1020 UTILIZATION MANAGEMENT

REVISION DATE: 1/25/2023, 7/20/2022, 10/1/2021, 8/4/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 13-3994, A.R.S. § 31-501, A.R.S. § 36-551, A.R.S. §38-211; A.A.C. R9-201, 42 CFR 435.1010, 438.3, 438.114(a), 438.210, 438.236, 438.240(b)(3), 447.26, 456.125; Section F3, 42 CFR Part 457, and 42 CFR Part 438, Contractor Chart of Deliverables; AMPM Policy 310, AMPM Attachment 1020-A, AMPM Attachment 1020-B

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy outlines utilization management functions provided by the AdSS to ensure effective treatment services and coordination of care are furnished that achieve optimal outcomes for members. The policy also addresses how the AdSS identifies opportunities for improvement in utilization management.

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 immediate medical attention to result in:

   a. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in

serious jeopardy;

b. Serious impairment to bodily functions;

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

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

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

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

6. “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.
7. “Inter-Rater Reliability (IRR)” means the process of monitoring and evaluating qualified healthcare professional staff’s level of consistency with decision making and adherence to clinical review criteria and standards.

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

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

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

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

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

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

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

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

15. “Subcontracted health plan” means an organization with which the Division has contracted or delegated some of its management/administrative functions or responsibilities.

16. “Support Coordination” means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.

17. “Telehealth” means healthcare services delivered via asynchronous , remote patient monitoring, teledentistry, or telemedicine (interactive audio and video).

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 organization. All such strategies shall have measurable

outcomes that are reported in AdSS MM Committee minutes and shared at quarterly Division and AdSS meetings.

B. CONCURRENT REVIEW

1. The AdSS shall have policies, procedures, processes, and criteria in place that govern the use of services in institutional settings.
2. The AdSS shall have procedures for review of medical necessity before a planned institutional admission (pre-certification) and for determination of the medical necessity for ongoing institutional care (concurrent review).
3. The AdSS shall have policies and procedures for the concurrent review process that:
   a. Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information shall include, but is not limited to symptoms, diagnostic test results, diagnoses, and required services.
   b. Specify timeframes and frequency for conducting concurrent review and decisions:

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

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

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

i. Necessity of admission and appropriateness of the service setting;

ii. Quality of care;

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

6. Initial institutional stays shall be based on the AdSS' adopted criteria, the member's specific condition, and the projected

discharge date. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay shall be assigned a next review date each time the review occurs. The AdSS ensures that each continued stay review date is recorded in the member's record.

7. Coordination shall include proactive discharge planning, starting within one day of admission, between all potential payment and care sources and shall continue after completion of the institutional stay.
8. AdSS shall submit the "Contractor Quarterly Showing Report for Inpatient Hospital Services" as specified in Contract.
9. Providers who request authorization for a service shall be notified of the option to request a peer-to-peer discussion with the appropriate AdSS health plan when additional information is requested or when the admission or continued stay is denied. Requests for peer-to-peer review and disposition of the request shall be clearly documented.

C. DISCHARGE PLANNING

1. The AdSS shall have policies and procedures in place that govern the process for proactive discharge planning and coordinating services with the Division's Support Coordination.

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

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

4. The AdSS shall develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio psychosocial and medical needs of the

member in order to arrange necessary services and resources for appropriate and timely discharge from a facility.

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

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

7. The AdSS staff participating in the discharge planning process shall ensure the member/responsible person, as applicable:
    a. Is involved and participates in the discharge planning process,
    b. Understands the written discharge plan, instructions, and recommendations provided by the facility,
    c. Is provided with resources, referrals, and possible interventions to meet the member’s assessed and

anticipated needs after discharge.

8. The AdSS shall allow:

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

   b. Care management, intensive outpatient services, support coordination, and/or peer service are available to the member while waiting for the appropriate covered behavioral health service.

9. The support coordinator shall seek assistance to elevate the issue for resolution of the barrier in accordance with established procedures.

10. Discharge planning, coordination, and management of care shall include:

   a. Follow-up appointment with the PCP and/or specialist within 7 days;

b. Safe and clinically appropriate placement, and community support services;

c. Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team, TRBHA and other contractors when appropriate;

d. Prescription medications;

e. Medical Equipment;

f. Nursing Services;

g. End-of-Life Care related services such as Advance Care Planning;

h. Practical supports;

i. Hospice;

j. Therapies (within limits for outpatient physical/occupational therapy visits for members 21 years of age and older);

k. Referral to appropriate community resources;

l. Referral to AdSS' Disease Management or Care

Management (if needed);

m. A post discharge follow-up call to the member/responsible person within three business days of discharge to confirm the member’s well-being and the progress of the discharge plan according to the member’s assessed clinical, behavioral, physical health, and social needs;

n. Proactive discharge planning when the AdSS is not the primary payer.

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.
4. The AdSS shall develop and implement policies and procedures, coverage criteria, and processes for approval of covered services, which include required time frames for authorization determination.
5. The AdSS shall have policies and procedures for approval of specified services that:
   a. Identify and communicate to providers, TRBHAs and members, those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization shall also

be identified. Methods of communication with members include newsletters, AdSS website, and/or member handbook. Methods of communication with providers and TRBHAs include newsletters, AdSS websites, and/or provider manuals. Changes in the coverage criteria shall be communicated to members, TRBHAs, and providers at least 30 days before implementation of the change;

b. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria shall be made available to providers and TRBHAs through the provider manual and AdSS website. Criteria shall be available to members upon request;

c. Authorize services in a sufficient amount, duration, and scope to achieve the purpose for which the services are furnished;

d. Ensure consistent application of review criteria by incorporating inter-rater reliability assessments;

e. Specify timeframes for responding to requests for initial

and continuous determinations for standard and expedited authorization requests as defined in, AdSS Operations Manual Policy 414, and 42 CFR 438.210;

f. Provide decisions and notice as expeditiously as the member's health condition requires and no later than 72-hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i);

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

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

6. The AdSS shall develop and implement policies for processing

and making determinations for PA requests for medications.

7. The AdSS shall ensure the following:

   a. A decision to a submitted PA request for a medication is provided by telephone, fax, electronically, or other telecommunication device within 24 hours of receipt of the submitted request for PA;

   b. A request for additional information is sent to the prescriber by telephone, fax, electronically, or other telecommunication device within 24 hours of the submitted request when the PA request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven business days from the initial date of the request;

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

8. The AdSS criteria for decisions on coverage and medical

necessity for both physical and behavioral services shall be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.

9. The AdSS may not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the setting, diagnosis, type of illness, or condition of 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 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 consensus of relevant health care professionals.

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

4. Guidelines for Provider-Preventable Conditions:

a. Title 42 CFR Section 447.26 prohibits payment for services related to Provider Preventable Conditions. Provider Preventable Condition means a condition that meets the definition ofHealth Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC);

b. A member’s health status may be compromised by hospital

conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication." If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC shall not be reimbursed;

c. If it is determined that the HCAC or OPPC was a result of an error by a hospital or medical professional, the AdSS shall conduct a quality of care (QOC) investigation and report it in accordance with AdSS Medical Policy 960.

G. CLINICAL PRACTICE GUIDELINES

1. The AdSS shall develop or adopt and disseminate practice guidelines for physical and behavioral health services that:

    a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field;

    b. Consider the needs of people with intellectual/developmental disabilities (I/DD) who are

enrolled with the AdSS;

c. Are either:

   i. Adopted in consultation with contracting health care professionals and National Practice Standards, or

   ii. Developed in consultation with health care professionals and include a thorough review of peer reviewed articles in medical journals published in the United States when national practice guidelines are not available. Published peer-reviewed medical literature shall include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

d. Are disseminated by the AdSS to all affected providers and, upon the request, to members/responsible person and potential members; and

e. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply (42 CFR 438.236).

2. The AdSS shall evaluate the practice guidelines through a MM multi-disciplinary committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards every two years.
3. The AdSS shall document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines.

H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. The AdSS shall develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology that include an evaluation of benefits for physical and behavioral healthcare services, pharmaceuticals and devices.
2. The AdSS shall have policies and procedures that include the

process and timeframe for making a clinical determination when a time sensitive request is made.

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

4. The AdSS shall include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage 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;

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

I. MONITORING AND OVERSIGHT

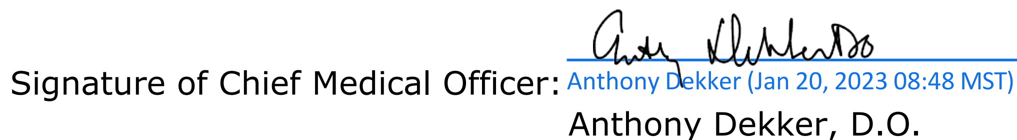
1. The AdSS shall meet with the Division Health Care Services (HCS) quarterly to review the Medical Management Committee minutes, reports with data analysis and action plans, over and under utilization, outliers, and opportunities for performance improvement.

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

J. SUPPLEMENTAL INFORMATION

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

Signature of Chief Medical Officer:



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