



2026 Utilization Management Program Description

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Accreditation and Regulatory References

National Committee for Quality Assurance 2025 Health Plan Standards
• UM1 Element A

State and federal laws and regulations

Approval signature: *Paul Johnson, M.D.*

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Overview

This utilization management program description defines the structure of our UM programs for members of Blue Cross and Blue Shield of Montana with:

- Individual and family market on-exchange marketplace and off-exchange products
- Fully insured commercial groups

The following information:

- Provides a clear definition of authority and accountability within the organization
- Articulates the scope and content of the program
- Identifies the roles and responsibilities of individuals involved
- Outlines the program evaluation

In the case where UM is delegated, oversight is conducted to ensure delegated programs meet requirements. This includes annual review and approval of the delegate's UM program description.

UM program structure

The UM program is structured to maximize the effectiveness of care and services by ensuring appropriate access to quality and cost-effective care for members.

Medical management UM is integrated with our Quality Improvement Committee, and behavioral health UM is integrated with our Behavioral Health Quality Improvement Committee. This promotes objective and systematic monitoring and evaluation of processes and services within our overall care management program.

Medical management seamlessly interfaces with behavioral health colleagues face to face, by phone and electronically. UM activities are conducted in compliance with applicable legal, regulatory and accreditation standards and are developed with input from corporate committees with subject matter expertise, along with corporate legal and regulatory input.

Program objectives

UM processes support members in accessing services available to them through their benefit plans. The main objective is to identify and avoid unnecessary services before services are rendered and to identify alternatives. This fosters appropriate health care practice patterns, improved quality of care and cost containment.

The UM program facilitates:

- Equitable member access to appropriate, quality and affordable delivery of care, programs and services
- Evidence-based and timely utilization decisions that accommodate the clinical urgency of the situation
- Individual consideration of criteria for members with special circumstances or complex conditions using ASAM Criteria, MCG care guidelines and our medical policies
- Special circumstances include, but are not limited to, availability of specified level of care, member unique cultural preferences and individual needs of the specific case
- Benefit determinations that are fair, impartial, consistent and easily interpreted by members and providers

Program scope

Definitions

Utilization review

Utilization review means a set of formal techniques designed to monitor the use of or to evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

Techniques may include ambulatory review, prospective review, second opinions, certification, concurrent review, case management, discharge planning or retrospective review.

Prior authorization/recommended clinical review

Two types of preservice reviews are used to assess benefits and medical necessity – prior authorization and recommended clinical review. The primary difference is that prior authorization is required for certain services, whereas recommended clinical review is voluntary for services subject to medical necessity review, but that do not require prior authorization.

Once requested, prior authorizations and recommended clinical reviews are processed in the same manner including, but not limited to, reviewer qualifications to approve and deny and notification of determinations. Because they condition receipt of benefits upon a review before a service is rendered, prior authorization reviews include appeal rights.

Neither prior authorization nor recommended clinical review guarantee benefits or payments. The following control the available benefits:

- The member's coverage eligibility at the time of service;
- Changes in the member's condition between the prior authorization or recommended clinical review and the actual rendering of services;
- Rendering of services different than those that were the subject of the prior authorization or recommended clinical review request; and
- The terms of the member's plan

Medical necessity

Medical necessity means health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing or relieving a health condition, illness, injury or disease or its symptoms and that are:

- In accordance with generally accepted standards of practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

Authorized representative

With respect to a benefit, claim or an appeal of an adverse benefit determination, authorized representative means a person to whom a covered person has given express written consent to represent the covered person; a person authorized by law to provide substituted consent for a covered person; a family member of the covered person; or the covered person's treating health care provider only if the covered person is unable to provide consent.

UM program staffing

Non-clinical staff

Non-clinical staff with training in care management may process all incoming calls, provide member eligibility and benefit information, and facilitate member access to appropriate providers and facilities. Non-clinical staff members do not conduct utilization review.

UM clinical staff (preservice, concurrent, post-service/retrospective)

Medical management UM coordinators: Licensed registered nurses utilize their medical knowledge and expertise to review requests for admissions and level of care, procedures and services according to established standard operating procedures.

Behavioral health care coordinators: Licensed clinical practitioners (registered nurse or master's-level behavioral health professional) who are licensed to practice at the independent level assess treatment progress, authorize benefits for treatment services utilizing clinical criteria and offer care collaboration during the active treatment and review appeals.

Pharmacy reviewer: Licensed, registered pharmacists conduct preservice review of outpatient provider administered drug therapies, cellular immunotherapy, gene therapy and other medical benefit drug therapies

Physician reviewer (preservice, concurrent, post-service/retrospective)

Physician reviewer medical management: Licensed, board certified doctor of medicine, doctor of osteopathy, doctor of podiatric medicine or doctor of dental medicine. Physician reviewers evaluate cases for medical necessity determinations based on medical knowledge, experience and current standards of practice. In addition, physician reviewers conduct peer-to-peer reviews with providers, if requested. Physician reviewers are available during standard business hours for consultation with providers and UM staff. The review in connection with an appeal of a clinical-based denial is conducted by an appropriate physician reviewer who was not involved in or a subordinate of anyone involved in any previous non-authorization (denial/adverse) determination

pertaining to the same episode of care and who is located in a state or territory of the U.S. when conducting an appeals review. The physician reviewer will be in the same profession and in a similar specialty as typically manages the medical, behavioral health or dental conditions, procedures or treatments under review.

Behavioral health physician reviewer: Licensed, board certified psychiatrists or board certified in a specialty other than psychiatry with additional background and training in substance misuse or addiction treatment. Physician reviewers perform the physician review role. This includes peer initial or second level medical necessity reviews as well as appeal reviews. Behavioral health physician reviewers are available for case consultation with providers to assist in finding the most appropriate level and type of care for each member.

Psychologist reviewer (peer clinical reviewer): Possesses a doctorate degree in psychology, with a current, valid license to practice psychology. Psychologists are responsible for review of psychological testing requests and determine medical necessity of testing requested, clinical appropriateness of tests and hours requested for testing being authorized. They conduct and document peer consultations in regard to psychological testing requests and review of outpatient therapy cases using a focused outpatient care management model. The behavior health psychologist can also be a board-certified behavior analyst doctoral level certified by the Behavior Analyst Certification Board to independently practice Applied Behavior Analysis. This psychologist is responsible for review of ABA requests and determining the medical necessity of ABA therapy requested and the clinical appropriateness of hours requested for authorized ABA therapy. This reviewer conducts and documents peer consultations in regard to ABA requests and reviews ABA treatment documentation using a prior authorization model. The behavior health psychologist may serve as a peer. Clinical reviewer is making initial adverse determinations for outpatient requests when they are in the same licensure category as the ordering provider. All appeal determinations will be made by a behavioral health physician reviewer.

Clinical review criteria

UM clinicians utilize ASAM, MCG care guidelines and medical policy of BCBSMT to determine the following:

- Medical necessity of the requested care;
- Appropriateness of the location and level of care;
- Appropriateness of the length of stay, including diagnosis related group criteria; and
- Assignment of the next anticipated review point

Requests that do not meet ASAM, MCG care guidelines, medical policy of BCBSMT and/or potential contract exclusions are referred to physician reviewers or peer clinical reviewers for determination.

The ASAM Criteria

These treatment criteria for addictive, substance-related and co-occurring conditions are utilized as the behavioral health clinical screening criteria for patients with addiction disorders for all levels of care.

The ASAM criteria are designed to support multidimensional assessments and treatments, attending to the multiple needs of each person and not just their alcohol or drug use. There is also a greater emphasis on the need for integrated care, addressing both the mental and physical health disorders present in patients with addictions.

The ASAM criteria are evaluated at least annually or earlier if new data regarding indications or technologies becomes available. The criteria are presented annually to the Behavioral Health Quality Improvement Committee.

MCG care guidelines

MCG care guidelines are nationally recognized clinical criteria utilized to screen and evaluate for medical necessity and appropriateness of services, in accordance with the terms of the member's health benefit plan. MCG care guidelines are explicitly written and evidence-based, created by practicing clinicians and based on current clinical principles and processes.

MCG care guidelines are evaluated annually or earlier if new data regarding indications or technologies becomes available and is approved by

our chief medical officer or delegate. Our Quality Improvement Committee and Behavioral Health Quality Improvement Committee are informed of the MCG criteria version updates annually.

Clinical review staff use MCG care guidelines to review requests for medical, surgical and behavioral health procedures and services and inpatient admissions (preservice and concurrent care) not completed through the automated web platform.

Medical policy/technology assessment

Our medical policies contain the comprehensive body of evidence that supports current standards of clinical practice and establish medical necessity of certain clinical services, procedures, technology and medications covered under the medical benefit.

Our medical policies reflect treatment guidelines supported by:

- Unaffiliated nonprofit professional associations for the relevant clinical specialty (e.g., the American Society of Addiction Medicine),
- Third party entities that develop and regularly update clinical guidelines consistent with generally accepted standards of care (e.g., MCG care guidelines), and/or,
- Other federal or state governmental agencies involved in review of clinical standards for the industry (e.g., the Centers for Medicare & Medicaid Services). Clinical review staff use current, explicit and written medical policies of BCBSMT as guides to assist with benefit determinations regarding new technology, medical procedures, behavioral health care procedures, pharmaceuticals and devices.

UM process

Process overview

Medical management preservice, concurrent, post-service/retrospective services: UM personnel are accessible to members and providers during the business hours of 8 a.m. to 5 p.m. Monday through Friday, except legal holidays. A confidential voicemail is available for after-hours messages. UM personnel reply to after-hours messages within one business day. Requests for health care services are reviewed and a determination made regarding the authorization or denial of those services within the time frames based on the urgency of the member's condition as required by applicable law/regulation.

Requests not completed via the automated web platform for elective or emergent inpatient admissions, select outpatient services, coordinated home care and home infusion therapy services and transplants are reviewed through the utilization review process. Emergency care services for screening and stabilization do not require prior authorization. Non-clinical UM intake staff may complete requests that meet the automated web platform approval guidelines for diagnoses and procedures that do not require clinician review. This is a clerical function to facilitate claims payment and is not based on medical necessity or use or consideration of clinical information.

Behavioral health care management services:

The program's care management services are accessible 24 hours a day, seven days a week for all time zones for prior authorization requests by telephone. Members, professional providers and facilities may access the behavioral health unit using a toll-free telephone number. Normal service hours are 7 a.m. to 5 p.m. Monday through Friday.

After hours, clinicians and psychiatrists are available to provide emergency inpatient prior authorization. Members indicating that they require immediate medical assistance are referred to network providers. If network providers are not available, members will be referred to an appropriate out-of-network provider. Behavioral health care management does not perform clinical triage and referral of members. Members who are in crisis outside of normal service hours are immediately

connected with a licensed care coordinator, who will assist the member in directing them to the nearest emergency room or, when necessary, reaching out to emergency medical personnel as appropriate.

Policies and procedures

All aspects of UM activities and operations are governed by written policies and procedures, which are maintained in our UM department. Program policies and procedures are formally reviewed and approved annually and as indicated when revised. Initial policy approval is issued by the Plan Policy and Procedure Committee, with final approval issued by our Quality Improvement Committee or the Behavioral Health Quality Improvement Committee, as applicable. Policies are developed to support ongoing compliance with all state and federal agency laws and accreditation organization standards.

The application of the ASAM, MCG care guidelines and our medical policy by utilization management coordinators, licensed pharmacists, behavioral health care coordinators, psychologists and physician reviewers facilitate collection of pertinent information required to review the request and determine the following:

- Medical necessity of the requested procedure or service;
 - Appropriateness of the treatment setting and level of care;
 - Appropriateness of the length of stay (including diagnosis related group criteria);
 - Appropriateness of the duration of service; and
 - Assignment of the next anticipated review point
- UM clinicians document and accept clinical information from multiple reliable sources for assistance in making coverage determinations. Sources include but are not limited to verbal information from the physician, medical office and facility personnel as well as provider office and facility medical record information. This information is used to determine whether established clinical criteria are met for the requested service. The UM clinicians and clinical reviewers may approve requests that meet established ASAM Criteria, MCG care guidelines and/or our medical policy.

Requests that do not meet ASAM Criteria, MCG care guidelines, our medical policy and/or that are potential contract exclusions are referred to physician reviewers or behavioral health physician reviewers (or a behavioral health psychologist when applicable) for determination unless the request is an absolute contract exclusion. A physician reviewer is available to UM clinicians, and behavioral health physician reviewers or behavioral health psychologists are available to behavioral health care coordinators to discuss determinations based on medical appropriateness. All adverse determinations are communicated in writing to the member or authorized individual acting on behalf of the member and the member's provider of record, including the health care provider who requested the service. If members and/or providers are not satisfied with the outcome of the decision, they have the right to an appeal. Adverse determinations may only be determined by a physician or other health care provider with appropriate credentials to determine medical necessity or appropriateness, or the experimental or investigational nature of health care services.

Discharge planning

Discharge planning is an ongoing essential part of UM processes. Discharge planning is the process of assessing a member's needs for appropriate and timely discharge. This process involves evaluation of the member's benefits, the member's support and member's family support of the discharge from the inpatient setting to home or to a less acute setting as well as the provider's assessment of the member's health care needs following discharge.

Referral management

UM coordinators, behavioral health care coordinators, psychologists and physician reviewers and behavioral health physician reviewers evaluate out-of-network referral requests for appropriateness. Requests for coverage of out-of-network provider services at in-network benefits may be evaluated when a member has a special circumstance in which the current health care treatment plan cannot be interrupted without disrupting the continuity of care or decreasing the quality of the outcome of that care, or in circumstances under which the most appropriate treatment for the member's condition is not available in network.

Automated web platform prior authorization/recommended clinical review notification program

The automated web platform is utilized for submission and notification of referrals, and select inpatient admissions and outpatient services, 24 hours a day, seven days a week for network providers and facilities. Physicians or facility personnel may input data, such as diagnosis and procedure codes, and submit medical records to request a review for referrals and prior authorization/recommended clinical reviews. Customization of the automated web platform system allows routing of out-of-network referrals, select inpatient prior authorizations and outpatient service requests that require further review to the appropriate UM personnel.

Retrospective (post-service) review

A retrospective (post-service) UM review occurs after the service is rendered. During a post-service utilization management review, UM clinicians review clinical documentation and information to determine whether a service, drug, procedure, treatment or test was medically necessary, was not experimental or investigational, and was covered under the member's benefit plan.

Appeals

Appeals are formal written or verbal requests for a review of an adverse benefit determination, which includes denials, reduction of benefits or termination of, or a failure to provide or make a payment (in whole or in part) for a service. Adverse benefit determinations may be based on the lack of medical necessity for a service for a specific member, the experimental or investigational nature of a service or instances where a service is not a covered benefit (contract exclusion), or due to network exclusions or other limitations on otherwise covered benefits.

Appeal rights are provided at the time of the adverse benefit determination notification and are available upon request to any member or the authorized representative of the member, which may include the provider or facility rendering the service.

Requests for appeal may be initiated by telephone, fax or in writing. Appeals are accepted from the member or the authorized representative of the member, which may include the provider, facility rendering the service or an attorney.

Conflict of interest

Policies and procedures have been established to ensure no conflict of interest occurs during case review. BCBSMT retained physicians or non physician reviewers may not review a case in which there may be a conflict of interest. Conflicts of interest may be either personal or financial in nature. Employees must review and sign the Conflict of Interest policy upon hire and annually thereafter.

Delegation of review

BCBSMT may elect to have prior authorization, concurrent review, retrospective review, referral management, appeals or discharge planning performed by another entity. If any UM activities are delegated, the entity must meet the following criteria:

- Comply with plan program standards
- Comply with all federal and state laws, regulatory and accrediting agency standards that provide certification and accreditation of the UM program
- Allow oversight by UM personnel, including an annual assessment/audit
- Provide regular reports of review and quality improvement activity as required

Note: Delegation of utilization review activities does not relieve BCBSMT of full responsibility for compliance with Montana Commissioner of Securities and Insurance regulations for utilization review agents, including the conduct of those to

whom utilization review has been delegated. Delegation of the UM program does not relieve BCBSMT of full responsibility for compliance with accreditation standards and/or federal and state regulatory requirements.

Confidentiality

Policies and procedures have been established to ensure the confidentiality of patient information. Internal policies on confidentiality are outlined in employee and management handbooks, corporate policy manual and Health Insurance Portability and Accountability Act privacy policies. Employees receive training upon hire and must also sign a confidentiality statement during corporate orientation and annually thereafter.

UM program role in the quality improvement program

The UM program is integrated with the plan quality improvement program, and the behavioral health UM program is integrated with the behavioral health quality program. Both programs promote objective monitoring and evaluation methods that are based on the use of clinical and service indicators.

The quality improvement program oversees the following activities:

- Quality of clinical care projects
- Quality of service projects
- Safety of clinical care projects
- Member experience surveys
- Primary care provider and practitioner surveys
- UM complaints
- Utilization data

Annually, the UM program clinical and service indicators and initiatives are evaluated based on outcomes and any federal and state regulatory changes.

Provider, practitioner and member education of UM requirements and member beneficiary health plan reference

There are multiple resources available to educate providers, practitioners and members on utilization review requirements. Having multiple modalities allows the provider, practitioner or member to engage in ways that are meaningful to them. Resources may include, but are not limited to:

Provider and practitioner education

Provider and practitioner educational tools are developed to enhance provider knowledge of the UM program and utilization review requirements. Education is provided by the following means:

- Educational programs;
- Quick reference guides;
- Newsletters and bulletins;
- Provider manuals;
- Website, which provides access to resources including our medical policies and UM prior authorization requirements; and
- Evidence-based guidelines of care

Member education

Member educational materials are developed to increase knowledge and encourage active participation when making informed decisions regarding health care options. Member educational materials include:

- Member guide/handbooks (member rights and responsibilities);
- Health and wellness information;
- Contract booklets (prior authorization requirements);
- Provider directories;
- Web-based education; and
- Website, including:
 - Utilization review – Prior authorization and recommended clinical review information
 - Sample policy documents for qualified health plans on and off exchange, standard insured plans and custom large group plans are available

Members with disabilities, special needs or language barriers, and their authorized representatives, can request this information via alternate means or in another language.

UM program evaluation and authority

The chief medical officer of BCBSMT provides clinical supervision and oversight, and participates in the development, implementation and evaluation of the medical management UM program.

The CMO of behavioral health provides clinical oversight and participates in the development, implementation and evaluation of the behavioral health UM program.

The CMO of BCBSMT, Quality Improvement Committee and Behavioral Health Quality Improvement Committee perform review and approval of the UM policies and procedures annually and when updates occur.

Utilization goals are established using recognized benchmarks and are approved by the designated Quality Improvement Committee and Behavioral Health Quality Improvement Committee. Potential and actual trends of over- and underutilization and interventions to improve utilization are reported to our Quality Improvement Committee and Behavioral Health Quality Improvement Committee, respectively. The committees make recommendations as applicable and approve interventions to improve utilization trends.

The UM program description is updated at least annually and approved by the CMO and the Quality Improvement Committee. The Behavioral Health Care Management Program description is reviewed and approved by the Behavioral Health Quality Improvement Committee at least annually.

Ultimate authority and oversight of the UM program for BCBSMT rests with our Quality Improvement Committee.

Attachment 1: Dental utilization review program – Dental Network of America

Criteria

BCBSMT uses the following criteria for its utilization review activities in general. Any entities to which BCBSMT delegates utilization review activities are required to use the same criteria for business of BCBSMT.

Business of BCBSMT means fully insured individual and group blocks of business of BCBSMT and its third-party administrative services business.

- MCG criteria for observation level of care and medical/surgical inpatient admission review, rehabilitation, sub-acute, long-term care reviews and psychiatric care both inpatient and outpatient.
- Medical policy of BCBSMT. The complete medical policy manual is on our provider website.
- The American Society of Addiction Medicine Criteria is utilized as the behavioral health clinical screening criteria for patients with addiction disorders for all levels of care.
- Dental policies, criteria from Dental Networks of America.

Purpose

This DNoA utilization review plan shall define the policies, standards, criteria and procedures followed when processing and paying dental claims for and on behalf of BCBSMT.

Responsibility

All dental claims processing personnel and dental consultants shall be required to follow these criteria and procedures.

Utilization review application

Dental benefits are rendered by contracted and non-contracted dentists who are compensated for services on a fee-for-service basis. Even though dentists are not required to submit claims for prior authorization of services, utilization review occurs both prospectively and retrospectively.

Adverse determinations

A decision to deny or partially deny a claim payment is an adverse benefit determination. BCBSMT maintains appeal and review procedures for members and providers who wish to appeal or dispute an adverse benefit determination.

Dentally necessary

Dentally necessary services are services that are medically necessary and appropriate for the diagnosis or treatment of a member's dental condition according to accepted standards of dental practice and that are not provided only as a convenience. Most utilization decisions are limited to determinations of whether services are covered under the terms of the plan contract. Evidence of coverage documents distributed to enrollees of BCBSMT include a list of covered dental services, exclusions, limitations and other relevant information that define member dental benefits. A denial or rejection of a prior authorization or payment request in most instances indicates only that the service is either not a covered service or is subject to an exclusion and/or limitation. The determination is not intended to reflect any opinion of whether the service is medically/dentally required.

BCBSMT abides by applicable federal and state laws and regulations concerning utilization review and medical/dental necessity determinations. Medical/dental necessity decisions are made with the input and expertise of a dental consultant, who:

- Is in possession of an active and unrestricted license to practice dentistry; and
- Requests information relevant to the dental condition and bases decisions upon standards that are objective, valid and consistent with accepted professional standards for dentistry.

Dental recommended clinical review of BCBSMT

A recommended clinical review is recommended for some services to help providers and members avoid unexpected expenses, benefit reductions or claim denials. Coverage for medically necessary services, supplies or treatment is determined through the recommended clinical review process. If a recommended clinical review is not obtained, a retrospective review is performed to determine whether the services, supplies or treatment were medically necessary or were a benefit of the member's contract.

Documentation requirements

The recommended clinical review process may require additional documentation from the dental services provider for some services and should include:

- Pertinent documentation explaining the proposed services;
- Functional aspects of the treatment;
- Projected outcome;
- Treatment plan and any other supporting documentation (e.g., study models, photographs and x-rays); and
- Appropriate Current Dental Terminology codes