1020 UTILIZATION MANAGEMENT

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PURPOSE

This policy outlines Utilization Management (UM) functions provided by the AdSS to ensure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care from preventative care to hospice, including Advance Care Planning at any age or stage of illness. This policy also addresses how the AdSS identifies opportunities for improvement in UM.

DEFINITIONS

1. "Behavioral Health Inpatient Facility" or "BHIF" means a health

institution, as specified in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

a. Have a limited or reduced ability to meet the individual's basic physical needs;

b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;

c. Be a danger to self;

d. Be a danger to others;

e. Be an individual with a persistent or acute disability as specified in A.R.S § 36-501; or

f. Be an individual with a grave disability as specified in A.R.S. § 36-501.

2. "Behavioral Health Residential Facility" or "BHRF" means, as specified in A.A.C. R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that:

a. Limits the individual's ability to be independent, or

b. Causes the individual to require treatment to maintain or enhance independence.

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

4. "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.

5. "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) concerns.

6. "Denial" means the decision to deny a request made by, or on

behalf of, an individual for the authorization or payment of a covered service.

7. "Health Care-Acquired Condition" or "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).
8. "Institution for Mental Disease" or "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.
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.

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

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

12. "Other Provider-Preventable Condition" or "OPPC" means a condition occurring in the inpatient and outpatient health care setting which the Division and Arizona Health Care Cost Containment System (AHCCCS) has limited to the following:
    a. Surgery on the wrong Member:
    b. Wrong surgery on a Member; or
    c. Wrong site surgery.
13. "Practitioner" means a certified nurse practitioner in midwifery, physician assistant(s), and other nurse practitioners, physician assistant(s) and nurse practitioners as specified in A.R.S. Title 32, Chapters 15 and 25, respectively.
14. "Prior Authorization" or "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.
15. "Prior Period Coverage" means for Title XIX Members, the period of time prior to the Member's enrollment with the AdSS during

which a Member is eligible for covered services. The time frame is from the effective date of eligibility to the day a Member is enrolled with the AdSS.

16. "Provider" means any individual or entity contracted with the AdSS that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.
17. "Provider Preventable Condition" or "PPC" means a condition that meets the definition of Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC);
18. "Qualified Healthcare Professional" means a health care professional qualified to do discharge planning.
19. "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.
20. "Retrospective Review" means the process of determining the medical necessity of a treatment/service post-delivery of care.

21. "Standard of Care Medical Necessity Guidelines" means the relevant clinical information to make hospital length of stay determinations for both planned and unplanned admissions using MCG, InterQual, American Society of Addiction Medicine (ASAM), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS-CASII). If none of the previous standards exist for the admission type then other Utilization Management Criteria may be used as appropriate.
22. "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.
23. "Utilization Management Criteria" means medical guidelines that determine which services, levels of care, and lengths of stay are appropriate for Members in different clinical situations.

POLICY

A. CLINICAL CRITERIA FOR UTILIZATION MANAGEMENT DECISIONS

1. The AdSS shall have written criteria which are objective, evidence based, and take individual circumstances and the local medical services into account when determining the medical appropriateness of healthcare services.
2. The AdSS shall have written criteria that includes:
    a. Written UM decision-making criteria that are objective and based on medical evidence.
    b. Written policies for applying the criteria based on Member needs,
    c. Written policies for applying the criteria based on an assessment of the local medical services,
    d. Involving appropriate Providers in developing, adopting, and reviewing criteria, and
    e. Reviewing the criteria and procedures for applying the criteria annually and updating the criteria when appropriate.

B. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

1. The AdSS shall have a UM program that reports to the Division's Medical Management (MM) committee and involves a designated

senior-level physician and behavioral healthcare Provider in the implementation of physical and behavioral healthcare aspects.

2. The AdSS shall develop and implement policies and processes to review utilization and detect both underutilization and overutilization of services.
3. The AdSS shall develop and implement policies and processes to collect, validate, analyze, monitor, and report the Division's enrollment utilization data for AdSS Members.
4. The AdSS' MM Committee shall annually and on an ongoing basis, review and evaluate the utilization data and make or approve recommendations for implementing actions for improvement when variances are identified.
5. The AdSS MM Committee shall include in their utilization data evaluation a review of the impact to both service quality and outcome.
6. The AdSS 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.
7. The AdSS shall integrate intervention strategies throughout each

AdSS to address both over and underutilization of services.

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

C. CONCURRENT REVIEW

1. The AdSS shall have policies, procedures, processes, and criteria in place that govern the use of services during short-term and long-term hospital and institutional stays to ensure that the Member continues to receive reasonable, appropriate care in the right health care setting to meet the Member's health care needs.
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 the following clinical information when making

hospital length of stay decisions:

i. Symptoms,

ii. Diagnostic test results,

iii. Diagnoses, and

iv. Required services.

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

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

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

5. The AdSS shall provide a process for review that includes:

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

b. Quality of care;

c. Length of stay;

d. Whether services meet the Member needs;

e. Discharge needs; and

f. Utilization pattern analysis.

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

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

8. The AdSS shall document and base the criteria for decisions on medical necessity on reasonable medical evidence or a consensus of relevant health care professionals.

9. The AdSS' MM Committee shall annually approve the medical criteria used for Concurrent Review,

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

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

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

service when providing Concurrent Review.

13. The AdSS shall base initial institutional stays on:
    a. AdSS adopted criteria,
    b. The Member's specific condition, and
    c. The projected discharge date.
14. The AdSS shall base continued stay determinations on written medical care criteria that assess the need for the continued stay.
15. The AdSS shall record each continued stay review date in the Member's record ~~every 3 business days, or~~ as Standard of Care Medical Necessity Guidelines indicate or if there are no Standard of Care Medical Necessity Guidelines then no more than every 3 business days.
16. The AdSS shall assign a new review date each time the review occurs for an extension of a medical stay.
17. The AdSS shall include proactive discharge planning between all potential payment and care sources starting within one day of admission, and shall continue proactive discharge planning after completion of the institutional stay.
18. The AdSS shall submit the "Contractor Quarterly Showing Report

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

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

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

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

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

D. DISCHARGE PLANNING

1. The AdSS shall have policies and procedures in place that govern proactive discharge planning and coordination of services between settings of care, including appropriate discharge planning from short-term and long-term hospital and institutional stays.
2. The AdSS shall ensure the discharge planning process is designed to:

a. Improve the management of inpatient admissions,

b. Reduce unnecessary institutional and hospital stays,

c. Meet Member discharge needs, and

d. Decrease readmissions within 30 days of discharge

3. 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.

4. The AdSS shall allow a Member to remain in an inpatient setting or residential facility in the event that a covered behavioral health service is temporarily unavailable for Members who are discharge ready and require covered post-discharge behavioral health services, or ensure Care Management, intensive outpatient services Provider case management, or peer service are available to the Member while waiting for the appropriate covered physical or behavioral health services.

5. The AdSS shall require an interdisciplinary staffing to be

conducted with the relevant health plan, Division staff, Long Term Services and Supports (LTSS) Providers and the inpatient team for care coordination, as indicated once the Member has been identified as awaiting discharge to the appropriate level of care.

6. The AdSS shall require notification and involvement of the AdSS Chief Medical Officer or Medical Director for Members experiencing a delay in discharge from Institutional Settings or the Emergency Department.
7. The AdSS shall require a proactive assessment of discharge needs is conducted prior to admission, when feasible, or as soon as possible upon admission.
8. The AdSS shall have discharge planning 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.
9. The AdSS staff participating in the discharge planning process shall ensure the Member or Responsible Person:

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

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

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

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

a. Follow-up appointment with the PCP or specialist within 7 days, unless the Member is discharged to a facility or institution in which they are evaluated by a healthcare professional based on the needs of the Member;

b. Coordination and communication with inpatient and facility Providers, the relevant health plan and Division staff, and LTSS for safe and clinically appropriate discharge 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, Tribal Regional Behavioral Health Authority (TRBHA) and other contractors when appropriate;

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

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

i. Prescription medications;

ii. Medical Equipment;

iii. Nursing Services;

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

v. Informal or natural supports;

vi. Hospice;

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

viii. Referral to appropriate community resources;

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

f. A post discharge follow-up call to the Member or Responsible Person within three Business Days of discharge to confirm the Member's well-being and the progress of the discharge plan unless the Member is discharged to a facility or institution in which they are 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 includes 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 such as telephone, fax, or electronically through a portal on the AdSS' website.
3. The AdSS shall notify Providers who request authorization for a service that they have the option to request a peer-to-peer discussion with the appropriate Medical Director when additional information is requested by the AdSS or when the Prior Authorization (PA) request is denied.
4. The AdSS shall allow at least ten Business Days from the date the Provider has been made aware of the Denial for the Provider to request a peer-to-peer discussion and coordinate the discussion with the requesting Provider when appropriate.
5. 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.

6. The AdSS shall respond within 24 hours from the receipt of initial and continuous determinations for standard, and expedited and medication authorization requests, regardless of the due date falling on a weekend or legal holiday.
7. The AdSS shall review all PA requirements for services, items, or medications annually.
8. The AdSS shall report the PA review through the AdSS MM Committee and include the rationale for any changes made to PA requirements.
9. The AdSS shall document the summary of the PA requirement changes and the rationale for those changes in the MM Committee meeting minutes.
10. The AdSS shall document and base the criteria for decisions on coverage and medical necessity for both physical and behavioral health services on reasonable medical evidence or a consensus of relevant health care professionals.
11. The AdSS shall require decisions regarding behavioral health covered services be compliant with mental health parity.
12. The AdSS shall 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.

13. The AdSS shall place limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome.
14. The AdSS shall have written procedures for using professionals who are licensed in medical professions with expertise in making medical necessity determinations.
15. The AdSS shall use and document all relevant information when making coverage decisions.
16. The AdSS shall use any of the following information when determining coverage:
    a. Office and hospital records;
    b. History of presenting problem;
    c. Physical exam results;
    d. Treatment plans and progress notes;
    e. Patient psychosocial history;
    f. Information on consultations with treating practitioner;

g. Evaluations from other health care Practitioners and Providers;
h. Operative and pathological reports;
i. Rehabilitation evaluations;
j. Printed copies of the criteria related to the request;
k. Information regarding benefits for services or procedures;
l. Information regarding the local delivery system;
m. Member characteristics and information;
n. Information from family codes; and
o. Diagnosis codes.

17. The AdSS shall provide evidence to the Division that it uses licensed professional staff for conducting medical necessity determinations when completing PA.
18. The AdSS shall have criteria in place to make decisions on coverage when the AdSS receives a request for service involving Medicare or other third party payers.
19. When a third party payer has approved a service request as medically necessary, The AdSS shall not apply a secondary PA.
20. The AdSS shall provide a decision for a submitted PA request to

the Provider and Member for a medication by telephone, fax, electronically, or other telecommunication device within 24 hours of receipt of the submitted request for PA.

21. The AdSS shall send a request for additional information 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.
22. The AdSS shall render a final decision for PA within seven Business Days from the initial date of the request for PA.
23. The AdSS MM committee shall determine PA criteria and have it submitted to the Division's MM committee annually for review.
24. The AdSS shall ~~require~~ have PA criteria for the following Medical and Behavioral Health Services and supplies:
    a. Behavioral Health Residential Facility (BHRF);
    b. Non-emergency acute inpatient admissions;
    c. Level I BHIF and Residential Treatment Center (RTC) Admissions;
    d. Elective hospitalizations;

e. Elective surgeries;

f. Medical equipment;

g. Medical supplies, annually;

h. Home health;

i. ~~Home and Community Based Services (HCBS)~~ Long Term Services and Supports (LTSS);

j. Hospice;

k. Skilled Nursing Facility (SNF);

l. Therapies - Rehabilitative/Restorative and Developmental/Habilitative;

m. Medical or behavioral health services;

n. Emergency alert system services;

o. Behavior analysis services;

p. Augmentative and Alternative Communication (AAC) services, supplies, and accessories;

q. Non-emergency transportation; and

r. ~~Select~~ Medications.

25. The AdSS shall not require PA for the following services or circumstances:

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

b. Services covered by Medicare or other commercial insurance;

c. Emergency medical hospitalization less than 72 hours;

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

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

f. Dental care - emergency and non-emergency, check the Member's AdSS PA requirements;

g. Eyeglasses for Members younger than 21 years old;

h. Family Planning Services and Supplies;

i. Physician or Specialty Consultations and Office Visits;

j. Behavioral Analysis Assessment;

k. Prenatal Care;

l. Emergency Transportation;

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

n. Emergency room visit.

F. INTER-RATER RELIABILITY

1. The AdSS shall have in place a process for consistent application of review criteria in making medical necessity decisions that include Prior Authorization (PA), Concurrent Review, and Retrospective Review.
2. The AdSS shall perform Inter-Rater Reliability (IRR) testing of all staff who make medical necessity decisions in PA, Concurrent Review and Retrospective Review at new employee orientation and at least annually thereafter.
3. The AdSS shall include a corrective action plan for staff that do not meet the minimum compliance score of 90%.
4. The AdSS shall present the IRR testing results to the MM Committee for review and report the approved medical criteria at least annually.
5. The AdSS shall provide IRR testing results to the Division at least annually as per the Contract and upon request.

G. 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 that require Retrospective Review, and

c. Specify time frames for completion of the review.

2. For retrospective decisions, the AdSS shall provide electronic or written notification of the decision to the Responsible Person, and the ordering or prescribing Practitioner or facility within 30 calendar days of the request.

3. The AdSS shall document and base the criteria for decisions on medical necessity on reasonable medical evidence or a consensus of relevant health care professionals.

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

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

b. A Member's health status may be compromised by hospital conditions or medical personnel in ways that are

sometimes diagnosed as a "complication";

c. 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; and

d. 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 the occurrence and results of the investigation to AHCCCS Quality Management.

H. 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 Members who are enrolled with the AdSS;

c. Are adopted in consultation with contracting health care professionals and national practice standards, or developed

in consultation with health care professionals and network Providers and include a thorough review of peer reviewed articles in medical journals published in the United States when national practice guidelines are not available.

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

e. Provide a basis for consistent decisions for UM, Member education, coverage of services, and any other areas to which the guidelines apply.

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.

I. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. The AdSS shall develop and implement written policies and

procedures for evaluating new medical technologies and new uses of existing technology.

2. The AdSS shall include in the review of new technologies and new uses of existing technology an evaluation of benefits for physical and behavioral healthcare services, pharmaceuticals and devices.
3. The AdSS shall have policies and procedures that include both a mechanism for MM Committee review on a quarterly basis and a time frame for making a clinical determination when a time sensitive request is made.
4. The AdSS shall make a decision in response to an urgent request as expeditiously as the Member's condition warrants and not later than 72 hours from receipt of request.
5. The AdSS shall include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, peer-reviewed literature, and Federal and State Medicaid coverage decisions in its evaluation.
6. The AdSS shall evaluate published or unpublished information sources that may establish that a new medical

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

7. The AdSS shall establish:
   a. Coverage rules, practice guidelines, payment policies, policies and procedures, ~~utilization management~~ UM, 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 MM Committee meeting minutes; and
   d. A process for seeking input from relevant specialists and professionals who have expertise in the technology.

SUPPLEMENTAL INFORMATION

1. The AdSS are responsible for the administration of UM activities for all contracted services they provide to Members served by

the Division.

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

Signature of Chief Medical Officer: