - The federal Agency for Healthcare Research and Quality;
    - The National Institutes of Health;
    - The National Cancer Institute;
    - The National Academy of Sciences;
    - The Centers for Medicare & Medicaid Services;
    - The federal Food and Drug Administration; and
    - Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

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- Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (1) through (5).

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**: This definition comes from the Institute for Healthcare Improvement (IHI), Reconcile Medication at All Transition Points, available through the following Web site: http://www.ihi.org.

Messenger Contracting Model: The "classic" messenger model is a contracting arrangement wherein the payer communicates about fee schedules through a messenger while each provider individually accepts or rejects the terms wherein networks do not enter into agreements among competitors on prices or price-related terms.

Adapted from
1996 "Statements of Antitrust Enforcement Policy in Health Care"
issued jointly by the DOJ and FTC

Multiple chronic conditions: Chronic illnesses are "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living." More than one in four Americans has multiple (two or more) concurrent chronic conditions.

- **Note**: In 2001, the IOM noted that there was evidence that patients receiving care for one chronic condition may not receive care for other, unrelated conditions. The IOM articulated that a challenge of designing care around specific conditions is to avoid defining patients solely by their disease or condition. 66% of total healthcare spending is directed toward care for the approximate 27% of Americans with Multiple Chronic Conditions.

  Source: U.S. Department of Health and Human Services. Multiple Chronic Conditions – A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions. Washington, DC. December 2010.

Multi-provider Joint Ventures: a multi-provider network joint venture is a provider-controlled venture in which the network's participating providers collectively agree on prices or price-related terms and jointly market their services.

Adapted from
1996 "Statements of Antitrust Enforcement Policy in Health Care"
issued jointly by the DOJ and FTC

Negotiated Contract Model: a strategy in which individual providers delegate to a multi-provider joint venture the authority to contract prices and/or price-related terms with payers and employer purchasers on their behalf. The provider's direct contract is between the provider and the multi-provider organization.

Adapted from
1996 "Statements of Antitrust Enforcement Policy in Health Care"
issued jointly by the DOJ and FTC

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 benefit plan.

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.

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Normalize: Map data elements to a standard hierarchy for accurate analytics.
URAC Clinically Integrated Networks Advisory Committee 2012

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

- **Note**: 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**: 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**: 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(s): 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.

Palliative care: Palliative care is a specialized area of health care that focuses on relieving and preventing the suffering of patients, but that does not serve to halt or cure a disease. Unlike hospice care, palliative medicine is appropriate for patients in all disease stages, including those undergoing treatment for curable illnesses and those living with chronic diseases, as well as patients who are nearing the end of life. Palliative medicine utilizes a multidisciplinary approach to patient care, relying on input from physicians, pharmacists, nurses, chaplains, social workers, psychologists, and other allied health professionals in formulating a plan of care to relieve suffering in all areas of a patient's life. This multidisciplinary approach allows the palliative care team to address physical, emotional, spiritual, and social concerns that arise with advanced illness.
Source: Based on a definition from the World Health Organization (March 2006) and the Center to Advance Palliative Care [http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc].

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.

Glossary for Health Accreditation Standards

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

- **Interpretive Note**: 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.
- **Interpretive Note for CIN**: Use of the term "patient" implies an established relationship between consumer and provider.

Patient Centered: In a patient-centered model, patients become active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to advice and counsel from health professionals.

Source: http://www.ahrq.gov
Research In Action, Issue 5

Patient-centered care (see "consumer-centered")

- **Note**: "consumer" and "patient" are defined terms.

Patient engagement (see "consumer engagement")

- **Note**: "consumer" and "patient" are defined terms.

Patient experience: (see" consumer- experience")

- **Note:** "consumer" and "patient" are defined terms.

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.

Performance Measures: Please reference the definition for the term "measures" included in this glossary.

- **Note definition of Performance Measurement**: processes using performance measures for program, provider or practice evaluation purposes**.**

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.

Pharmacist: A licensed health professional who practices the art and science of pharmacy.

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.

Point of Care: the location at which patient services are delivered.

URAC Clinically Integrated Networks Advisory Committee, 2012

Population: Depending on the model of the program, the population for which an organization is responsible may be all of the consumers assigned by virtue of a contract, or the population may be only those consumers who enroll.

- **Interpretive Note for CIN**: If the CIN advances to the stage where it assumes business or medical risk, or becomes an accountable care organization the population may be those consumers who are assigned or enroll.

Glossary for Health Accreditation Standards

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.

Predictive risk modeling; Predictive risk modeling is a useful technique with practical application for organizations to anticipate who may need more intense intervention (i.e., stratifying interventions) with the consequence of potentially avoiding preventable utilization while facilitating cost containment.

- **Note**: Approximately two-thirds of healthcare costs are accounted for by 10% of the patients. Identifying such high-cost patients early can help improve their health and reduce costs. Risk modeling foundations include such data as: Adjusted Clinical Groups (ACG), Diagnostic Cost Groups (DCG), Global Risk-Adjustment Model (GRAM), RxRisk, and Prior Expense.

  To predict whether a patient is high-risk or not, these models use healthcare utilization information and disease-related features or morbidity indicators based on diagnoses codes and other administrative claims-based data. Demographic variables like age and sex are known to impact healthcare costs. Disease-related predictors from various utilization classes such as inpatient, outpatient and pharmacy have also been used to predict cost outcomes. Other risk modeling foundations include comorbidity indices, number of prescriptions and number of claims.

  Source: Excerpt from reference Moturu, S.T., Johnson, W.G. and Liu, H. (2010) 'Predictive risk modeling for forecasting high-cost patients: a real-world application using Medicaid data', Int. J. Biomedical Engineering and Technology, Vol. 3, Nos. 1/2, pp.114-132.

Prescriber: A licensed health professional who writes prescriptions for consumers within their scope of practice.

Primary Physician (also known as "(PCP) Primary Care 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," prospective review can include prospective prescription drug utilization review.

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)).

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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 Management (QM)/Quality Improvement (QI)/Performance Improvement (PI) 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.

Referral
The recommendation by a physician, other clinician health care team member, or case manager for a consumer to receive care from a different physician, service or facility for a specific health related issue.
Adapted from Delaware Healthcare Association
Glossary of Health Care Terms and Acronyms
http://www.deha.org/Glossary

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**: 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.

Glossary for Health Accreditation Standards

Reviewer(s): The individual (or individuals) selected by the organization to consider a case.

- Note: Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 through IR 6.
- All reviewer(s) who are health care practitioners must have the following qualifications:
  - Active U.S. licensure;
  - Recent experience or familiarity with current body of knowledge and medical practice;
  - At least five (5) years of 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 one of the following:
  - American Board of Podiatric Surgery (ABPS)
  - American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
  - American Board of Multiple Specialties in Podiatry (ABMSP)
- All reviewer(s) who are health insurance lawyers conducting rescission, benefit interpretation, reimbursement or other administrative/legal review, must have the following qualifications:
  - Active U.S. licensure as a lawyer, which may need to be specific to the state with jurisdiction over review;
  - Recent experience or familiarity with current body of knowledge and health insurance practice;
  - At least five (5) years' experience providing legal services regarding health insurance matters.

Risk factor: Any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury. Some examples of the more important risk factors are underweight, overweight, unsafe sex, high blood pressure, tobacco and alcohol consumption, and unsafe water, sanitation and hygiene. Other risk factors include diet, pregnancy, low birth weight, sedentary lifestyle, family history, and inappropriate drug use.

Source: Based on the World Health Organization (WHO) definition.

Risk-type: An individual's likelihood of developing an acute or chronic health condition. Risk types may be specific (e.g., at risk to develop diabetes) or general (e.g., overweight).

Safe Transitions: Effective and efficient movement of *consumer*s from one health care provider or setting to another without an adverse event. An adverse event during transition is defined as an injury resulting from medical management rather than the underlying disease and an event that can be avoided or mitigated, Transition adverse events include such occurrences as readmission within 30 days, medication error, follow-up failures, and DME related events resulting from poor communication and poor coordination between providers.

Adapted from: http://www.healthcare.gov

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).

Self-Management: Self-management is defined as the tasks that individuals must undertake to live well that include having the confidence to deal with medical management, role management, and emotional management of their chronic and/or complex conditions. Health care staff provides self-management support, defined as the systematic provision of education and supportive interventions to increase consumer's skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.

Source: Based on definitions from the 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities Published in 2004 – Publication of Institute of Medicine. Definition from Institute of Medicine 2003.

Glossary for Health Accreditation Standards

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.

Shared Decision-Making: Shared decision-making is a collaborative process that allows consumers and their provider(s) to make health care decisions together, taking into account the best scientific evidence available, as well as the consumer's values and preferences.

Source: Based on definitions from the Informed Medical Decision Foundation - http://informedmedicaldecisions.org/what-is-shared-decision-making

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

- **Interpretive Note for CIN:** this refers to staff of the organization or network, not to practice staff.
- **Note:** May include physicians.

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.

State market conduct survey: an audit by a state or series of cooperating states to verify the behavior of a particular market segment. By way of example, in the context of the healthcare market states will complete a market conduct survey to verify whether health insurance companies are following the state's health insurance laws and regulations.

- **Note:** During the course of an onsite review for Health Plan accreditation, if a Medicaid line of business is within the scope of the application for accreditation, questions for the compliance officer related to standard Core 4 – Regulatory Compliance – would often include one about his or her role during a state market conduct survey and the outcome of the most recent survey for the health plan's Medicaid line of business.

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.

Target Population The group of individuals, as defined by the purchaser, who are eligible to become participants. The target population may be defined broadly (e.g., all eligible consumers regardless of health status) or narrowly (e.g., all eligible consumers who smoke).

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

Therapeutic Interchange: Authorized exchange of therapeutic alternatives.

Adapted from Academy of Managed Care Pharmacy's (AMCP) Principles of a Sound Drug Formulary System, 2000.

Glossary for Health Accreditation Standards

Transitional Care: A broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another. Transitional care is complementary to, but not the same as primary care, care coordination, discharge planning, disease management, or case management. Transitional care focuses on educating patients and family caregivers to address root causes of poor outcomes and avoid preventable re-hospitalizations.

Source: MD Naylor, LH Aiken, ET Kurtzman, DM Olds and KB Hirschman. The Importance of Transitional Care in Achieving Health Reform. Health Affairs, 30, no.4 (2011):746-754.

Transitions of Care (also known as "Care Transitions"): Transitions of care is the movement of patients from one health care practitioner or setting to another as their condition and care needs change.

Source: Case Management Society of America (CMSA.org)

Transparency/Transparent Reporting: is the belief that providing information about quality or value will be useful to both providers and consumers of health care services. Patients and their families have the right to the information that will help them make informed choices about health care services. If relative value information is made available to health care purchasers, the expectation is that they will make more informed decisions and may perhaps reward higher value providers of care with their business. In this way, the market will drive the provision of higher-value health care.

Source: The Measurement of Health Care Performance: A Primer from the CMSS M42639 11/07 © 2007 United Healthcare Services, Inc.

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."

User Organization: An organization seeking to use a previously designated functional site for the purposes of achieving accreditation.

Utilization Management (UM): Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities. Utilization management encompasses prospective, concurrent and retrospective review; it does not include claims review, even if the organization chooses to conduct utilization review on a claims submission, unless a specific request from the claimant for retrospective review accompanies the claims submission. UM is sometimes called "utilization review."

- **Interpretive Note:** For the Clinically Integrated Organization, "utilization management" may include a variety of structural strategies and practice processes designed to improve care coordination and delivery of the right service by the right provider, at the right time, at the right level of care.

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 (also referred to as "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 includes contracts with or without attachments or addenda.

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

Medical Loss Ratio (MLR) Applied to URAC Application Fees and Standards Compliance Expenses

Section 2718 of the Public Health Service Act as added by Section 1001 of the Patient Protection and Affordable Care Act (PPACA) requires “health insurance issuers” to report to the Department of Health and Human Services (HHS) the amount of premium revenues spent on clinical services, quality improvement activities and all other non-claims costs as defined by the National Association of Insurance Commissioners (NAIC) and certified by HHS. The new law requires issuers to meet specified Medical Loss Ratios (MLRs) – or calculations of the percentage of premiums collected by insurers spent on health care, including quality improvement activities, as opposed to administrative costs and profits.

In October 2010, the NAIC adopted the PPACA MLR Regulation (NAIC Model Regulation), which included language delineating specified application fees as quality improvement expenses. The NAIC delivered the Model Regulation to HHS for certification by the Secretary and HHS issued the MLR Interim Final Rule (HHS Interim Final Rule) in December 2010. The HHS Interim Final Rule closely resembles the NAIC recommendations.

In response to the NAIC Model Regulation and the HHS Interim Final Rule, URAC has developed an analytical framework and methodology that issuers or their delegees may utilize to assist in the allocation of URAC application fees between quality improvement expenses (QI expenses) and administrative expenses for purposes of the MLR calculation. URAC submitted a letter to HHS to inform regulators of URAC’s new MLR methodology. Please note: the final determination of the appropriate category for a certain expense needs to be made by the accredited organization in light of the latest guidance available in its jurisdiction.

URAC believes that the expenses related to many of its accreditation, certification, and designation programs may qualify as QI expenses. Please see the following table showing the categories of expenses supported by these various programs. In addition, specific standard elements are identified in supporting guide information and tables found in URAC’s standards and guide publications.

Medical Loss Ratio (MLR) Applied to URAC Application Fees and Standards Compliance Expenses

This table outlines the URAC programs where related (non-fee) standards compliance expenses may qualify as QI expenses. The last five columns identify the specific MLR quality improvement activities for which the QI expenses may qualify. Accreditation, certification, and designation application fees that may be included in the MLR calculation are addressed on the following page.

Program Category	URAC Program	Outcomes	Readmissions	Safety or Reduction of Errors/Mortality	Wellness	HIT
Care Management[1]	Health Call Center	X	X	X	X	X
	Comprehensive Wellness	X	X	X	X	X
	Case Management	X	X	X	X	X
	Disease Management	X	X	X	X	X
	Health Utilization Management[2]	X	X	X	X	X
	Transitions of Care Designation[3]	X	X	X	X	X
Health Care Operations[1]	Core (stand-alone)	X	X	X	X	X
	Consumer Education and Support	X	X	X	X	X
	Health Plan	X	X	X	X	X
	Health Plan with Florida Addendum	X	X	X	X	X
	Health Plan for Health Insurance Marketplace	X	X	X	X	X
	Patient Centered Medical Home Program Designation[4]	X	X	X	X	X
	Health Network	X	X	X	X	X
	Dental Plan	X	X	X	X	X
	Dental Plan for Health Insurance Marketplace	X	X	X	X	X
	Dental Network	X	X	X	X	X
Pharmacy[1]	Pharmacy Benefits Management	X	X	X	X	X
	Drug Therapy Management	X	X	X	X	X
	Mail Service Pharmacy	X	X	X	X	X
	Specialty Pharmacy	X	X	X	X	X
	Community Pharmacy	X	X	X	X	X
Health IT	Health Website	X	X	X	X	X
	Health Content Provider	X	X	X	X	X
	URAC HIPAA Privacy[3]					X
	URAC HIPAA Security[3]					X
Health Care Provider	URAC Patient Centered Medical Home Certification[3]	X	X	X	X	X
	Clinical Integration Accreditation	X	X	X	X	X
	Accountable Care Accreditation	X	X	X	X	X

1. Even though the Care Management, Health Care Operations, and Pharmacy programs support all five of the categories for MLR quality improvement activities, with the exception of the Transitions of Care designation (see footnote 3), not all of the standards within these programs would include activities that support MLR.
2. For Health Utilization Management, only prospective review activities apply to MLR.
3. All activities and resources used to meet the intent of the standards in the URAC Transitions of Care designation, HIPAA accreditation, and Patient Centered Medical Home certification may constitute MLR quality expenses.
4. Only the organizations applying for Health Plan or Health Plan with Health Insurance Marketplace accreditation are eligible to apply for the Patient Centered Medical Home Program Designation. There is no additional fee for this designation.

Medical Loss Ratio (MLR) Applied to URAC Application Fees and Standards Compliance Expenses

When All Application Fees may be Included in the MLR Calculation

By the nature of the function covered by an accreditation, certification, or designation, there are some URAC programs where all of the standards and their related activities may support MLR quality improvement activities. In the standards and guide publications for these particular programs, URAC did not include a separate table of standard elements and there are no "Points to Remember" notations for individual standards.

The following URAC programs may have all standards support MLR quality improvement activities:

- HIPAA Privacy Accreditation
- HIPAA Security Accreditation
- Patient Centered Medical Home Certification
- Transitions of Care Designation

Application Fees Excluded from the MLR Calculation

There are circumstances when a health insurance issuer *may not include any of the application fees* for an accreditation, certification, or designation in the MLR calculation, such as:

1. When none of the standards for a given program qualify as a quality improvement activity:
    - Claims Processing Administration Accreditation
    - Claims Processing Administration with Claims Review and Appeals Accreditation
    - Credentials Verification Organization Accreditation
    - Independent Review Organization Accreditation
    - Provider Credentialing Accreditation
2. When the program is limited to a line of business that is not within the scope of the MLR Interim Final Rule (“IFR”) (e.g., Medicare, Medicaid, and Workers’ Compensation):
    - Medicare Advantage Health Plan Accreditation
    - Workers’ Compensation Utilization Management Accreditation
    - Workers’ Compensation and Property and Casualty Pharmacy Benefit Management Accreditation

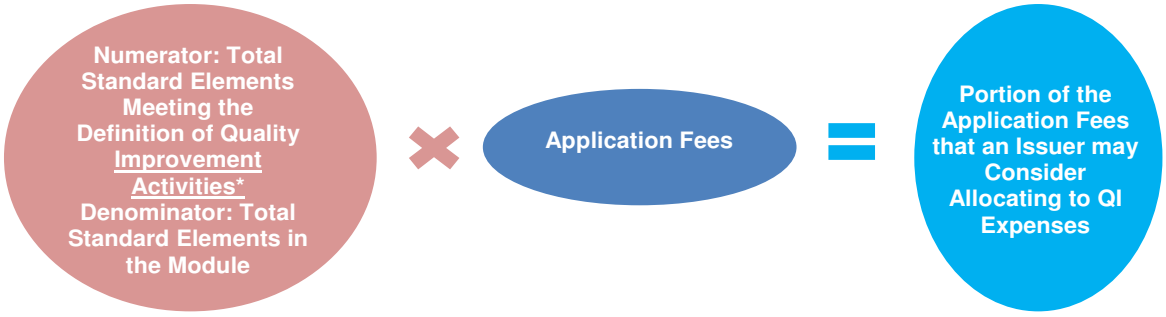
Medical Loss Ratio (MLR) Applied to URAC Application Fees and Standards Compliance Expenses

For some applications, the accreditation, certification, or designation may apply to both a line of business within the scope of the MLR IFR and a line of business that is not within the scope of the MLR IFR. If this is the case, then the issuer should consider seeking the counsel of appropriate professionals to ensure the allocation methodology it utilizes is appropriate.

An example would be when an organization includes commercial and Medicaid lines of business in its application for Health Plan accreditation. Given this example, the portion of expenses and application fees related to the Medicaid line of business would not be included in the MLR calculation.

URAC's Proposed MLR Methodology for Allocation of Application Fees

URAC's proposed methodology is based upon the percentage of met standards that qualify as quality improvement activities. The calculation described below determines the portion of application fees that qualifies as quality improvement activities. If a particular standard is not met or is not applicable to an issuer for any reason, then based upon this proposed methodology, the percentage of the application fee included in the category of QI expenses is reduced.*



*Under URAC's proposed methodology, standard elements that are not met, not applicable, or ones that an issuer chooses not to meet, should not be included in the count of MLR standard elements met in the numerator and should not be removed from the denominator. Application fees encompass application submission, measures reporting, and onsite review charges.

MLR Standard Elements in URAC Program Guides

Within its standards and program guide publications, URAC includes a table identifying the standard elements that may be consistent with the definition of quality improvement activities. This is the case unless it is a program where none of the standard elements are likely to qualify as MLR quality improvement activities. These programs are listed in part 1 of the section titled, "Application Fees Excluded from the MLR Calculation."

Medical Loss Ratio (MLR) Applied to URAC Application Fees and Standards Compliance Expenses

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If you have any questions, please contact URAC by phone at 202-216-9010, by email at businessdevelopment@urac.org, or visit our website at www.urac.org.

IRO CORE, Version 3.0

Organizational Structure

IRO CORE 1 - Organizational Structure

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

Policies and Procedures

IRO 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

IRO 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)

Oversight of Delegated Functions

IRO CORE 6 - Delegation Review Criteria

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

IRO 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)

IRO CORE 8 - Delegation Contracts

The *organization* enters into *written agreements* with *contractor*s 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)

IRO 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)

Business Relationships

IRO CORE 11 - Written Business Agreements

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

IRO 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

IRO 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)

IRO 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)

IRO 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)

IRO 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)

Staff Qualifications

IRO 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)

IRO CORE 26 - Staff Qualifications

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

Staff Management

IRO 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)

IRO 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)

Clinical Staff Credentialing and Oversight Role

IRO 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)

IRO 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)

IRO 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)

Consumer Protection and Empowerment

IRO 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)

Independent Review Organization: Comprehensive Review (Internal & External), Version 5.0

Reviewer Credentialing & Qualifications

IR 1 - Reviewer Credentialing Program

The *organization* establishes and implements a *reviewer* credentialing program that: (No Weight)

(a) Establishes selection criteria for *reviewers;* (4)

(b) Requires verification of all credentials specified in the credentialing program: (No Weight)

(i) Prior to assigning reviews to a newly-hired *reviewer*; **and** (Mandatory)

(ii) Thereafter no later than scheduled expiration for those credentials that expire; **and** (Mandatory)

(c) For credentials that expire, includes a written policy and/or documented procedure for not assigning cases to a *reviewer* whose credentials are verified as inactive or have not been re-verified prior to scheduled expiration. (4)

IR 2 - Reviewer Credentials Verification

At a minimum, the *reviewer* credentialing program shall address professional credentials, including: (No Weight)

(a) *Primary source verification* of the requisite *licensure* or *certification* required for clinical or legal practice; (Mandatory)

(b) If a reviewer is an M.D., D.O. or D.P.M. and is *board certified*, then *primary source verification* of the *reviewer's board certification(s)*; (Mandatory)

(c) Verification of history of sanctions and/or disciplinary actions; **and** (Mandatory)

(d) Collection of information regarding professional experience, including: (No Weight)

(i) Length of time providing direct patient care; **and** (Mandatory)

(ii) Dates indicating when the direct patient care occurred. (Mandatory)

IR 3 - Credential Status Changes

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

(a) Require *staff* to notify the *organization* in a timely manner of an adverse change in *licensure* or *certification* status, including *board certification* status; **and** (Mandatory)

(b) Implement corrective action in response to adverse changes in *licensure* or *certification* status, including *board certification* status. (Mandatory)

IR 4 - Reviewer Qualifications

Per IR 1(a), the *organization* establishes for the qualification of *reviewers*. Such criteria will specify that for all *cases* the organization selects *reviewers* who: (No Weight)

(a) Have current, non-restricted *licensure* or *certification* as required for clinical practice in a state of the United States; (Mandatory)

(b) Have at least five (5) years full-time equivalent experience providing direct clinical care to *patients*; (3)

(c) At a minimum, are *clinical peers*; **and** (Mandatory)

(d) Have a scope of *licensure* or *certification* and professional experience that typically manages the medical condition, procedure, treatment, or issue under review. (Mandatory)

IR 5 - Internal Review: Additional Reviewer Qualifications for Appeals

Per IR 1 (a), the *organization* establishes criteria for the qualification of *reviewers*. At a minimum, such criteria will specify that for *appeals* conducted as part of the *internal review* process the *organization* selects *reviewers* who: (No Weight)

(a) Meet the requirements specified in IR 4; (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 (ABMS) or the American Osteopathic Association (AOA); **and** (Mandatory)

(c) If a D.P.M., has board certification by the American Board of Podiatric Surgery (ABPS) or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM). (Mandatory)

IR 6 - External Review: Additional Reviewer Qualifications

Per IR 1 (a), the *organization* establishes criteria for the qualification of *reviewers*. At a minimum such criteria will specify that for all *external review cases* the *organization* selects *reviewers* who: (No Weight)

(a) Meet the requirements as specified in IR 4; (Mandatory)

(b) Meet the requirements as specified in IR 5; **and** (Mandatory)

(c) Have experience providing direct clinical care to *patients* within the past three (3) years. (3)

Conflict of Interest

IR 7 - Defining Reviewer Conflict of Interest

Prior to executing a contract to provide review services, the *organization* verifies what constitutes *reviewer conflict of interest* according to applicable state or federal law or regulation as well as contracting entity, including clarification of the following situation with regards to *conflict of interest*: (No Weight)

(a) A *reviewer* has a contract to provide health care services to enrollees of a *health benefit plan* of an insurance issuer or *group health plan* that is the subject of a review; **and** (4)

(b) A *reviewer* has staff privileges at a *facility* where the recommended health care service or treatment would be provided if the insurance issuer's or *group health plan's* previous non-certification is reversed. (4)

IR 8 - Reviewer Conflict of Interest Attestation

For each *case* they accept, *reviewers* attest that they do not have a *conflict of interest* as follows: (No Weight)

(a) The *reviewer* does not accept compensation for review activities that is dependent in any way on the specific outcome of the *case*; (Mandatory)

(b) To the best of the *reviewer's* knowledge, the *reviewer* was not involved with the specific episode of care prior to referral of the case for review; **and** (Mandatory)

(c) The *reviewer* does not have a material professional, familial, or financial *conflict of interest* regarding any of the following: (No Weight)

(i) The *referring entity*; (Mandatory)

(ii) The insurance issuer or *group health plan* that is the subject of the review; (Mandatory)

(iii) The *covered person* whose treatment is the subject of the review and the *covered person's authorized representative*, if applicable; (Mandatory)

(iv) Any officer, director or management employee of the insurance issuer that is the subject of the review; (Mandatory)

(v) Any *group health plan* administrator, plan fiduciary, or plan employee; (Mandatory)

(vi) The health care *provider*, the health care *provider's* medical group or independent practice association recommending the health care service or treatment that is the subject of the review; (Mandatory)

(vii) The *facility* at which the recommended health care service or treatment would be provided; **or** (Mandatory)

(viii) The developer or manufacturer of the principle drug, device, procedure, or other therapy being recommended for the *covered person* whose treatment is the subject of the review. (Mandatory)

IR 9 - Reviewer Attestation Regarding Credentials and Knowledge

For each *case* they accept, *reviewers* attest to: (No Weight)

(a) Having a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review; **and** (Mandatory)

(b) Current, relevant experience and/or knowledge to render a determination for the *case* under review. (Mandatory)

IR 10 - Reviewer Attestation Regarding Experience

For each *external review case* they accept, *reviewers* attest to meeting identified minimum requirements for direct patient care experience related to: (No Weight)

(a) Length of time providing direct patient care; **and** (Mandatory)

(b) How recent the *reviewer's* relevant direct patient care experience is. (Mandatory)

IR 11 - External Review: Independent Review Policy

The *organization* establishes a written policy applicable to *external reviews* whereby: (No Weight)

(a) In selecting a *reviewer*, the *organization* does not allow the *covered person*, the *covered person's authorized representative*, if applicable, or the insurance issuer or *group health plan* to choose or control the choice of the physician(s) or other health care professional(s) to be selected to conduct the review; (Mandatory)

(b) In reaching a conclusion, the *reviewer* is not bound by any decisions or conclusions reached during the insurance issuer's or *group health plan's utilization review* process or internal grievance process; (Mandatory)

(c) In rendering a review decision, the *organization* bases its decision upon the conclusion of the *reviewer(s)*; (Mandatory)

(d) The *organization* verifies that a *reviewer* does not have a *conflict of interest* with an assigned *case*; (Mandatory)

(e) The *organization* does not accept compensation for *external review* activities that is dependent in any way on the specific outcome of the *case*; (Mandatory)

(f) The *organization* will not knowingly accept a *case* with which it has an organizational *conflict of interest*; **and** (Mandatory)

(g) Pursuant to standard IR 14, the *organization* notifies the *referring entity* should it discover at any point prior to or during the *external review* process that it has an organizational *conflict of interest*. (Mandatory)

IR 12 - External Review: Defining Organizational Conflict of Interest

Prior to executing a contract to provide *external review* services, the *organization* verifies what constitutes an organizational *conflict of interest*: (No Weight)

(a) According to applicable state or federal law or regulation; (Mandatory)

(b) According to the contracting entity; **and** (Mandatory)

(c) Including clarification whether a relationship between the *organization* and an insurance issuer's or *group health plan's* parent company, sister companies or subsidiaries constitutes an organizational *conflict of interest*. (Mandatory)

IR 13 - External Review: Organizational Conflict of Interest Attestation

The *organization* attests to its known organizational *conflict of interest* prior to or as part of executing a contract for *external review* services. As part of that attestation, the *organization* definitively identifies whether: (No Weight)

(a) Is owned or controlled, or is a subsidiary of or in any way owned or controlled by, or exercises control with an insurance issuer or *group health plan*, a national, state or local trade association of issuers or plans, or a national, state or local trade association of health care *providers*; (Mandatory)

(b) Conducts *internal review* and if so, discloses the names of those entities for which it conducts *internal review* so that the referring entity has the opportunity to forward these cases to a different *organization* for *external review*; **and** (Mandatory)

(c) Has a material professional, familial, or financial *conflict of interest* regarding any of the following: (No Weight)

(i) An insurance issuer; (Mandatory)

(ii) Any officer, director or management employee of an insurance issuer; (Mandatory)

(iii) Any *group health plan* administrator, plan fiduciary, or plan employee; (Mandatory)

(iv) A medical group or independent practice association; (Mandatory)

(v) A *facility* providing health care service and treatments; **and** (Mandatory)

(vi) The developer or manufacturer of a drug, device, procedure, or other therapy. (Mandatory)

IR 14 - External Review: Organizational COI Transparency Process

If the *organization* discovers that an organizational *conflict of interest* does exist, then 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 *external review* from the *covered person,* insurance issuer or *group health plan,* and the *referring entity.* (Mandatory)

Tracking, Monitoring & Reporting

IR 15 - Review Database

The *organization* maintains a database of all *reviews* and is able to report, at a minimum, the following information for each *case*: (No Weight)

(a) The unique identifier assigned to the *case*; (Mandatory)

(b) The name of the *referring entity*; (2)

(c) The state relevant to the *case* under review; (2)

(d) The contract relevant to the *case* under review; (2)

(e) If available, the insurance issuer or *group health plan* relevant to the *case* under review; (2)

(f) The date the *organization* received the request to conduct a review from the *referring entity*; (2)

(g) The date the *organization* received the initial information packet from the *referring entity*; (2)

(h) If applicable, the date by which additional information beyond what was forwarded in the initial information packet is due to be received in order to resume the review process; (2)

(i) Whether it is an *internal* or *external review* and if an *internal review*, whether it is an *appeal* or not; (2)

(j) Whether the case relates to medical necessity and medical appropriateness, experimental or investigational treatment, administrative or legal issue, or a combination of these categories; (2)

(k) A description of the issue to be resolved; (2)

(l) Whether the *case* was expedited or not; (4)

(m) The date by which the *organization* must communicate the determination to the requisite parties; (2)

(n) The *organization's* determination regarding the *case*; (Mandatory)

(o) The date the *organization's* determination was made; **and** (Mandatory)

(p) The date the *organization's* determination was communicated to the requisite parties. (Mandatory)

IR 16 - Review File Documentation

For each *case*, the *organization* maintains a file that includes: (No Weight)

(a) The unique identifier assigned to the review *case*; (Mandatory)

(b) The name, credentials and specialty of the *reviewer(s)* and/or unique identifier for the *reviewer(s)*; (Mandatory)

(c) *Reviewer* attestation regarding *conflict of interest*; (Mandatory)

(d) The specific question or issue to be resolved by the review process; (3)

(e) Whether the *case* relates to medical necessity and medical appropriateness, experimental or investigational treatment, administrative or legal issue, or a combination of these categories; (3)

(f) Whether the *case* is expedited or not; (Mandatory)

(g) Clinical evidence and information considered during the review; (Mandatory)

(h) References to any applicable medical literature/research data or national clinical criteria upon which the *reviewer's* determination was based; **and** (Mandatory)

(i) 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. (Mandatory)

IR 17 - Performance Monitoring

The *organization* monitors its performance regarding review procedures according to its written policies and/or documented procedures, whereby: (No Weight)

(a) Prior to communicating a review determination with a *referring entity*: (No Weight)

(i) The medical director (or equivalent designate) conducts and documents a quality check for at least the first two (2) cases conducted by a *reviewer* new to the *organization*; **and** (Mandatory)

(ii) The *organization* conducts a quality check and if a review does not meet the *organization's* quality standards, then each issue and its outcome are documented; (Mandatory)

(b) The medical director (or equivalent designate) conducts and documents random quality checks; (Mandatory)

(c) The *organization* conducts and documents random regulatory compliance checks for each state that it does business in; (Mandatory)

(d) The *organization* conducts and documents random compliance checks among the current contracts that are within the scope of this accreditation; (Mandatory)

(e) At least quarterly, the *organization* generates reports to track and trend against measures of acceptable levels of performance with regards to: (No Weight)

(i) Review timelines; (Mandatory)

(ii) Routine quality checks per standard element (a)(ii); (Mandatory)

(iii) Random quality checks per standard element (b); (Mandatory)

(iv) Random compliance checks per standard elements (c) and (d); (Mandatory)

(v) Client *complaints*; **and** (Mandatory)

(f) As needed, the *organization* implements action plans to correct identified problems and meet acceptable levels of performance for measures. (Mandatory)

IR 18 - Summary Reports for External Entities

For the current year and any given calendar year with the past three (3) full consecutive years, the *organization* is capable of reporting in aggregate by contract: (No Weight)

(a) If applicable, on *internal reviews*: (No Weight)

(i) The total number of reviews; (Mandatory)

(ii) The number of each type of review (i.e., expedited and non-expedited) and average length of time for resolution of each type; (Mandatory)

(iii) The number of each type of review outcome (e.g., upheld, reversed or partially upheld and reversed); **and** (Mandatory)

(b) If applicable, on *external reviews*: (No Weight)

(i) The number of requests for *external review* and their outcome, including the number resolved upholding the *adverse determination* or *final adverse determination*, the number resolved reversing the *adverse determination* or *final adverse determination* and the number reflecting a combination thereof; (Mandatory)

(ii) The number of each type of review (i.e., expedited or non-expedited) and average length of time for resolution of each type; (Mandatory)

(iii) The number of each category of cases (i.e., medical necessity/appropriateness, experimental/investigational, administrative/legal, or a combination thereof); **and** (Mandatory)

(iv) Where the *organization* is allowed by state or federal regulation or contract to contact the insurance issuer or *group health plan*, the number of *external reviews* that were terminated as a result of a reconsideration by the insurance issuer or *group health plan* of its *adverse determination* or *final adverse determination* after the *organization* forwarded additional information received from the *covered person* or the *covered person's authorized representative*. (Mandatory)

Review Process

IR 19 - Initial Case Assessment

Upon accepting a *case* from a *referring entity*, the *organization* identifies: (No Weight)

(a) The specific question or issue to be resolved by the review process; (3)

(b) Whether the *case* relates to medical necessity and medical appropriateness, experimental or investigational treatment, administrative or legal issue, or a combination of these categories; (3)

(c) Whether the *case* is expedited or not; **and** (3)

(d) Applicable state or federal law or regulation as well as contract requirements, including: (3)

(i) The information that must be taken into consideration as part of reviewing the *case*; (3)

(ii) The process, including time frame, for securing additional information if it should be determined that *case* documentation is incomplete; (3)

(iii) Time frames applicable to steps in the review process, including communication of the review determination; **and** (3)

(iv) Identification of the parties to receive notification of the review determination. (3)

IR 20 - Review of Additional Information

At the direction of the *referring entity* and given additional information to conduct a review of a non-certification, the *organization* may use the same *reviewer* or one similarly qualified to render another review determination. (3)

IR 21 - External Review: Additional Information Processing

As required by state or federal law or regulation or contractual requirements, 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 *covered person* or *attending provider*, then the *organization* provides a copy to the insurance issuer or *group health plan* to provide this entity with the opportunity to reverse the decision that is the subject of the *external review*. Once the insurance issuer or *group health plan* issues a reversal in writing, the *external review* process is terminated. (4)

IR 22 - Time Frames for External Review

The *organization* completes an *external review* according to the following time frames (unless superseded by applicable law or regulations): (No Weight)

(a) An expedited review is completed as soon as possible, but in no event more than 72 hours after receipt of the request for an expedited *external review*; (Mandatory)

(b) A non-expedited review is completed within 45 calendar days after receipt of the request for an *external review*; **and** (Mandatory)

(c) The time frame starts upon receipt of the initial information packet and ends once the *organization* issues a determination to all requisite parties as required by contract, law or regulation. (Mandatory)

IR 23 - 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 non-expedited review would seriously jeopardize: (No Weight)

(i) The life or health of the *covered person*; **or** (Mandatory)

(ii) The *covered person's* ability to regain maximum function; **and** (Mandatory)

(b) Includes written policies and/or documented procedures for: (No Weight)

(i) Acting upon expedited *cases* received and/or processed after hours; **and** (Mandatory)

(ii) Issuing a determination in writing within forty-eight (48) hours after the date of providing notice, if that initial notice was not provided in writing. (Mandatory)

IR 24 - 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 as available*,* unless otherwise prohibited by state or federal regulation: (No Weight)

(a) The *covered person's* medical records; (Mandatory)

(b) The *attending provider's* recommendation; (Mandatory)

(c) The terms of coverage under the *covered person's health benefit plan;* (3)

(d) Information accumulated regarding the *case* prior to its referral for review, including rationale for prior review determinations; (4)

(e) Information submitted to the *organization* by the *referring entity, covered person* or *attending provider;* (Mandatory)

(f) *Clinical review criteria* and/or medical policy developed and used by the insurance issuer or *group health plan*; **and** (3)

(g) *Medical* or *scientific evidence*. (3)

IR 25 - 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 the following, unless otherwise prohibited by state or federal law or regulation: (No Weight)

(a) All of the information listed in IR 24; **and** (4)

(b) Whether: (No Weight)

(i) The recommended or requested health care service or treatment has been approved by the Federal Food and Drug Administration, if applicable, for the condition; **or** (4)

(ii) *Medical* or *scientific evidence* or *evidence-based clinical practice guidelines* or *criteria* demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the *covered person* than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments. (4)

IR 26 - Benefit Coverage/Rescission/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 benefit plan* contract, other relevant *health benefit plan* materials and documents, and applicable state or federal law or regulation. (4)

IR 27 - Decision Notice

At a minimum, the *organization* sends to the *referring entity* a notice of the determination that includes: (No Weight)

(a) A description of the issue to be resolved; (Mandatory)

(b) A description of the qualifications of the *reviewer(s)*; (Mandatory)

(c) If required, documentation of *peer-to-peer conversation* attempts and contacts; (Mandatory)

(d) A *clinical rationale* or explanation for the determination; **and** (Mandatory)

(e) Specific citations to supporting evidence or references per the *organization's* policy. (Mandatory)

Comprehensive Independent Review Organization (IRO), Version 5.0; External (IRO); Internal (IRO) Accreditation Publication Change Log

DATE	STANDARD	CHANGE
7/9/2011	IR 4	Interpretive Information/Commentary ➢ 2nd bullet, 2nd paragraph ➢ 3rd bullet, 1st paragraph
12/26/2012	IRO CORE 13	Points to Remember ➢ 2nd bullet, new content
12/26/2012	IRO CORE 14	Points to Remember ➢ 2nd bullet, new content
12/26/2012	IRO CORE 15	Points to Remember ➢ 2nd bullet, new content
12/26/2012	IRO CORE 16	Points to Remember ➢ 2nd bullet, new content
12/26/2012	IRO CORE 28	Interpretive Information/Commentary ➢ 4th bullet, new content Points to Remember ➢ 2nd bullet, deleted bullet ➢ 3rd bullet, deleted bullet Scope of Standards ➢ 2nd bullet
12/26/2012	IR 1	Interpretive Information/Commentary ➢ 3rd bullet, new content ➢ 4th bullet, deleted bullet
12/26/2012	IR 2	Points to Remember ➢ 1st bullet, content change
12/26/2012	IR 7	Interpretive Information/Commentary ➢ 1st bullet, content change ➢ 1st sub-bullet, new content ➢ 2nd bullet, new content ➢ 2nd sub-bullet (a), new content ➢ 2nd sub-bullet (b), new content ➢ 3rd bullet, new content (2nd sentence) Scope of Standards ➢ 2nd bullet, new content Evidence for Meeting the Standard – Desktop Review Materials ➢ 1st bullet, content change ➢ 3rd bullet, content change
12/26/2012	IR 8	Interpretive Information/Commentary ➢ 3rd bullet, new content, (1st bullet) ➢ 4th bullet, 4th sub-bullet (d), word change
12/26/2012	IR 13	Interpretive Information/Commentary ➢ 1st bullet, new change ➢ 2nd bullet, new content ➢ 3rd bullet, new content ➢ 3rd bullet, 1st sub-bullet, new content ➢ 3rd bullet, 2nd sub-bullet, new content ➢ 6th bullet, new content ➢ 6th bullet, sub-bullet, new content
12/26/2012	IR 15	Interpretive Information/Commentary ➢ 3rd bullet, new content ➢ 3rd bullet, sub-bullet, new content ➢ 4th bullet, new content ➢ 4th bullet, 1st sub-bullet (a), new content ➢ 4th bullet, 2nd sub-bullet (b), new content

New Information for IRO Accreditation Guides

December 2012

KEY: Blue underlined text = new text ~~Red strikethrough text~~ = deleted text

The text below will be inserted as the second bullet under "Points to Remember" section of the accreditation guide for all standards in the "Information Management" chapter of the IRO standards as follows:

IRO CORE 13 - Information Management

IRO CORE 14 - Business Continuity

IRO CORE 15 - Information Confidentiality and Security

IRO CORE 16 - Confidentiality of Individually-Identifiable Health Information

Points to Remember

- [first bullet]
- There are times when an IRO will have contractual agreements with its clients regarding data security standards that the IRO must meet. There are various IT data security certifications to consider. Examples of certifications in this area include, but are not limited to, ISO 27001/2, SSAE 16 SOC II, and HITRUST. (Note: URAC does not require these certifications in order to meet the standards; however, organizations may find them helpful as part of an overall data security strategy.)

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IRO 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)

Interpretive Information/Commentary

- Examples of a "documented process" referenced in standard element (a) include: Formal written policies and/or documented procedures, process flowcharts, escalation matrix, guidelines, etc.
- Where regulatory requirements are embedded in written policies and/or documented procedures and/or other documentation and the document identifies the regulatory requirement that it supports meeting, then this meets the intent of standard element (c) to provide staff with regulatory requirements related to their job function.
- Pursuant to the definition of "clinical decision support tools," these tools include protocols, guidelines, or algorithms that assist in the clinical decision-making process.
- Core 28(b) is not applicable to IRO accreditation.

Points to Remember

- The master list of written policies and/or documented

procedures submitted in response to Core 3 can be used as evidence for meeting Core 28(a).

- ~~Core 28(b): Written policies and/or documented procedures should be easily accessed by staff. During the URAC onsite review, the reviewer may ask staff to demonstrate how to access written policies and/or documented procedures.~~

- ~~Core 28(b): Clinical decision support tools may be included as part of the clinical information system.~~

- Core 28(c): Please refer to your compliance department staff for details on the organization's compliance program and policies/procedures documenting how organizational regulatory compliance is maintained.

- Core 28(c): If state or federal requirements conflict with URAC standards, an organization would follow the more stringent requirement.

- Staff is aware of the organization clinical decision support tools, location, and when to access them in clinical situations.

- Staff utilizes only those Web sites approved by the organization.

Scope of Standards

- Core 28 applies to program written policies and/or documented procedures and related clinical decision support tools as appropriate for the organization's programs

coming under accreditation.

- Core 28 (b) is not applicable to those accreditations that do not use clinical decision support criteria such as Independent Review Organization (IRO) and Credentials Verification Organization (CVO) accreditation.

New Information for IRO Accreditation Guides

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IR 1 - Reviewer Credentialing Program

The *organization* establishes and implements a *reviewer* credentialing program that: (No Weight)

(a) Establishes selection criteria for *reviewers;* (4)

(b) Requires verification of all credentials specified in the credentialing program: (No Weight

(i) Prior to assigning reviews to a newly-hired *reviewer*; **and** (Mandatory)

(ii) Thereafter no later than scheduled expiration for those credentials that expire; **and** (Mandatory)

(c) For credentials that expire, includes a written policy and/or documented procedure for not assigning cases to a *reviewer* whose credentials are verified as inactive or have not been re-verified prior to scheduled expiration. (4)

Interpretive Information/Commentary

- Organizations must ensure that reviewers have the appropriate professional qualifications to consider cases referred for review.
- For standard element IR 1(b)(ii), credentials that expire include those items identified in IR 2(a) and (b). The one exception to this would be for IR 2(b) (i.e., board certification) for an MD, DO or DPM who was “grandfathered” into a lifetime board certification. This exception, where it exists, must be documented in the credentialing file.
- As part of the credentialing program, organizations periodically verify sanctions and/or disciplinary actions pursuant to its credentialing program plan.
- ~~For standard element IR 1(b)(iii), credentials that can change over time include those items identified in IR 2(c), (d) and (e).~~

New Information for IRO Accreditation Guides

December 2012

IR 2 - Reviewer Credentials Verification

At a minimum, the *reviewer* credentialing program shall address professional credentials, including: (No Weight)

(a) *Primary source verification* of the requisite *licensure* or *certification* required for clinical or legal practice; (Mandatory)

(b) If a reviewer is an M.D., D.O. or D.P.M. and is *board certified*, then *primary source verification* of the *reviewer's board certification(s)*; (Mandatory)

(c) Verification of history of sanctions and/or disciplinary actions; **and** (Mandatory)

(d) Collection of information regarding professional experience, including: (No Weight)

(i) Length of time providing direct patient care; **and** (Mandatory)

(ii) Dates indicating when the direct patient care occurred. (Mandatory)

Points to Remember

- IR 2(c): History of sanctions and/or disciplinary actions must be verified with an outside source (i.e., state licensing board, **or** National Practitioner Da~~b~~ta Bank (NPDB), **or** Office of Inspector General/U.S. Department of Health and Human Services (OIG)). It is understood that not all IROs will have access to NPDB; therefore, one or more of the other sources is acceptable. Peer reviewer self reporting is not an acceptable method of evaluating history of sanctions and/or disciplinary actions. The credentialing policy should address next steps when a history of a sanction or disciplinary action is reported.

New Information for IRO Accreditation Guides

December 2012

IR 7 - Defining Reviewer Conflict of Interest

Prior to executing a contract to provide review services, the *organization* verifies what constitutes *reviewer conflict of interest* according to applicable state or federal law or regulation as well as contracting entity, including clarification of the following situation with regards to *conflict of interest*: (No Weight)

(a) A *reviewer* has a contract to provide health care services to enrollees of a *health benefit plan* of an insurance issuer or *group health plan* that is the subject of a review; **and** (4)

(b) A *reviewer* has staff privileges at a *facility* where the recommended health care service or treatment would be provided if the insurance issuer's or *group health plan's* previous non-certification is reversed. (4)

Interpretive Information/Commentary

- The elements (a) and (b) are not required exclusions, but rather, need to be clarified ~~before executing a contract~~ as to whether they are considered exclusions before executing a contract or establishing an agreement to conduct reviews.
    - URAC recognizes that an IRO may not have a contract or other written agreement with a state assigning reviews to the IRO. The intent here is that *where a relationship exists*, written or otherwise, both parties need to mutually determine if the circumstances described in (a) and (b) above constitute a conflict of interest.

- There is no action required on the part of the IRO except to clarify with prospective clients whether or not (a) or (b) is considered a conflict of interest and if one or both of them is, then reflect that in the reviewer conflict of interest attestation.

- These decisions can be recorded in various ways including retaining a copy of the applicable law or regulation, meeting notes, addenda to a written agreement, or in a document incorporated by reference in a contract or other written agreement.
- If it is determined that (a) or (b) are considered a conflict of interest, then the IRO would identify this in its reviewer conflict of interest attestation. This will help ensure that selected reviewers also know that these situations constitute a conflict of interest and as such, can determine if they have a conflict of interest with the case they are being asked to review.

- Note that standard element (a) *is not* referring to situations where a reviewer is conducting reviews for an insurance issuer or group health plan, which is considered a conflict of interest under these standards; please reference IR 8(c)(ii) along with its supporting interpretive information for further clarification. Rather, the intent of this standard element is for the requisite parties to mutually agree as to whether a provider can be a "participating provider" for a given insurance issuer or group health plan and still conduct reviews involving that insurance issuer or group health plan when it is the subject of a review

- Element (a) includes participation in advisory groups that provide guidance to the various programs that support a provider network, including credentialing, medical policy and quality management committees. However, under these standards participation in an insurance issuer's or group health plan's board of directors or any sub-committee of that board is considered a conflict of interest for an individual clinical practitioner [IR 8(c)(iv)].
  - In addition, having a role in management – in particular, as a medical director at any level of any department of an insurance issuer or group health plan – is also considered to be a "material professional" conflict of interest for a reviewer. Again, reference IR 8(c)(iv) along with its supporting interpretive information for more information.

New Information for IRO Accreditation Guides

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Points to Remember

- For applicants complying with this standard for the first time, IR 7 is implemented on a going-forward basis, such that written policies and/or documented procedures must be in effect at the time an organization submits its application for initial accreditation or reaccreditation. For every contract initiated after that submittal date, URAC will examine client-specific documentation demonstrating that these reviewer conflict of interest issues were determined and agreed upon between the organization and its clients.
    - For desktop review, documentation defining reviewer conflict of interest includes state or federal law or regulation, contract language, contract addendum, letter of understanding (LOU) or memorandum of understanding (MOU) between the parties. A template copy of the reviewer attestation is also submitted for desktop.

- The term “enrollees” in standard element (a) is synonymous with “covered person.”

- For external review in particular, elements (a) and (b) may be determined by state or federal law or regulation.

- The nature of a conflict of interest may vary from state to state and among clients.

Scope of Standards

- This standard applies to all signed contracts that the organization has in place to perform review functions for the books of business included in the application for accreditation.

- This standard also applies to situations where there is no signed contract with the state (or other entity) that has assigned reviews to an IRO.
- For organizations applying under this standard for the first time, URAC will look to see that this standard is addressed for contracts initiated after the application submittal date.

Evidence for Meeting the Standard - Desktop Review Materials

- Where it exists, contract language, contract addendum, letter of understanding (LOU) or memorandum of understanding (MOU) between the parties defining reviewer conflict of interest
- State or federal law or regulation as it defines reviewer conflict of interest
- If there are states (or other clients) where standard elements (a) or (b) are determined to be conflicts of interest, then provide a template copy of the reviewer attestation showing where these particular situations, considered conflicts of interest, are addressed

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of a minimum of 30 case files, randomly selected, along with their associated reviewer files to verify signed reviewer attestation - including credentialing files
- Interview with management involved in contracting with organizations to perform review services
- Interview with regulatory compliance staff
- Interview with two (2) peer reviewers (pre-arranged by applicant)

New Information for IRO Accreditation Guides

December 2012

IR 8 - Reviewer Conflict of Interest Attestation

For each case they accept, reviewers attest that they do not have a conflict of interest as follows: (No Weight)

(a) The reviewer does not accept compensation for review activities that is dependent in any way on the specific outcome of the case; (Mandatory)

(b) To the best of the reviewer's knowledge, the reviewer was not involved with the specific episode of care prior to referral of the case for review; and (Mandatory)

(c) The reviewer does not have a material professional, familial, or financial conflict of interest regarding any of the following: (No Weight)

(i) The referring entity; (Mandatory)

(ii) The insurance issuer or group health plan that is the subject of the review; (Mandatory)

(iii) The covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; (Mandatory)

(iv) Any officer, director or management employee of the insurance issuer that is the subject of the review; (Mandatory)

(v) Any group health plan administrator, plan fiduciary, or plan employee; (Mandatory)

(vi) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; (Mandatory)

(vii) The facility at which the recommended health care service or treatment would be provided; or (Mandatory)

(viii) The developer or manufacturer of the principle drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review. (Mandatory)

Interpretive Information/Commentary

- Acceptable means for reviewers to "…attest that they do not have a conflict of interest…" for each case they accept includes: electronic signature, wet signature, electronic or wet mark in a checkbox where the identity of the reviewer can be determined (e.g., by name and/or unique identifier).

- For element (a), the operative word is "episode of care," where for a particular patient a reviewer may not conduct a review if s/he was previously involved in any way with the given episode of care under review. URAC uses "episode of care" and "specific case" to mean the same thing. See also URAC's definition of "conflict of interest."

- For element (c), in order to have a financial conflict of interest, a reviewer would have ownership interest of greater than 5% in a particular entity as listed in the sub-elements for this standard (i)-(ii) and (vi)-(viii). See also URAC's definition of "conflict of interest."

- For element (c):
  - Refer to standard IR 7(a) when addressing IR 8(c)(ii).
  - Refer to standard IR 7(b) when addressing IR 8(c)(vii).
  - In addition, for IR 8(c)(ii) and (iv), if a reviewer conducts reviews for an insurance issuer or group health plan that is the subject of a review, or participates in management, including supervises others on behalf of the insurance issuer or group health plan (i.e., a medical director at any level of any department), or participates on the insurance issuer's or group health plan's board of directors or any subcommittee of the board, then this is considered a conflict of interest pursuant to this standard; whereas,
  - Depending upon the decision made for IR 7(a), being a participating provider for a group health plan under review does not necessarily create a conflict of interest, ~~nor~~ neither does having used a procedure or device under review, as long as the provider is not financially benefiting from using that procedure or device.

- In cases where the insurance issuer or group health plan is not known to the organization, then it is presumed that there is no conflict of interest with the insurance issuer or group health plan [IR 8(c)(ii)].

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IR 13 - External Review: Organizational Conflict of Interest Attestation

The organization attests to its known organizational conflict of interest prior to or as part of executing a contract for external review services. As part of that attestation, the organization definitively identifies whether: (No Weight)

(a) Is owned or controlled, or is a subsidiary of or in any way owned or controlled by, or exercises control with an insurance issuer or group health plan, a national, state or local trade association of issuers or plans, or a national, state or local trade association of health care providers; (Mandatory)

(b) Conducts internal review and if so, discloses the names of those entities for which it conducts internal review so that the referring entity has the opportunity to forward these cases to a different organization for external review; and (Mandatory)

(c) Has a material professional, familial, or financial conflict of interest regarding any of the following: (No Weight)

(i) An insurance issuer; (Mandatory)

(ii) Any officer, director or manage~~r~~ment employee of an insurance issuer; (Mandatory)

(iii) Any group health plan administrator, plan fiduciary, or plan employee; (Mandatory)

(iv) A medical group or independent practice association; (Mandatory)

(v) A facility providing health care service and treatments; and (Mandatory)

(vi) The developer or manufacturer of a drug, device, procedure, or other therapy. (Mandatory)

Interpretive Information/Commentary

- IR 13 applies only to external review.
- URAC recognizes that an IRO may not have a contract or other written agreement with a state assigning reviews to the IRO. The intent here is that *where a relationship exists*, written or otherwise, the organization is transparent

with the state about its relationships with other entities that would create a conflict of interest when conducting an external review involving that entity.

- In IR 13(b), the "referring entity" is the state.
    - If the organization conducts external review, then this standard is applicable. Conversely, it is not applicable if the applicant organization does not conduct external review.
    - If a state requests or requires the names of the entities (i.e., health plans) for which the organization conducts internal review, then the IRO must provide that information to the state regardless of non-disclosure agreements with its internal review clients. Conversely, if a state does not require this information (i.e., it will not distribute reviews based on this information), then the applicant organization is not required to provide it.
- As part of the desktop review, the organization submits a copy of its current organizational conflict of interest attestation. URAC will verify that all standard elements are definitively addressed one way or the other (i.e., a relationship does or does not exist). If certain elements are not addressed, then the organization will be requested to amend its attestation in order to come into compliance with that particular element of the standard.

- All elements in this standard must be addressed one way or the other in the organization's conflict of interest attestation.

- For IR 13(a) and IR 13(c), the organization identifies entities with which it or members of its staff has a relationship whereby a conflict of interest would exist if the organization conducted a review involving the entity.
    - It is not the intent of this standard to require an organization to know ahead of time the types of cases it will receive, but rather to be transparent about its relationships prior to providing external review services.

New Information for IRO Accreditation Guides

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- For IR 13(c)(i), the organization is expected to identify the insurance issuer or group health plan for which it does reviews. This transparency with its external review clients allows a state/ state commissioner to clarify if this is considered an organizational conflict of interest and if so, screen for it prior to referring the case. *

- Note that per IR 8(c)(ii) and (iv), however, if a reviewer conducts reviews for an insurance issuer or group health plan that is the covered person's insurance issuer or group health plan related to the case, or participates in management, including supervising others on behalf of the insurance issuer or group health plan (i.e., a medical director at any level of any department), or participates on the insurance issuer's or group health plan's board of directors or any subcommittee of the board, then this is considered a conflict of interest at the reviewer level.

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IR 15 - Review Database

The *organization* maintains a database of all *reviews* and is able to report, at a minimum, the following information for each *case*: (No Weight)

(a) The unique identifier assigned to the *case*; (Mandatory)

(b) The name of the *referring entity*; (2)

(c) The state relevant to the *case* under review; (2)

(d) The contract relevant to the *case* under review; (2)

(e) If available, the insurance issuer or *group health plan* relevant to the *case* under review; (2)

(f) The date the *organization* received the request to conduct a review from the *referring entity*; (2)

(g) The date the *organization* received the initial information packet from the *referring entity*; (2)

(h) If applicable, the date by which additional information beyond what was forwarded in the initial information packet is due to be received in order to resume the review process; (2)

(i) Whether it is an *internal* or *external review* and if an *internal review*, whether it is an *appeal* or not; (2)

(j) Whether the case relates to medical necessity and medical appropriateness, experimental or investigational treatment, administrative or legal issue, or a combination of these categories; (2)

(k) A description of the issue to be resolved; (2)

(l) Whether the *case* was expedited or not; (4)

(m) The date by which the *organization* must communicate the determination to the requisite parties; (2)

(n) The *organization's* determination regarding the *case*; (Mandatory)

(o) The date the *organization's* determination was made; **and** (Mandatory)

(p) The date the *organization's* determination was communicated to the requisite parties. (Mandatory)

Interpretive Information/Commentary

- The database consists of key data for the reviews conducted by the organization. These data elements support the performance monitoring covered in standard IR 17 as well as the summary reporting for external entities outlined in standard IR 18.
- During the onsite review, reviewers will use a report consisting of data elements outlined in IR 15 to select cases for every level of review that the organization conducts (e.g., internal clinical peer review, internal appeal and external review). URAC will also use this report to select expedited appeals if conducted.
- IR 15(c) refers to the state in which the individual that is the subject of the review was treated, which is not necessarily where this person resides. The intent is to determine which state law presides over the case.
    - The organization may have other state-related fields identifying where the corporate office or state of incorporation for the insurance issuer or group health plan that is the subject of the review, or where the reviewer is licensed.
- In IR 15(d), the word "contract" includes other types of written agreements.
    - URAC recognizes that an IRO may not have a contract or other written agreement with a state assigning reviews to the IRO. The intent here is that *where a relationship exists* and it is not supported by a written agreement of any kind, the organization identifies what gives the

organization the authority to conduct the reviews (e.g., licensure, certification, registration, or Web site, etc.)

- A copy of the contract/written agreement or other related documentation is not required to be in the review file. For information on what is required to be in the review file, please reference standard IR 16 - Review File Documentation.