1 **1020 UTILIZATION MANAGEMENT**
2
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6 REFERENCES: 42 CFR 412.87; 42 CFR 435.1010; 42 CFR 438.3;42 CFR
7 438.114(a); 42 CFR 438.208(b)(2)(i); 42 CFR 438.210; 42 CFR 438.210(b);
8 42 CFR 438.210(d)(2)(i); 42 CFR 438.236; 42 CFR 438.240(b)(3); 42 CFR
9 447.26; 42 CFR 456.125; 42 CFR 457.1230(c); 42 CFR 457.1230(d); 42
10 CFR 457.1233(c); A.R.S. § 13-3994; A.R.S. § 31-501; A.R.S. § 36- 401;
11 A.R.S. § 36-501; A.R.S. § 36-551; A.R.S. § 38-211; A.R.S. §1902(a)(31);
12 A.A.C. R9-10-101; A.A.C. R9-22-101; A.A.C. R9-28-201; A.A.C. R9-201;
13 Contractor Chart of Deliverables; AMPM Policy 310; AMPM Attachment 1020-
14 A; AMPM Attachment 1020-B; ACOM 110; ACOM 414; Div Ops 414; Provider
15 Chapter 17; National Committee for Quality Assurance; Case Management
16 Long Term Services and Supports; Standard 4.
17
18 **PURPOSE**
19
20 This policy outlines utilization management functions provided by
21 the AdSS to ensure appropriate utilization of health care resources, in the
22 amount and duration necessary to achieve desired health outcomes, across
23 the continuum of care from preventative care to hospice, including Advance
24 Care Planning at any age or stage of illness. This policy also
25 addresses how the AdSS identifies opportunities for improvement in
26 utilization management.
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29 **DEFINITIONS**
30
31 1. "Behavioral Health Inpatient Facility" or "BHIF" means a health
32 institution, as specified in A.A.C. R9-10-101, that provides
33 continuous treatment to an individual experiencing a behavioral
34 health issue that causes the individual to:
35 a. Have a limited or reduced ability to meet the individual's
36 basic physical needs;
37 b. Suffer harm that significantly impairs the individual's
38 judgment, reason, behavior, or capacity to recognize
39 reality;
40 c. Be a danger to self;
41 d. Be a danger to others;
42 e. Be an individual with a persistent or acute disability as
43 specified in A.R.S § 36-501; or
44 f. Be an individual with a grave disability as specified in
45 A.R.S. § 36-501.

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46 2. "Behavioral Health Residential Facility" or "BHRF" means, as
47 specified in A.A.C. R9-10-101, a health care institution that
48 provides treatment to an individual experiencing a behavioral
49 health issue that:
50 a. Limits the individual's ability to be independent, or
51 b. Causes the individual to require treatment to maintain or
52 enhance independence.

53 3. "Business Day" means 8:00 a.m. to 5:00 p.m., Monday through
54 Friday, excluding holidays listed in A.R.S. § 1-301.

55 4. "Care Management" means a group of activities performed to
56 identify and manage clinical interventions or alternative
57 treatments for identified Members to reduce risk, cost, and help
58 achieve better health outcomes. Distinct from Support
59 Coordination, Care Management does not include the day-to-day
60 duties of service delivery.

61 5. "Concurrent Review" means the process of reviewing an
62 institutional stay at admission and throughout the stay to
63 determine medical necessity for an institutional Level of Care

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64 (LOC). Reviewers assess the appropriate use of resources, LOC,
65 and service, according to professionally recognized standards of
66 care. Concurrent Review validates the medical necessity for
67 admission and continued stay and evaluates for Quality Of Care
68 (QOC) concerns.

69 6. "Denial" means the decision to deny a request made by, or on
70 behalf of, an individual for the authorization or payment of a
71 covered service.

72 7. "Health Care-Acquired Condition" or "HCAC" means a condition
73 that occurs in any inpatient hospital setting and is not present on
74 admission (Refer to the current Centers for Medicare and
75 Medicaid Services (CMS) list of Hospital-Acquired Conditions).

76 8. "Institution for Mental Disease" or "IMD" means a hospital,
77 nursing facility, or other institution of more than 16 beds that is
78 primarily engaged in providing diagnosis, treatment, or care of
79 individuals with mental diseases (including substance use
80 disorders), including medical attention, nursing care and related

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services. Whether an institution is an Institution for Mental Diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an Institution for Mental Diseases as specified in 42 CFR 435.1010.

9. "Institutional Setting" means:
   a. A nursing facility as specified in 42 U.S.C. 1396 r(a);
   b. An Institution for Mental Diseases (IMD) for an individual who is either under age 21 or age 65 or older;
   c. A hospice (free-standing, hospital, or nursing facility subcontracted beds) as specified in A.R.S. § 36- 401;
   d. A Behavioral Health Inpatient Facility (BHIF) as specified in A.A.C. R9-10-101; or
   e. A Behavioral Residential Setting (BHRF) as specified in A.A.C. R9-10-101.

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98 10. "Inter-Rater Reliability" or "IRR" means the process of
99 monitoring and evaluating the process of ensuring that multiple
100 observers are able to consistently define a situation or
101 occurrence in the same manner with a level of consistency in
102 decision making and adherence to clinical review criteria and
103 standards.

104 11. "Medication Reconciliation" means the process of identifying the
105 most accurate list of all medications that the patient is taking,
106 including name, dosage, frequency, purpose and route by
107 comparing the medical record to the most current external list of
108 medications obtained from a patient, hospital, or other Provider.

109 12. "Other Provider-Preventable Condition" or "OPPC" means a
110 condition occurring in the inpatient and outpatient health care
111 setting which the Division and Arizona Health Care Cost
112 Containment System (AHCCCS) has limited to the following:
113 a. Surgery on the wrong Member,
114 b. Wrong surgery on a Member, or
115 c. Wrong site surgery.

116 13. "Practitioner" means a certified nurse practitioner in midwifery,
117 physician assistant(s), and other nurse practitioners, physician
118 assistant(s) and nurse practitioners as specified in A.R.S. Title
119 32, Chapters 15 and 25, respectively.

120 14. "Prior Authorization" or "PA" means a process by which the AdSS
121 authorizes, in advance, the delivery of covered services based on
122 factors including but not limited to medical necessity, cost
123 effectiveness, compliance with this policy as specified in A.A.C.
124 R9-201, and any applicable contract provisions. PA is not a
125 guarantee of payment as specified in A.A.C. R9-22-101.

126 15. "Prior Period Coverage" means for Title XIX Members, the period
127 of time prior to the Member's enrollment with an AdSS during
128 which a Member is eligible for covered services. The time frame
129 is from the effective date of eligibility to the day a Member is
130 enrolled with an AdSS.

131 16. "Provider" means any individual or entity contracted with the
132 AdSS that is engaged in the delivery of services, or ordering or

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133 referring for those services, and is legally authorized to do so by
134 the State.

135 17. “Provider-Preventable Condition” or “PPC” means a condition
136 that meets the definition of Health Care-Acquired Condition
137 (HCAC) or an Other Provider-Preventable Condition (OPPC);

138 18. “Qualified Healthcare Professional” means a health care
139 professional qualified to do discharge planning.

140 19. “Responsible Person” means the parent or guardian of a minor
141 with a developmental disability, the guardian of an adult with a
142 developmental disability or an adult with a developmental
143 disability who is a client or an applicant for whom no guardian
144 has been appointed. A.R.S. § 36-551.

145 20. “Retrospective Review” means the process of determining the
146 medical necessity of a treatment/service post-delivery of care.

147 21. “Support Coordination” means a collaborative process which
148 assesses, plans, implements, coordinates, monitors, and
149 evaluates options and services to meet an individual’s health

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150 needs through communication and available resources to
151 promote quality, cost-effective outcomes.

152 **POLICY**
153
154 **A. CLINICAL CRITERIA FOR UTILIZATION MANAGEMENT**
155 **DECISIONS**

156 1. The AdSS shall have written criteria that is objective, evidence
157 based, and takes individual circumstances and the local medical
158 services into account when determining the medical
159 appropriateness of healthcare services.

160 2. The AdSS shall have written criteria that includes:
161 a. Written policies for applying the criteria based on Member
162 needs,
163 b. Written policies for applying the criteria based on an
164 assessment of the local medical services,
165 c. Involving appropriate Providers in developing, adopting,
166 and reviewing criteria, and
167 d. Reviewing the criteria and procedures for applying the

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168 criteria annually and updating the criteria when
169 appropriate.
170

171 **B. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT**

172 1. The AdSS shall have a Utilization Management (UM) program
173 that reports to the Division's Medical Management (MM)
174 committee and involves a designated senior-level physician and
175 behavioral healthcare Provider in the implementation of physical
176 and behavioral healthcare aspects.

177 2. The AdSS shall develop and implement policies and processes to
178 review utilization and detect both underutilization and
179 overutilization of services.

180 3. The AdSS shall develop and implement policies and processes to
181 collect, validate, analyze, monitor, and report the Division's
182 enrollment utilization data for AdSS Members.

183 4. The AdSS' Medical Management (MM) Committee shall annually
184 and on an ongoing basis, review and evaluate the utilization data

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185 and make or approve recommendations for implementing actions
186 for improvement when variances are identified.

187 5. The AdSS MM Committee shall include in their utilization data
188 evaluation a review of the impact to both service quality and
189 outcome.

190 6. The MM Committee shall determine, based on its review, if
191 action (new or changes to current intervention) is required to
192 improve the efficient utilization of health care services.

193 7. The AdSS shall integrate intervention strategies throughout each
194 AdSS to address both over and underutilization of services.

195 8. The AdSS shall meet with the Division Health Care Services
196 (HCS) quarterly to review the Medical Management Committee
197 minutes, reports with data analysis and action plans, over and
198 underutilization, outliers, and opportunities for performance
199 improvement.

200

201 **C. CONCURRENT REVIEW**

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202 1. The AdSS shall have policies, procedures, processes, and criteria
203 in place that govern the use of services during short-term and
204 long-term hospital and institutional stays to ensure that the
205 Member continues to receive reasonable, appropriate care in the
206 right health care setting to meet the Member's health care
207 needs.

208 2. The AdSS shall have procedures for review of medical necessity
209 before a planned institutional admission (pre-certification) and
210 for determination of the medical necessity for ongoing
211 institutional care (Concurrent Review).

212 3. The AdSS shall have policies and procedures for the Concurrent
213 Review process that:
214 a. Include the following clinical information when making
215 hospital length of stay decisions:
216 i. Symptoms,
217 ii. Diagnostic test results,
218 iii. Diagnoses, and
219 iv. Required services.

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220 b. Specify time frames and frequency for conducting
221 Concurrent Review and decisions;

222 c. Review authorization for institutional stays that have a
223 specified date for the need for continued stay based on the
224 expected course of the stay and medical necessity

225 4. The AdSS shall conduct admission reviews within one Business
226 Day after notification is provided to the AdSS by the hospital or
227 institution (this does not apply to pre-certifications).

228 5. The AdSS shall provide a process for review that includes:
229 a. Necessity of admission and appropriateness of the service
230 setting;

231 b. Quality of care;

232 c. Length of stay;
233 d. Whether services meet the Member needs;

234 e. Discharge needs; and
235 f. Utilization pattern analysis.

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236 6. The AdSS shall establish a method for their participation in the
237 proactive discharge planning of all Members in hospitals and
238 Institutional Settings.

239 7. The AdSS shall establish a proactive discharge planning process
240 that demonstrates communication with the Division's support
241 coordinator assigned to the Member.

242 8. Criteria for decisions on coverage and medical necessity shall be
243 documented and based on reasonable medical evidence or a
244 consensus of relevant health care professionals.

245 9. The AdSS' Medical Management Committee shall annually
246 approve the medical criteria used for Concurrent Review,

247 10. The AdSS shall adopt the medical criteria from the national
248 standards.

249 11. The AdSS shall have the medical criteria approved by the
250 Division's MM Committee.

251 12. The AdSS shall compare the Member's medical information
252 against medical necessity criteria that describe the condition or

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253 service when providing Concurrent Review.

254 13. The AdSS shall base initial institutional stays on:

255 a. AdSS adopted criteria,

256 b. The Member's specific condition, and

257 c. The projected discharge date.

258 14. The AdSS shall base continued stay determinations on written
259 medical care criteria that assess the need for the continued stay.

260 15. The AdSS shall record each continued stay review date in the
261 Member's record.

262 16. The AdSS shall assign a new review date each time the review
263 occurs for an extension of a medical stay.

264 17. The AdSS shall include proactive discharge planning between all
265 potential payment and care sources starting within one day of
266 admission, and shall continue proactive discharge planning after
267 completion of the institutional stay.

268 18. The AdSS shall submit the "Contractor Quarterly Showing Report

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269 for Inpatient Hospital Services" quarterly as specified in the
270 Contract, after ensuring the report is signed by the AdSS' Chief
271 Medical Officer attesting that:

272 a. A physician has certified the necessity of inpatient hospital
273 services;

274 b. The services were periodically reviewed and evaluated by a
275 physician;

276 c. Each admission was reviewed or screened under a
277 utilization review program; and

278 d. All hospitalizations of Members were reviewed and certified
279 by medical utilization staff.

280

281 **D. DISCHARGE PLANNING**

282 1. The AdSS shall have policies and procedures in place that govern
283 proactive discharge planning and coordination of services
284 between settings of care, including appropriate discharge
285 planning from short-term and long-term hospital and

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286 institutional stays.

287 2. The AdSS shall ensure the discharge planning process is
288 designed to:

289 a. Improve the management of inpatient admissions,
290 b. Reduce unnecessary institutional and hospital stays,
291 c. Meet Member discharge needs, and
292 d. Decrease readmissions within 30 days of discharge

293 3. The AdSS shall develop and implement a discharge planning
294 process that ensures Members receiving inpatient services have
295 proactive discharge planning to identify and assess the post-
296 discharge bio-psychosocial and medical needs of the Member in
297 order to arrange necessary services and resources for
298 appropriate and timely discharge from a facility.

299 4. The AdSS shall allow a Member to remain in an inpatient setting
300 or residential facility in the event that a covered behavioral
301 health service is temporarily unavailable for Members who are
302 discharge ready and require covered post-discharge behavioral

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303 health services or ensure Care Management, intensive outpatient
304 services, Provider case management, or peer service are
305 available to the Member while waiting for the appropriate
306 covered physical or behavioral health services.

307 5. The AdSS shall require an interdisciplinary staffing to be
308 conducted with the inpatient team for care coordination once the
309 Member has been identified as awaiting discharge to the
310 appropriate level of care.

311 6. The AdSS shall require involvement of the Chief Medical Officer
312 or Medical Director for Members experiencing a delay in
313 discharge from Institutional Settings or the Emergency
314 Department.

315 7. The AdSS shall require a proactive assessment of discharge
316 needs is conducted prior to admission, when feasible, or as soon
317 as possible upon admission.

318 8. The AdSS shall have discharge planning performed by a Qualified
319 Healthcare Professional and initiated on the initial Concurrent

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320 Review, updated periodically during the inpatient stay, and
321 continued post discharge to ensure a timely, effective, safe, and
322 appropriate discharge.

323 9. The AdSS staff participating in the discharge planning process
324 shall ensure the Member or Responsible Person:

325 a. Is involved and participates in the discharge planning
326 process;

327 b. Understands the written discharge plan, instructions, and
328 recommendations provided by the facility; and

329 c. Is provided with resources, referrals, and possible
330 interventions to meet the Member's assessed and
331 anticipated needs after discharge.

332 10. The AdSS shall include the following in discharge planning,
333 coordination, and management of care:

334 a. Follow-up appointment with the PCP or specialist
335 within 7 days, unless the Member is discharged to a facility
336 or institution in which they are evaluated by a healthcare

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337 professional based on the needs of the Member;

338 b. Coordination and communication with inpatient and facility
339 Providers for safe and clinically appropriate discharge
340 placement, and community support services;

341 c. Communication of the Member's treatment plan and
342 medical history across the various outpatient Providers,
343 including the Member's outpatient clinical team, Tribal
344 Regional Behavioral Health Authority (TRBHA) and other
345 contractors when appropriate;

346 d. Coordination and review of medications upon discharge to
347 the community or transfer to another facility to ensure
348 Medication Reconciliation occurs; and

349 e. Referral for services as identified in the discharge plan
350 including:

351 i. Prescription medications;

352 ii. Medical Equipment;

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353 iii. Nursing Services;

354 iv. End-of-Life Care related services such as Advance
355 Care Planning;

356 v. Informal or natural supports;

357 vi. Hospice;

358 vii. Therapies (within limits for outpatient
359 physical,occupational and speech therapy visits for
360 Members 21 years of age and older);

361 viii. Referral to appropriate community resources;

362 ix. Referral to AdSS' Disease Management or Care
363 Management (if needed);

364 f. A post discharge follow-up call to the Member or
365 Responsible Person within three Business Days of
366 discharge to confirm the Member's well-being and the
367 progress of the discharge plan unless the Member is
368 discharged to a facility or institution in which they are

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evaluated by a healthcare professional; and

g. Additional follow-up actions as needed based on the Member's assessed clinical, behavioral, physical health, and social needs; and

h. Proactive discharge planning when the AdSS becomes aware of the admission even if the AdSS is not the primary payer.

E. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

1. The AdSS shall have Prior Authorization (PA) staff that include an Arizona-licensed nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or an Arizona-licensed behavioral health professional with appropriate training, to apply the AdSS' medical criteria or make coverage decisions.

2. The AdSS shall develop and utilize a system that includes at least two modes of delivery for Providers to submit PA requests

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387 such as telephone, fax, or electronically through a portal on the
388 AdSS' website.

389 3. The AdSS shall notify Providers who request authorization for a
390 service that they have the option to request a peer-to-peer
391 discussion with the appropriate Medical Director when additional
392 information is requested by the AdSS or when the Prior
393 Authorization (PA) request is denied.

394 4. The AdSS shall allow at least ten Business Days from the date
395 the Provider has been made aware of the Denial for the Provider
396 to request a peer-to-peer discussion and coordinate the
397 discussion with the requesting Provider when appropriate.

398 5. The AdSS shall develop and implement policies and procedures,
399 coverage criteria, and processes for approval of covered
400 services, which include required time frames for authorization
401 determination.

402 6. The AdSS shall respond within 24 hours from the receipt of initial
403 and continuous determinations for standard, and expedited and

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404 medication authorization requests, regardless of the due date
405 falling on a weekend or legal holiday.

406 7. The AdSS shall review all PA requirements for services, items, or
407 medications annually.

408 8. The AdSS shall report the PA review through the MM Committee
409 and include the rationale for any changes made to PA
410 requirements.

411 9. The AdSS shall document the summary of the PA requirement
412 changes and the rationale for those changes in the MM
413 Committee meeting minutes.

414 10. The AdSS shall document and base the criteria for decisions on
415 coverage and medical necessity for both physical and behavioral
416 health services on reasonable medical evidence or a consensus
417 of relevant health care professionals.

418 11. The AdSS shall require decisions regarding behavioral health
419 covered services be compliant with mental health parity.

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420 12. The AdSS shall not arbitrarily deny or reduce the amount,
421 duration, or scope of a medically necessary service solely
422 because of the setting, diagnosis, type of illness, or condition of
423 the Member.

424 13. The AdSS shall place limits on services based on a reasonable
425 expectation that the amount of service to be authorized will
426 achieve the expected outcome.

427 14. The AdSS shall have written procedures for using professionals
428 who are licensed in medical professions with expertise in making
429 medical necessity determinations.

430 15. The AdSS shall provide evidence to the Division that it uses
431 licensed professional staff for conducting medical necessity
432 determinations when completing PA.

433 16. The AdSS shall have criteria in place to make decisions on
434 coverage when the AdSS receives a request for service involving
435 Medicare or other third party payers.

436 17. The AdSS shall provide a decision to a submitted PA request for

437 a medication by telephone, fax, electronically, or other
438 telecommunication device within 24 hours of receipt of the
439 submitted request for PA.

440 18. The AdSS shall send a request for additional information to the
441 prescriber by telephone, fax, electronically, or other
442 telecommunication device within 24 hours of the submitted
443 request when the PA request for a medication lacks sufficient
444 information to render a decision.

445 19. The AdSS shall render a final decision for PA within seven
446 Business Days from the initial date of the request for PA.

447 20. The AdSS Medical Management committee shall determine PA
448 criteria and have it approved by the Division's MM committee.

449 21. The AdSS shall require PA for the following Medical and
450 Behavioral Health Services:

451 a. Behavioral Health Residential Facility (BHRF);

452 b. Non-emergency acute inpatient admissions;

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453 c. Level I BHIF and Residential Treatment Center (RTC)
454 Admissions;
455 d. Elective hospitalizations;
456 e. Elective surgeries;
457 f. Medical equipment;
458 g. Medical supplies, annually;
459 h. Home health;
460 i. Home and Community Based Services (HCBS);
461 j. Hospice;
462 k. Skilled Nursing Facility (SNF);
463 l. Therapies - rehabilitative/habilitative;
464 m. Medical or behavioral health services;
465 n. Emergency alert system services;
466 o. Behavior analysis services;
467 p. Augmentative and Alternative Communication (AAC)

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468 services, supplies, and accessories;

469 q. Non-emergency transportation; and

470 r. Select medications.

471 22. The AdSS shall not require PA for these services or
472 circumstances:

473 a. Services performed prior to eligibility during a Prior Period
474 Coverage time frame.

475 b. Services covered by Medicare or other commercial
476 insurance;

477 c. Emergency medical hospitalization less than 72 hours;

478 d. Emergency admission to behavioral health level 1 inpatient
479 facility, however, notification of the admission to the AdSS
480 shall occur within 72 hours;

481 e. Some diagnostic procedures, e.g., EKG, MRI, CT Scans, x-
482 rays, labs, check the Member's AdSS PA requirements;

483 f. Dental care - emergency and non-emergency, check the

484 Member's AdSS PA requirements;

485 g. Eyeglasses for Members younger than 21 years old;

486 h. Family Planning Services;

487 i. Physician or Specialty Consultations and Office Visits;

488 j. Behavioral Analysis Assessment;

489 k. Prenatal Care;

490 l. Emergency Transportation;

491 m. Non-Emergency Transportation of less than 100 miles; and

492 n. Emergency room visit.

493

494 **F. INTER-RATER RELIABILITY**

495 1. The AdSS shall have in place a process for consistent application
496 of review criteria in making medical necessity decisions that
497 include Prior Authorization (PA), Concurrent Review, and
498 Retrospective Review.

499 2. The AdSS shall perform Inter-Rater Reliability (IRR) testing of all

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500 staff who make medical necessity decisions in PA, Concurrent
501 Review and Retrospective Review at new employee orientation
502 and at least annually thereafter.

503 3. The AdSS shall include a corrective action plan for staff that do
504 not meet the minimum compliance score of 90%.

505 4. The AdSS shall present the IRR testing results to the MM
506 Committee for review and report the approved medical criteria at
507 least annually.

508 5. The AdSS shall provide IRR testing results to the Division at least
509 annually as per the Contract and upon request.

510

511 **G. RETROSPECTIVE REVIEW**

512 1. The AdSS shall conduct a Retrospective Review, which is guided
513 by policies and procedures that:

514 a. Include the identification of health care professionals with
515 appropriate clinical expertise who are responsible for
516 conducting Retrospective Reviews,

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517 b. List services that require Retrospective Review, and

518 c. Specify time frames for completion of the review.

519 2. Criteria for decisions on medical necessity shall be documented
520 and based on reasonable medical evidence or a consensus of
521 relevant health care professionals.

522 3. The AdSS shall use the following Guidelines for Provider-
523 Preventable Conditions (PPC):

524 a. Title 42 CFR Section 447.26 prohibits payment for services
525 related to Provider Preventable Conditions.

526 b. A Member's health status may be compromised by hospital
527 conditions or medical personnel in ways that are
528 sometimes diagnosed as a "complication";

529 c. If it is determined that the complication resulted from an
530 HCAC or OPPC, any additional hospital days or other
531 additional charges resulting from the HCAC or OPPC shall
532 not be reimbursed; and

533 d. If it is determined that the HCAC or OPPC was a result of

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534 an error by a hospital or medical professional, the AdSS
535 conducts a Quality of Care (QOC) investigation and reports
536 the occurrence and results of the investigation to AHCCCS
537 Quality Management.

538

539

540 **H. CLINICAL PRACTICE GUIDELINES**

541 1. The AdSS shall develop or adopt and disseminate practice
542 guidelines for physical and behavioral health services that:
543 a. Are based on valid and reliable clinical evidence or a
544 consensus of health care professionals in that field;
545 b. Consider the needs of Members who are enrolled with the
546 AdSS;
547 c. Are adopted in consultation with contracting health care
548 professionals and national practice standards, or developed
549 in consultation with health care professionals and network
550 Providers and include a thorough review of peer reviewed
551 articles in medical journals published in the United States

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552 when national practice guidelines are not available.

553 d. Are disseminated by the AdSS to all affected Providers
554 and, upon request to the Member or Responsible Person
555 and Members who are not yet enrolled with an AdSS; and

556 e. Provide a basis for consistent decisions for utilization
557 management, Member education, coverage of services,
558 and any other areas to which the guidelines apply.

559 2. The AdSS shall evaluate the practice guidelines through a MM
560 multi-disciplinary committee to determine if the guidelines
561 remain applicable, represent the best practice standards, and
562 reflect current medical standards every two years.

563 3. The AdSS shall document the review and adoption of the practice
564 guidelines as well as the evaluation of efficacy of the guidelines.

565

566 **I. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING**
567 **TECHNOLOGIES**

568 1. The AdSS shall develop and implement written policies and

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569 procedures for evaluating new medical technologies and new
570 uses of existing technology that include an evaluation of benefits
571 for physical and behavioral healthcare services, pharmaceuticals
572 and devices.

573 2. The AdSS shall have policies and procedures that include both a
574 mechanism for MM Committee review on a quarterly basis and a
575 time frame for making a clinical determination when a time
576 sensitive request is made.

577 3. The AdSS shall make a decision in response to an urgent request
578 as expeditiously as the Member's condition warrants and not
579 later than 72 hours from receipt of request.

580 4. The AdSS shall include coverage decisions by Medicare
581 intermediaries and carriers, national Medicare coverage
582 decisions, peer-reviewed literature, and Federal and State
583 Medicaid coverage decisions in its evaluation.

584 5. The AdSS shall evaluate published or unpublished
585 information sources that may establish that a new medical

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586 service or technology represents an advance that substantially
587 improves the diagnosis or treatment of Members.

588 6. The AdSS shall establish:

589 a. Coverage rules, practice guidelines, payment policies,
590 policies and procedures, utilization management, and
591 oversight that allows for the individual Member’s medical
592 needs to be met;

593 b. A process for change in coverage rules and practice
594 guidelines based on the evaluation of trending requests.
595 Additional review and assessment is required if multiple
596 requests for the same technology or application of an
597 existing technology are received;

598 c. A process for documenting the coverage determinations
599 and rationale in the Medical Management Committee
600 meeting minutes; and

601 d. A process for seeking input from relevant specialists and
602 professionals who have expertise in the technology.

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604 **SUPPLEMENTAL INFORMATION**

605 1. The AdSS are responsible for the administration of utilization
606 management activities for all contracted services they provide to
607 Members served by the Division.

608 2. Expedited PA requests shall meet Federal standards, because a
609 delay in processing could seriously jeopardize the Member's life,
610 health, or ability to attain, maintain or regain maximum function.
611 If the PA request does not meet the criteria for an expedited
612 request, the requesting Provider will be notified and given the
613 opportunity to provide additional clinical information to support
614 the expedited request status. However, if the additional clinical
615 information does not support an expedited request, the PA
616 request will be processed as a standard request within the
617 specified timelines.

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620 Signature of Chief Medical Officer:

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626 ~~**1020 UTILIZATION MANAGEMENT**~~
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628 ~~REVISION DATE: 1/25/2023, 7/20/2022, 10/1/2021, 8/4/2021~~
629 ~~EFFECTIVE DATE: October 1, 2019~~
630 ~~REFERENCES: A.R.S. § 13-3994, A.R.S. § 31-501, A.R.S. § 36-551, A.R.S.~~
631 ~~§38-211; A.A.C. R9-201, 42 CFR 435.1010, 438.3, 438.114(a), 438.210,~~
632 ~~438.236, 438.240(b)(3), 447.26, 456.125; Section F3, 42 CFR Part 457, and~~
633 ~~42 CFR Part 438, Contractor Chart of Deliverables; AMPM Policy 310, AMPM~~
634 ~~Attachment 1020-A, AMPM Attachment 1020-B~~
635
636 ~~**PURPOSE**~~
637 ~~This policy applies to the Division's Administrative Services Subcontractors~~
638 ~~(AdSS). This policy outlines utilization management functions provided by~~
639 ~~the AdSS to ensure effective treatment services and coordination of care are~~
640 ~~furnished that achieve optimal outcomes for members. The policy also~~
641 ~~addresses how the AdSS identifies opportunities for improvement in~~
642 ~~utilization management.~~

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~~DEFINITIONS~~

1. ~~"Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.~~

2. ~~"Concurrent Review" means the process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional Level of Care(LOC). Reviewers assess the appropriate use of resources, LOC,and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates for Quality Of Care(QOC).~~

3. ~~"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of~~

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661 ~~immediate medical attention to result in:~~

662 ~~a. Placing the patient's health (or, with respect to a pregnant~~
663 ~~woman, the health of the woman or her unborn child) in serious~~
664 ~~jeopardy;~~

665 ~~b. Serious impairment to bodily functions;~~

666 ~~c. Serious dysfunction of any bodily organ or part [42 CFR~~
667 ~~438.114(a)]; or~~

668 ~~d. Serious physical harm to another individual (for behavioral~~
669 ~~health conditions).~~

670 ~~4. "Health Care Acquired Condition (HCAC)" means a condition that~~
671 ~~occurs in any inpatient hospital setting and is not present on admission~~
672 ~~(Refer to the current Centers for Medicare and Medicaid Services~~
673 ~~(CMS) list of Hospital-Acquired Conditions.)~~

674 ~~5. "Institution for Mental Disease (IMD)" means a hospital, nursing~~
675 ~~facility, or other institution of more than 16 beds that is primarily~~
676 ~~engaged in providing diagnosis, treatment, or care of individuals with~~
677 ~~mental diseases (including substance use disorders), including medical~~
678 ~~attention, nursing care and related services. Whether an institution is~~

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679 ~~an institution for mental diseases is determined by its overall character~~
680 ~~as that of a facility established and maintained primarily for the care~~
681 ~~and treatment of individuals with mental diseases, whether or not it is~~
682 ~~licensed as such. An institution for Individuals with Intellectual~~
683 ~~Disabilities is not an institution for mental diseases as specified in 42~~
684 ~~CFR 435.1010.~~

685 ~~6. "Institutional Setting" means:~~
686 ~~a. A nursing facility as specified in 42 U.S.C. 1396 r(a);~~
687 ~~b. An Institution for Mental Diseases (IMD) for an individual who is~~
688 ~~either under age 21 or age 65 or older;~~
689 ~~c. A hospice (free-standing, hospital, or nursing facility~~
690 ~~subcontracted beds) as specified in A.R.S. § 36- 401;~~
691 ~~d. A Behavioral Health Inpatient Facility (BHIF) as specified in~~
692 ~~A.A.C. R9-10-101; or~~
693 ~~e. A Behavioral Residential Setting (BHRF) as specified in A.A.C.~~
694 ~~R9-10-101.~~

695 ~~7. "Inter-Rater Reliability (IRR)" means the process of monitoring and~~
696 ~~evaluating qualified healthcare professional staff's level of consistency~~

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697 ~~with decision making and adherence to clinical review criteria and~~
698 ~~standards.~~

699 ~~8. "Other Provider-Preventable Condition (OPPC)" means a condition~~
700 ~~occurring in the inpatient and outpatient health care setting which the~~
701 ~~Division and AHCCCS has limited to the following:~~
702 ~~a. Surgery on the wrong member,~~
703 ~~b. Wrong surgery on a member, or~~
704 ~~c. Wrong site surgery.~~

705 ~~9. "Peer-Reviewed Study" means prior to publication, a medical study~~
706 ~~that has been subjected to the review of medical experts who:~~
707 ~~a. Have expertise in the subject matter of the study,~~
708 ~~b. Evaluate the science and methodology of the study,~~
709 ~~c. Are selected by the editorial staff of the publication,~~
710 ~~d. Review the study without knowledge of the identity or~~
711 ~~qualifications of the author, and~~
712 ~~e. Are published in the United States.~~

713 ~~10. "Prior Authorization (PA)" means a process by which the AdSS~~

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714 ~~authorizes, in advance, the delivery of covered services based on~~
715 ~~factors including but not limited to medical necessity, cost~~
716 ~~effectiveness, compliance with this policy as specified in A.A.C. R9-~~
717 ~~201, and any applicable contract provisions. PA is not a guarantee of~~
718 ~~payment as specified in A.A.C. R9-22-101.~~

719 ~~11. "Responsible Person" means the parent or guardian of a minor~~
720 ~~with a developmental disability, the guardian of an adult with a~~
721 ~~developmental disability or an adult with a developmental disability~~
722 ~~who is a client or an applicant for whom no guardian has been~~
723 ~~appointed. A.R.S. § 36-551.~~

724 ~~12. "Retrospective Review" means the process of determining the~~
725 ~~medical necessity of a treatment/service post-delivery of care.~~

726 ~~13. "Service Plan (SP)" means a complete written description of all~~
727 ~~covered health services and other informal supports which includes~~
728 ~~individualized goals, family support services, peer recovery and~~
729 ~~support, care coordination activities and strategies to assist the~~
730 ~~member in achieving an improved quality of life.~~

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731 ~~14. "Special Health Care Needs (SHCN)" means serious and chronic~~
732 ~~physical, developmental, or behavioral conditions requiring medically~~
733 ~~necessary health and related services of a type or amount beyond that~~
734 ~~required by members generally, that lasts or is expected to last one~~
735 ~~year or longer and may require ongoing care not generally provided by~~
736 ~~a primary care provider.~~

737 ~~15. "Subcontracted health plan" means an organization with which~~
738 ~~the Division has contracted or delegated some of its~~
739 ~~management/administrative functions or responsibilities.~~

740 ~~16. "Support Coordination" means a collaborative process which~~
741 ~~assesses, plans, implements, coordinates, monitors, and evaluates~~
742 ~~options and services to meet an individual's health needs through~~
743 ~~communication and available resources to promote quality, cost-~~
744 ~~effective outcomes.~~

745 ~~17. "Telehealth" means healthcare services delivered via~~
746 ~~asynchronous , remote patient monitoring, teledentistry, or~~
747 ~~telemedicine (interactive audio and video).~~

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~~POLICY~~

~~A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT~~

1. ~~The AdSS shall develop and implement policies and processes to collect, validate, analyze, monitor, and report the Division's enrollment utilization data.~~

2. ~~On an ongoing basis, the AdSS' Medical Management (MM) Committee shall review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified specific to the Division enrolled members. Evaluation shall include a review of the impact to both service quality and outcome.~~

3. ~~The MM Committee shall determine, based on its review, if action (new or changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address overutilization and underutilization of services shall be integrated throughout the~~

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765 ~~organization. All such strategies shall have measurable outcomes~~
766 ~~that are reported in AdSS MM Committee minutes and shared at~~
767 ~~quarterly Division and AdSS meetings.~~
768
769
770 ~~**A. CONCURRENT REVIEW**~~
771 ~~1. The AdSS shall have policies, procedures, processes, and criteria~~
772 ~~in place that govern the use of services in institutional settings.~~
773 ~~2. The AdSS shall have procedures for review of medical necessity~~
774 ~~before a planned institutional admission (pre-certification) and~~
775 ~~for determination of the medical necessity for ongoing~~
776 ~~institutional care (concurrent review).~~
777 ~~3. The AdSS shall have policies and procedures for the concurrent~~
778 ~~review process that:~~
779 ~~a. Include relevant clinical information when making hospital~~
780 ~~length of stay decisions. Relevant clinical information shall~~
781 ~~include, but is not limited to symptoms, diagnostic test~~

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782 ~~results, diagnoses, and required services.~~

783 ~~b. Specify timeframes and frequency for conducting~~
784 ~~concurrent review and decisions:~~

785 ~~i. Authorization for institutional stays that shall have a~~
786 ~~specified date by which the need for continued stay~~
787 ~~shall be reviewed based on the expected course of~~
788 ~~the stay and medical necessity.~~

789 ~~ii. Admission reviews shall be conducted within one~~
790 ~~business day after notification is provided to the~~
791 ~~AdSS by the hospital or institution (this does not~~
792 ~~apply to pre-certifications) (42 CFR 456.125).~~

793 ~~c. Provide a process for review that includes, but is not~~
794 ~~limited to:~~

795 ~~i. Necessity of admission and appropriateness of the~~
796 ~~service setting;~~

797 ~~ii. Quality of care;~~

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~~iii. Length of stay;~~

~~iv. Whether services meet the member needs;~~

~~v. Denials or reduction in the level of service;~~

~~vi. Discharge needs;~~

~~vii. Utilization pattern analysis;~~

~~viii. Establish a method for the AdSS’ participation in the proactive discharge planning of all members in hospital, and institutional settings. The proactive discharge planning process shall demonstrate communication with the Division’s support coordinator assigned to the member.~~

~~4. Criteria for decisions on coverage and medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.~~

~~5. The AdSS’ Medical Management Committee shall annually approve the medical criteria used for concurrent review, which shall be adopted from the national standards. Subsequently it~~

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815 ~~shall be approved by the Division's MM Committee. When~~
816 ~~providing concurrent review, the AdSS shall compare the~~
817 ~~member's medical information against medical necessity criteria~~
818 ~~that describe the condition or service.~~

819 ~~6. Initial institutional stays shall be based on the AdSS' adopted~~
820 ~~criteria, the member's specific condition, and the projected~~
821 ~~discharge date. Continued stay determinations are based on~~
822 ~~written medical care criteria that assess the need for the~~
823 ~~continued stay. The extension of a medical stay shall be~~
824 ~~assigned a next review date each time the review occurs. The~~
825 ~~AdSS ensures that each continued stay review date is recorded~~
826 ~~in the member's record.~~

827 ~~7. Coordination shall include proactive discharge planning, starting~~
828 ~~within one day of admission, between all potential payment and~~
829 ~~care sources and shall continue after completion of the~~
830 ~~institutional stay.~~

831 ~~8. AdSS shall submit the "Contractor Quarterly Showing Report for~~

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832 ~~Inpatient Hospital Services" as specified in Contract.~~

833 ~~9. Providers who request authorization for a service shall be~~
834 ~~notified of the option to request a peer-to-peer discussion with~~
835 ~~the appropriate AdSS health plan when additional information is~~
836 ~~requested or when the admission or continued stay is denied.~~
837 ~~Requests for peer-to-peer review and disposition of the request~~
838 ~~shall be clearly documented.~~
839

840 ~~**C. DISCHARGE PLANNING**~~
841 ~~1. The AdSS shall have policies and procedures in place that govern~~
842 ~~the process for proactive discharge planning and coordinating~~
843 ~~services with the Division's Support Coordination.~~

844 ~~2. The AdSS shall furnish acute care services to the member~~
845 ~~between settings of care, including appropriate discharge~~
846 ~~planning for short-term and long-term hospital and institutional~~
847 ~~stays while the Division shall furnish any HCBS/LTC services for~~
848 ~~the member.~~

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849 ~~3. The intent of the discharge planning policy and procedure is to~~
850 ~~increase the management of inpatient admissions, improve the~~
851 ~~coordination of post discharge services, reduce unnecessary~~
852 ~~hospital stays, ensure discharge needs are met, and decrease~~
853 ~~readmissions.~~

854 ~~4. The AdSS shall develop and implement a discharge planning~~
855 ~~process that ensures members receiving inpatient services have~~
856 ~~proactive discharge planning to identify and assess the post-~~
857 ~~discharge bio psychosocial and medical needs of the member in~~
858 ~~order to arrange necessary services and resources for~~
859 ~~appropriate and timely discharge from a facility.~~

860 ~~5. The AdSS shall conduct a proactive assessment of discharge~~
861 ~~needs before admission when feasible.~~

862 ~~6. The AdSS shall ensure discharge planning is performed by a~~
863 ~~qualified healthcare professional and initiated on the initial~~
864 ~~concurrent review, updated periodically during the inpatient~~
865 ~~stay, and continued post discharge to ensure a timely, effective,~~

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866 safe, and appropriate discharge.

867 7. The AdSS staff participating in the discharge planning process
868 shall ensure the member/responsible person, as applicable:

869 a. Is involved and participates in the discharge planning
870 process,

871 b. Understands the written discharge plan, instructions, and
872 recommendations provided by the facility,

873 c. Is provided with resources, referrals, and possible
874 interventions to meet the member's assessed and
875 anticipated needs after discharge.

876 8. The AdSS shall allow:

877 a. If a covered behavioral health service required after
878 discharge is temporarily unavailable for individuals in an
879 inpatient or residential facility who are discharge-ready,
880 the member may remain in that setting until the service is
881 available.

882 b. Care management, intensive outpatient services, support
883 coordination, and/or peer service are available to the

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884 ~~member while waiting for the appropriate covered~~
885 ~~behavioral health service.~~
886 ~~9. The support coordinator shall seek assistance to elevate the~~
887 ~~issue for resolution of the barrier in accordance with established~~
888 ~~procedures.~~
889 ~~10. Discharge planning, coordination, and management of care shall~~
890 ~~include:~~
891 ~~a. Follow-up appointment with the PCP and/or specialist~~
892 ~~within 7 days;~~
893 ~~b. Safe and clinically appropriate placement, and community~~
894 ~~support services;~~
895 ~~c. Communication of the member's treatment plan and~~
896 ~~medical history across the various outpatient providers,~~
897 ~~including the member's outpatient clinical team, TRBHA~~
898 ~~and other contractors when appropriate;~~
899 ~~d. Prescription medications;~~
900 ~~e. Medical Equipment;~~
901 ~~f. Nursing Services;~~

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902 ~~g. End-of-Life Care related services such as Advance Care~~
903 ~~Planning;~~
904 ~~h. Practical supports;~~
905 ~~i. Hospice;~~
906 ~~j. Therapies (within limits for outpatient~~
907 ~~physical/occupational therapy visits for members 21 years~~
908 ~~of age and older);~~
909 ~~k. Referral to appropriate community resources;~~
910 ~~l. Referral to AdSS' Disease Management or Care~~
911 ~~Management (if needed);~~
912 ~~m. A post discharge follow-up call to the member/responsible~~
913 ~~person within three business days of discharge to confirm~~
914 ~~the member's well-being and the progress of the discharge~~
915 ~~plan according to the member's assessed clinical,~~
916 ~~behavioral, physical health, and social needs;~~
917 ~~n. Proactive discharge planning when the AdSS is not the~~
918 ~~primary payer.~~
919

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~~D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION~~

~~1. The AdSS shall have an Arizona-licensed PA staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training, to apply the AdSS' medical criteria or make coverage decisions. PA is required in certain circumstances.~~

~~2. The AdSS shall develop and implement a system that includes at least two modes of delivery for providers to submit PA requests such as telephone, fax, or electronically through a portal on the AdSS' website.~~

~~3. The AdSS shall ensure providers who request authorization for a service are notified that they have the option to request a peer-to-peer discussion with the AdSS Medical Director when additional information is requested by the AdSS or when the prior authorization request is denied. The AdSS shall coordinate the discussion with the requesting provider when appropriate.~~

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937 ~~4. The AdSS shall develop and implement policies and procedures,~~
938 ~~coverage criteria, and processes for approval of covered~~
939 ~~services, which include required time frames for authorization~~
940 ~~determination.~~
941 ~~5. The AdSS shall have policies and procedures for approval of~~
942 ~~specified services that:~~
943 ~~a. Identify and communicate to providers, TRBHAs and~~
944 ~~members, those services that require authorization and~~
945 ~~the relevant clinical criteria required for authorization~~
946 ~~decisions. Services not requiring authorization shall also be~~
947 ~~identified. Methods of communication with members~~
948 ~~include newsletters, AdSS website, and/or member~~
949 ~~handbook. Methods of communication with providers and~~
950 ~~TRBHAs include newsletters, AdSS websites, and/or~~
951 ~~provider manuals. Changes in the coverage criteria shall~~
952 ~~be communicated to members, TRBHAs, and providers at~~
953 ~~least 30 days before implementation of the change;~~
954 ~~b. Delineate the process and criteria for initial authorization~~

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955 ~~of services and/or requests for continuation of services.~~
956 ~~Criteria shall be made available to providers and TRBHAs~~
957 ~~through the provider manual and AdSS website. Criteria~~
958 ~~shall be available to members upon request;~~
959 ~~c. Authorize services in a sufficient amount, duration, and~~
960 ~~scope to achieve the purpose for which the services are~~
961 ~~furnished;~~
962 ~~d. Ensure consistent application of review criteria by~~
963 ~~incorporating inter-rater reliability assessments;~~
964 ~~e. Specify timeframes for responding to requests for initial~~
965 ~~and continuous determinations for standard and expedited~~
966 ~~authorization requests as defined in, AdSS Operations~~
967 ~~Manual Policy 414, and 42 CFR 438.210;~~
968 ~~f. Provide decisions and notice as expeditiously as the~~
969 ~~member's health condition requires and no later than 72-~~
970 ~~hours after receipt of an expedited service request~~
971 ~~pursuant to 42 CFR 438.210(d)(2)(i);~~

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972 ~~g. Provide for consultation with the requesting provider when~~
973 ~~appropriate; and~~

974 ~~h. Review all PA requirements for services, items, or~~
975 ~~medications annually. The review shall be reported through~~
976 ~~the MM Committee and shall include the rationale for~~
977 ~~changes made to PA requirements. A summary of the PA~~
978 ~~requirement changes and the rationale for those changes~~
979 ~~shall be documented in the MM Committee meeting~~
980 ~~minutes.~~

981 ~~6. The AdSS shall develop and implement policies for processing~~
982 ~~and making determinations for PA requests for medications.~~

983 ~~7. The AdSS shall ensure the following:~~
984 ~~a. A decision to a submitted PA request for a medication is~~
985 ~~provided by telephone, fax, electronically, or other~~
986 ~~telecommunication device within 24 hours of receipt of the~~
987 ~~submitted request for PA;~~

988 ~~b. A request for additional information is sent to the~~

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989 ~~prescriber by telephone, fax, electronically, or other~~
990 ~~telecommunication device within 24 hours of the submitted~~
991 ~~request when the PA request for a medication lacks~~
992 ~~sufficient information to render a decision. A final decision~~
993 ~~shall be rendered within seven business days from the~~
994 ~~initial date of the request;~~

995 ~~c. At least a 4-day supply of a covered outpatient prescription~~
996 ~~drug is provided to the member in an emergent situation.~~
997 ~~[42 CFR 438.3(s)(6)].~~

998 ~~8. The AdSS criteria for decisions on coverage and medical~~
999 ~~necessity for both physical and behavioral services shall be~~
1000 ~~clearly documented, based on reasonable medical evidence or a~~
1001 ~~consensus of relevant health care professionals.~~

1002 ~~9. The AdSS may not arbitrarily deny or reduce the amount,~~
1003 ~~duration, or scope of a medically necessary service solely~~
1004 ~~because of the setting, diagnosis, type of illness, or condition of~~
1005 ~~the member.~~

~~10. The AdSS may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome.~~

~~11. The AdSS shall have criteria in place to make decisions on coverage when the AdSS receives a request for service involving Medicare or other party payers. The fact that the AdSS is the secondary payer does not negate the AdSS' obligation to render a determination regarding coverage within the timeframes established in this policy.~~

~~E. INTER-RATER RELIABILITY~~

~~1. The AdSS shall have in place a process to ensure consistent application of review criteria in making medical necessity decisions that include prior authorization, concurrent review, and retrospective review. Inter-rater reliability (IRR) testing of all staff involved in these processes shall be done at orientation and at least annually thereafter. A corrective action plan shall be~~

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~~included for staff that do not meet the minimum compliance goal of 90%.~~

~~2. At least annually, the IRR testing results shall be presented to the MM Committee for review and approval.~~

~~3. At least annually and upon request, IRR testing results shall be provided to the Division.~~

~~F. RETROSPECTIVE REVIEW~~

~~1. The AdSS shall conduct a retrospective review, which is guided by policies and procedures that:~~

   ~~a. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,~~

   ~~b. List services requiring retrospective review, and~~

   ~~c. Specify time frame(s) for completion of the review.~~

~~2. Criteria for decisions on medical necessity shall be clearly documented and based on reasonable medical evidence or a~~

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1040 ~~consensus of relevant health care professionals.~~

1041 ~~3. The AdSS shall have a process for consistent application of~~
1042 ~~review criteria.~~

1043 ~~4. Guidelines for Provider-Preventable Conditions:~~
1044 ~~a. Title 42 CFR Section 447.26 prohibits payment for services~~
1045 ~~related to Provider Preventable Conditions. Provider~~
1046 ~~Preventable Condition means a condition that meets the~~
1047 ~~definition ofHealth Care-Acquired Condition (HCAC) or an~~
1048 ~~Other Provider-Preventable Condition (OPPC);~~
1049 ~~b. A member's health status may be compromised by hospital~~
1050 ~~conditions and/or medical personnel in ways that are~~
1051 ~~sometimes diagnosed as a "complication." If it is~~
1052 ~~determined that the complication resulted from an HCAC~~
1053 ~~or OPPC, any additional hospital days or other additional~~
1054 ~~charges resulting from the HCAC or OPPC shall not be~~
1055 ~~reimbursed;~~
1056 ~~c. If it is determined that the HCAC or OPPC was a result of~~
1057 ~~an error by a hospital or medical professional, the AdSS~~

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1058 ~~shall conduct a quality of care (QOC) investigation and~~
1059 ~~report it in accordance with AdSS Medical Policy 960.~~
1060
1061 ~~**G. CLINICAL PRACTICE GUIDELINES**~~
1062 ~~1. The AdSS shall develop or adopt and disseminate practice~~
1063 ~~guidelines for physical and behavioral health services that:~~
1064 ~~a. Are based on valid and reliable clinical evidence or a~~
1065 ~~consensus of health care professionals in that field;~~
1066 ~~b. Consider the needs of people with~~
1067 ~~intellectual/developmental disabilities (I/DD) who are~~
1068 ~~enrolled with the AdSS;~~
1069 ~~c. Are either:~~
1070 ~~i. Adopted in consultation with contracting health care~~
1071 ~~professionals and National Practice Standards, or~~
1072 ~~ii. Developed in consultation with health care~~
1073 ~~professionals and include a thorough review of peer~~
1074 ~~reviewed articles in medical journals published in the~~
1075 ~~United States when national practice guidelines are~~

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1076 ~~not available. Published peer-reviewed medical~~
1077 ~~literature shall include well-designed investigations~~
1078 ~~that have been reproduced by nonaffiliated~~
1079 ~~authoritative sources, with measurable results and~~
1080 ~~with positive endorsements of national medical~~
1081 ~~bodies or panels regarding scientific efficacy and~~
1082 ~~rationale.~~
1083 ~~d. Are disseminated by the AdSS to all affected providers~~
1084 ~~and, upon the request, to members/responsible person~~
1085 ~~and potential members; and~~
1086 ~~e. Provide a basis for consistent decisions for utilization~~
1087 ~~management, member education, coverage of services,~~
1088 ~~and any other areas to which the guidelines apply (42 CFR~~
1089 ~~438.236).~~

1090 ~~2. The AdSS shall evaluate the practice guidelines through a MM~~
1091 ~~multi-disciplinary committee to determine if the guidelines~~
1092 ~~remain applicable, represent the best practice standards, and~~
1093 ~~reflect current medical standards every two years.~~

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1094 ~~3. The AdSS shall document the review and adoption of the practice~~
1095 ~~guidelines as well as the evaluation of efficacy of the guidelines.~~

1096 **~~H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING~~**
1097 **~~TECHNOLOGIES~~**

1098 ~~1. The AdSS shall develop and implement written policies and~~
1099 ~~procedures for evaluating new technologies and new uses of~~
1100 ~~existing technology that include an evaluation of benefits for~~
1101 ~~physical and behavioral healthcare services, pharmaceuticals and~~
1102 ~~devices.~~

1103 ~~2. The AdSS shall have policies and procedures that include the~~
1104 ~~process and timeframe for making a clinical determination when~~
1105 ~~a time sensitive request is made.~~

1106 ~~3. The AdSS shall make a decision in response to an expedited~~
1107 ~~request as expeditiously as the member's condition warrants and~~
1108 ~~not later than 72 hours from receipt of request.~~

1109 ~~4. The AdSS shall include coverage decisions by Medicare~~
1110 ~~intermediaries and carriers, national Medicare coverage~~

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~~decisions, and Federal and State Medicaid coverage decisions in its evaluation.~~

~~5. The AdSS shall evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature shall include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature shall also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.~~

~~6. The AdSS shall establish:~~

~~a. Coverage rules, practice guidelines, payment policies, policies and procedures, utilization management, and oversight that allows for the individual member's medical needs to be met;~~

~~b. A process for change in coverage rules and practice guidelines based on the evaluation of trending requests. Additional review and assessment is required if multiple requests for the same technology or application of an existing technology are received;~~

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1129 ~~c. A process for documenting the coverage determinations~~
1130 ~~and rationale in the Medical Management Committee~~
1131 ~~meeting minutes.~~
1132

1133 ~~**I. MONITORING AND OVERSIGHT**~~

1134 ~~1. The AdSS shall meet with the Division Health Care Services~~
1135 ~~(HCS) quarterly to review the Medical Management Committee~~
1136 ~~minutes, reports with data analysis and action plans, over and~~
1137 ~~under utilization, outliers, and opportunities for performance~~
1138 ~~improvement.~~

1139 ~~2. Annually the Division shall perform an Operational Review of the~~
1140 ~~AdSS utilization process.~~

1141

1142 ~~**J. SUPPLEMENTAL INFORMATION**~~

1143 ~~1. The AdSS are responsible for the administration of utilization~~
1144 ~~management activities for all contracted services they provide to~~
1145 ~~members served by the Division.~~

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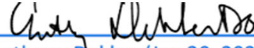
1146

~~Signature of Chief Medical Officer:~~ 
Anthony Dekker (Jan 20, 2023 08:48 MST)
Anthony Dekker, D.O.

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