



Utilization Management

One of the greatest challenges for health care organizations is to provide high-quality, yet cost-effective, treatment for patients.

UMR's Utilization Review Accreditation Commission (URAC)-approved Utilization Management program is based on three concepts:

1

Timely review and determination of medical necessity

2

Determination of appropriate inpatient lengths of stay

3

Identification of potential Complex Condition CARE and Ongoing Condition CARE referrals

Ensuring medical necessity

Our experienced review specialists use advanced software, extensive databases and nationally recognized review criteria to ensure our recommendations are logical and consistent for clients.

Thorough concurrent review

Concurrent review helps determine which setting is most appropriate for a hospitalized member who requires additional care. Our reviewers evaluate the member's case to determine if an inpatient setting is necessary or if other options, such as outpatient or home care, might be more suitable. We also check to ensure the length of stay is appropriate and observed. UMR's medical director oversees complex cases to determine the best course of action and consults with the member's physician, if necessary.

Proactive discharge planning

Discharge planning begins as early as the notification process. When possible, the Utilization Management specialist coordinates early discharge without sacrificing quality of care. UMR's goal is to intervene as early as possible to determine the resources needed to deliver quality clinical care at a reasonable expense.

Evidence-based UMR Prior Authorization List

As the largest TPA in the United States, UMR is in a unique position to extract insights from critical utilization trends in health care. Our experienced data analytics teams review this utilization on an ongoing basis to optimize financial savings and quality monitoring. As trends change, we update our evidence-based list of inpatient and outpatient procedures that require notification and/or authorization to ensure we're focused on the right services. Procedures that we commonly review include¹:

- Hospitalizations and inpatient surgeries²
- Advanced imaging (not including basic CT and MRI)
- Advanced radiation treatment
- Bariatric surgery
- Behavioral health stays
- Cardiology procedures
- Chemotherapy
- Cosmetic and reconstructive services
- Durable medical equipment
- Genetic testing
- Implantable spinal cord and nerve stimulators
- Joint procedures
- Medical specialty drugs and injectables
- Non-emergent air transportation
- Pain management
- Partial hospitalization programs
- Skilled nursing facility
- Sleep apnea treatment
- Sleep studies
- Spine surgery
- Surgical treatment for gender dysphoria
- Transplant and transplant related services
- Transplant (tissue and organs)
- Unlisted codes over \$5,000
- Partial hospitalization program

¹ This list is not all-inclusive. Please refer to your summary plan description (SPD) for a full list of services requiring prior authorization.

² Except stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a cesarean section.

Note: Customizations are subject to add-on pricing.

Prior authorization list subject to change at any time.

Cost-reducing prior authorization services

Early intervention can often lead to claims cost reduction. Through our prior authorization process, we work to ensure procedures are medically necessary and assigned a duration. Cases that might be deemed "high risk" are forwarded to our Complex Condition CARE or Ongoing Condition CARE programs for further review. Triggers for analysis include ICD diagnosis codes, CPT procedure codes, length-of-stay criteria and claims dollar thresholds, as well as specific criteria requested by clients or stop loss carriers.



For more information about the Utilization Management program, contact your UMR representative.

