

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.

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19 **PURPOSE**
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21 This policy outlines the oversight responsibilities of the Division of
22 Developmental Disabilities (Division) to require development of an
23 integrated process or system that is designed to ensure appropriate
24 utilization of health care resources, in the amount and duration necessary to
25 achieve desired health outcomes, across the continuum of care from
26 preventative care to hospice, including Advance Care Planning at any age or
27 stage of illness.

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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.
- 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
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 Hospital-
73 Acquired Condition (HAC) which occurs in any inpatient hospital
74 setting and is not present on admission (Refer to the current
75 Centers for Medicare and Medicaid Services (CMS) list of
76 Hospital-Acquired Conditions).

77 8. "H-NAT" means the Hourly Nursing Assessment Tool that is used
78 to analyze and display the relationship between the Skilled
79 Nursing task and the necessary time to complete the task.

80 9. "Inpatient Hospital Showings Report" means a certification that a
81 regular program of independent professional review (including
82 medical evaluation) of the care of recipients in intermediate care

83 facilities pursuant to A.R.S. §1902(a)(31).

84 10. "Institution for Mental Disease" or "IMD" means a hospital,
85 nursing facility, or other institution of more than 16 beds that is
86 primarily engaged in providing diagnosis, treatment, or care of
87 individuals with mental diseases (including substance use
88 disorders), including medical attention, nursing care and related
89 services. Whether an institution is an Institution for Mental
90 Diseases (IMD) is determined by its overall character as that of a
91 facility established and maintained primarily for the care and
92 treatment of individuals with mental diseases, whether or not it
93 is licensed as such. An institution for Individuals with
94 Intellectual Disabilities is not an IMD as specified in 42 CFR
95 435.1010.

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

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

107 13. "Other Provider-Preventable Condition" or "OPPC" means a
108 condition occurring in the inpatient and outpatient health care
109 setting which the Division and Arizona Health Care Cost
110 Containment System (AHCCCS) has limited to the following:

- 111 a. Surgery on the wrong Member,
- 112 b. Wrong surgery on a Member,
- 113 c. Wrong site surgery.

114 14. "Practitioner" means a certified nurse Practitioner in midwifery,
115 physician assistant(s), and other nurse Practitioners, physician
116 assistant(s) and nurse Practitioners as specified in A.R.S. Title
117 32, Chapters 15 and 25, respectively.

118 15. "Prior Authorization" or "PA" means a process by which the

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

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

129 17. "Provider-Preventable Condition" or "PPC" is a condition that
130 meets the definition of a Health Care-Acquired Condition (HCAC)
131 or another Provider-Preventable Condition (PPC) as defined by
132 the State of Arizona.

133 18. "Qualified Healthcare Professional" means a health care
134 professional qualified to do discharge planning.

135 19. "Responsible Person" means the parent or guardian of a minor
136 with a developmental disability, the guardian of an adult with a

137 developmental disability or an adult with a developmental
138 disability who is a client or an applicant for whom no guardian
139 has been appointed. A.R.S. § 36-551.

140 20. "Retrospective Review" means the process of determining the
141 medical necessity of a treatment/service post-delivery of care.

142 21. "Service Provider" means an agency or individual operating
143 under a contract or service agreement with the Department to
144 provide services to Division Members.

145 22. "Skilled Nursing Care" or "Skilled Nursing Services" means a
146 level of care that includes services that can only be performed
147 safely and correctly by a licensed nurse (either a Registered
148 Nurse or a Licensed Practical Nurse).

149 23. "Support Coordination" means a collaborative process which
150 assesses, plans, implements, coordinates, monitors, and
151 evaluates options and services to meet an individual's health
152 needs through communication and available resources to
153 promote quality, cost-effective outcomes.

154 **POLICY**

155 **A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT**

- 156 1. The Division Utilization Management (UM) sub-committee shall
157 report to the Division's Medical Management (MM) committee
158 and shall involve a designated senior-level physician and
159 behavioral healthcare Provider in the implementation of physical
160 and behavioral healthcare aspects.
- 161 2. The Division UM sub-committee shall review and evaluate the
162 utilization data annually and on an as needed basis, and make or
163 approve recommendations for implementing actions for
164 improvement when variances are identified.
- 165 3. The Division's Health Care Services (HCS) shall provide oversight
166 and identify trends, best practices and opportunities for
167 improvement in utilization management.
- 168 4. The Division's HCS shall review and approve annual AdSS'
169 Medical Management Program Plan, Work Plan and Evaluation to
170 ensure goals, service quality and outcomes reflect Member
171 needs and Division goals.

- 172 5. The MM Committee shall determine, based on its review, if
173 action (new or changes to current intervention) is required to
174 improve the efficient utilization of health care services.
- 175 6. The Division shall integrate intervention strategies throughout
176 the Division to address both underutilization and overutilization
177 of services.
- 178 7. The Division shall require the AdSS' UM Program to have
179 measurable outcomes that are reported in the MM Committee
180 minutes and shared at quarterly meetings between the Division
181 and AdSS.
- 182 8. The Division shall work in collaboration with AHCCCS Division of
183 Fee for Service Management (DFSM) to monitor health outcomes
184 of Members enrolled in the Tribal Health Program (THP).
- 185 9. The Division MM Committee shall review utilization data and
186 findings to make recommendations to improve performance and
187 achieve better outcomes.
- 188 10. The Division MM committee shall be responsible for:

- 189 a. The review of validated data provided by the Utilization
190 Management (UM) subcommittee and any other relevant
191 data; and
- 192 b. The review of tracking and trending utilization data on an
193 on-going basis to:
- 194 i. Identify under-utilization or over-utilization of
195 services;
- 196 ii. Identify opportunities for early intervention;
- 197 iii. Mitigate adverse outcomes;
- 198 iv. Identify opportunities for improvement and best
199 practices;
- 200 v. Review performance data related to integrated
201 care, such as Support Coordination activities, access
202 to services, and actions undertaken to resolve
203 barriers to care; and
- 204 vi. Review the utilization data, performance and
205 opportunities for improvement with the AdSS at least

206 quarterly.

207 11. The UM sub-committee shall provide a quarterly tracking and
208 trending report, including data provided by the AdSS, to the MM
209 committee.

210 12. The UM sub-committee shall meet at least 10 times per year.

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213 **B. CONCURRENT REVIEW**

214 1. The Division shall provide oversight of Concurrent Review
215 services conducted by the AdSS.

216 2. The Division shall monitor and review, at least annually, the
217 AdSS' hospital and institutional stays to ensure that treatment
218 and lengths of stay meet Member needs and are provided in
219 accordance with clinical standards of care.

220 3. The Division shall review the AdSS submission of the quarterly
221 Inpatient Hospital Showings Report and send it to AHCCCS after
222 ensuring the report is signed by the AdSS' Chief Medical Officer
223 attesting that:

- 224 a. A physician has certified the necessity of inpatient hospital
225 services,
- 226 b. The services were periodically reviewed and evaluated by a
227 physician,
- 228 c. Each admission was reviewed or screened under a
229 utilization review program, and
- 230 d. All hospitalizations of Members were reviewed and certified
231 by medical utilization staff.
- 232 4. The Division shall collaborate with AHCCCS DFMS to review the
233 Inpatient Hospital Showings Report for Division Members
234 enrolled in THP.

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236 **C. DISCHARGE PLANNING**

- 237 1. The Division shall furnish any Home and Community Based
238 Services (HCBS) or Long-Term Care (LTC) services for the
239 Member between settings of care, including appropriate
240 discharge planning from short-term and long-term hospital and
241 institutional stays.

- 242 2. The Division shall ensure the discharge planning process is
243 designed to:
- 244 a. Improve the management of inpatient admissions,
245 b. Reduce unnecessary institutional and hospital stays,
246 c. Meet Member discharge needs, and
247 d. Decrease readmissions within 30 days of discharge.
- 248 3. The Division shall identify and assess the Member’s post-
249 discharge bio-psychosocial and medical needs in order to
250 arrange necessary services and resources for appropriate and
251 timely discharge from a facility.
- 252 4. The Division shall allow a Member to remain in an inpatient
253 setting or residential facility in the event that a covered
254 behavioral health service is temporarily unavailable for Members
255 who are discharge ready and require covered post-discharge
256 behavioral health services or ensure Support Coordination, Care
257 Management, intensive outpatient services, Service Provider
258 case management, or peer service are available to the Member
259 while waiting for the appropriate covered physical or behavioral

260 health services.

261 5. The Division shall require an interdisciplinary staffing to be
262 conducted with the inpatient team for care coordination once the
263 Member has been identified as awaiting discharge to the
264 appropriate level of care.

265 6. The Division shall require involvement of the Chief Medical
266 Officer or Medical Director for Members experiencing a delay in
267 discharge from Institutional Settings or the Emergency
268 Department.

269 7. The Division shall conduct a proactive assessment of discharge
270 needs prior to admission, when feasible, or as soon as possible
271 upon admission.

272 8. The Division shall have discharge planning performed by a
273 Qualified Healthcare Professional and initiated on the initial
274 Concurrent Review, updated periodically during the inpatient
275 stay, and continued post discharge to ensure a timely, effective,
276 safe, and appropriate discharge.

- 277 9. The Division staff participating in discharge planning shall ensure
278 the Member or Responsible Person:
- 279 a. Is involved and participates in the discharge planning
280 process;
- 281 b. Understands the written discharge plan, instructions, and
282 recommendations provided by the facility; and
- 283 c. Is provided with resources, referrals, and possible
284 interventions to meet the Member’s assessed and
285 anticipated needs after discharge.
- 286 10. The Division shall include the following in discharge planning,
287 coordination, and management of care:
- 288 a. Follow-up appointment with the PCP or specialist as
289 indicated in the discharge plan within seven Business
290 Days, unless the Member is discharged to a facility or
291 institution in which they are evaluated by a healthcare
292 professional based on the needs of the Member;
- 293 b. Coordination and communication with inpatient and facility
294 Service Providers for safe and clinically appropriate

- 295 discharge placement, and community support services;
- 296 c. Communication of the Member's treatment plan and
297 medical history with the Member's outpatient clinical team,
298 other entities,, and other FFS Service Providers when
299 appropriate;
- 300 d. Coordination and review of medications upon discharge to
301 the community or transfer to another facility to ensure
302 Medication Reconciliation occurs; and
- 303 e. Referral for services as identified in the discharge plan
304 including:
- 305 i. Prescription medications;
- 306 ii. Medical equipment;
- 307 iii. Nursing services;
- 308 iv. End-of-Life Care related services such as Advance
309 Care Planning;
- 310 v. Informal or natural supports;
- 311 vi. Hospice;
- 312 vii. Therapies (within limits for outpatient physical,

- 313 occupational and speech therapy visits for Members
314 21 years of age and older);
- 315 viii. Referral to appropriate community resources;
- 316 ix. Referral to Disease Management or Care
317 Management;
- 318 f. A post-discharge follow-up call is made to the Member or
319 Responsible Person, within three Business Days of
320 discharge to confirm the Member's well-being and progress
321 of the discharge plan, unless the Member is discharged to
322 a facility or institution in which they are evaluated by a
323 healthcare professional.
- 324 g. Additional follow-up actions as needed based on the
325 Member's assessed clinical, behavioral, physical health,
326 and social needs.
- 327 h. Proactive discharge planning when the Division becomes
328 aware of the admission even if the Division is not the
329 primary payer.

330 11. The HCS Complex Care Nurse shall collaborate with AHCCCS
331 DFSM for THP enrolled Members admitted to a Skilled Nursing
332 Facility (SNF) or with barriers to discharge.

333 12. The Division shall conduct weekly meetings with each AdSS for
334 the purpose of care coordination for Members with repeat
335 admissions or barriers with discharge.

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337 **D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION**

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

344 2. The Division shall utilize a system that includes at least two
345 modes of delivery for Service Providers to submit PA requests via
346 telephone, fax, or electronically through email.

347 3. The Division shall notify Service Providers who request

348 authorization for a service that they have the option to request a
349 peer-to-peer discussion with the appropriate Medical Director
350 when additional information is requested by the Division or when
351 the PA request is denied.

352 4. The Division shall allow at least ten Business Days from the date
353 the Service Provider has been made aware of the Denial for the
354 Service Provider to request a peer-to-peer discussion and
355 coordinate the discussion with the requesting Service Provider
356 when appropriate.

357 5. The Division shall review all PA requirements for services, items,
358 or medications annually.

359 6. The Division shall report the PA review through the MM
360 Committee and include the rationale for any changes made to PA
361 requirements.

362 7. The Division shall document the summary of the PA requirement
363 changes and the rationale for those changes in the MM
364 Committee meeting minutes.

- 365 8. The Division criteria for decisions on coverage and medical
366 necessity for both physical and behavioral health services shall
367 be documented and based on reasonable medical evidence or a
368 consensus of relevant health care professionals.
- 369 9. The Division shall require decisions regarding behavioral health
370 covered services be compliant with mental health parity.
- 371 10. The Division shall not arbitrarily deny or reduce the amount,
372 duration, or scope of a medically necessary service solely
373 because of the setting, diagnosis, type of illness, or condition of
374 the Member.
- 375 11. The Division shall place limits on services based on a reasonable
376 expectation that the amount of service to be authorized will
377 achieve the expected outcome.
- 378 12. The Division shall have criteria in place to make decisions on
379 coverage when the AdSS receives a request for service involving
380 Medicare or other third party payers.
- 381 13. The Division shall send a request for additional information to

382 the prescriber by telephone, fax, electronically, or other
383 telecommunication device within 24 hours of the submitted
384 request when the PA request for a medication lacks sufficient
385 information to render a decision.

386 14. The Division's support coordinator and HCS staff shall work in
387 conjunction with the Division's Network Administrator to provide
388 needed support to Members experiencing homelessness to
389 identify available Service Providers and assist in obtaining PA to
390 ensure timely delivery of services that are included in the
391 Member plan of care.

392 15. The Division shall not require PA for Members utilizing Indian
393 Health Services (IHS)/638 Tribal Service Providers and facilities.
394 Non-IHS/638 Service Providers or facilities rendering covered
395 services shall obtain PA.

396 16. The Division's MM committee shall approve PA criteria that the
397 AdSS Medical Management committee determines.

398 17. The Division shall provide oversight of the PA process conducted
399 by the AdSS, including adherence to benefit coverage and

400 timeliness of PA requests.

401 18. The Division shall require PA for the following Medical and
402 Behavioral Health Services:

- 403 a. Behavioral Health Residential Facility (BHRF);
- 404 b. Non-emergency acute inpatient admissions;
- 405 c. Level I BHIF and Residential Treatment Center (RTC)
- 406 Admissions;
- 407 d. Elective hospitalizations;
- 408 e. Elective surgeries;
- 409 f. Medical equipment;
- 410 g. Medical supplies, annually;
- 411 h. Home health;
- 412 i. Home and Community Based Services (HCBS);
- 413 j. Hospice;
- 414 k. Skilled Nursing Facility (SNF);

- 415 l. Therapies - Rehabilitative/Habilitative;
- 416 m. Medical or behavioral health services;
- 417 n. Emergency alert system services;
- 418 o. Behavior analysis services;
- 419 p. Augmentative and Alternative Communication (AAC)
- 420 services, supplies, and accessories;
- 421 q. Non-Emergency Transportation; and
- 422 r. Select medications.
- 423 19. The Division shall not require PA for these services or
- 424 circumstances:
- 425 a. Services performed prior to eligibility during a Prior Period
- 426 Coverage time frame;
- 427 b. Services covered by Medicare or other commercial
- 428 insurance;
- 429 c. Emergency medical hospitalization less than 72 hours;

- 430 d. Emergency admission to behavioral health level 1 inpatient
431 facility, however, notification of the admission to the
432 health plan shall occur within 72 hours;
- 433 e. Some diagnostic procedures, e.g., EKG, MRI, CT Scans, x-
434 rays, labs, check the Member's health plan's prior
435 authorization requirements;
- 436 f. Dental care - emergency and non-emergency, check the
437 Member's health plan's PA requirements;
- 438 g. Eyeglasses for Members younger than 21 years old;
- 439 h. Family Planning Services;
- 440 i. Physician or Specialty Consultations and Office Visits;
- 441 j. Behavioral Analysis Assessment;
- 442 k. Prenatal Care;
- 443 l. Emergency Transportation;
- 444 m. Non-Emergency Transportation of less than 100 miles;
- 445 n. Emergency room visit.

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447 **E. INTER-RATER RELIABILITY**

448 1. The Division shall provide oversight of Inter-Rater Reliability
449 (IRR) done by the AdSS to provide the consistent application of
450 review criteria in making medical necessity decisions which
451 require PA, Concurrent Review, and Retrospective Review.

452 2. The Division shall conduct internal IRR testing for Long Term
453 Services and Supports (LTSS) Skilled Nursing Services using the
454 H-NAT tool.

455 3. The Division shall require IRR testing of all staff who make
456 medical necessity decisions in PA, Concurrent Review and
457 Retrospective Review at new employee orientation and at least
458 annually thereafter.

459 4. The Division shall present the IRR test results from the AdSS
460 plans to the AdSS Medical Management Committee for review
461 annually and upon request.

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463 **F. RETROSPECTIVE REVIEW**

- 464 1. The Division shall oversee the Retrospective Review of medical
465 necessity of a treatment or service post-delivery of care done by
466 the AdSS plans.
- 467 2. The Division shall document and base the criteria for making
468 medical necessity decisions on reasonable medical evidence or a
469 consensus of relevant health care professionals.
- 470 3. The Division shall use the following Guidelines for Provider-
471 Preventable Conditions (PPC):
- 472 a. Title 42 CFR Section 447.26 prohibits payment for services
473 related to PPCs;
- 474 b. A Member's health status may be compromised by hospital
475 conditions or medical personnel in ways that are
476 sometimes diagnosed as a "complication".
- 477 c. If it is determined that the complication resulted from an
478 HCAC or OPPC, any additional hospital days or other
479 additional charges resulting from the HCAC or OPPC will
480 not be reimbursed;

481 c. If it is determined that the HCAC or OPPC was a result of
482 an error by a hospital or medical professional, the Division
483 conducts a Quality of Care (QOC) investigation and reports
484 the occurrence and results of the investigation to AHCCCS
485 Quality Management.

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487 **G. CLINICAL PRACTICE GUIDELINES**

488 1. The Division shall require Clinical Practice Guidelines (CPGs) are
489 developed or adopted and disseminated for physical and
490 Behavioral Health Services that:

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

493 b. Have considered the individualized needs of the Division's
494 Members;

495 c. Are adopted in consultation with contracted health care
496 professionals and National Practice Guidelines or developed
497 in consultation with health care professionals and network
498 Service Providers, and include a thorough review of peer-

- 499 reviewed articles in medical journals published in the
500 United States when national practice guidelines are not
501 available;
- 502 d. Are disseminated by the Division to all their affected
503 Service Providers, Practitioners, and, upon request, to the
504 Member or Responsible Person and Members who are not
505 yet enrolled with the Division;
- 506 e. Provide a basis for consistent decisions for utilization
507 management, Member education, coverage of services,
508 and any other areas to which the guidelines apply.
- 509 2. The Division shall review the AdSS' approved CPGs and
510 document the review and adoption of the practice guidelines as
511 well as the evaluation of efficacy of the guidelines in the MM
512 committee meeting minutes.

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**H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING
TECHNOLOGIES**

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- 517 1. The Division shall evaluate new technologies and new uses of
518 existing technology which includes an evaluation of benefits for
519 medical and behavioral healthcare services, pharmaceuticals,
520 and devices.
- 521 2. The Division shall collaborate with the AdSS to ensure new
522 medical technologies and new uses of existing technologies to
523 meet the individualized needs of the Division Members.

524

525 **I. DIVISION MONITORING AND OVERSIGHT RESPONSIBILITIES**

- 526 1. The Division MM committee shall monitor the AdSS for their
527 administration of utilization management activities for all
528 contracted services they provide to Members served by the
529 Division.
- 530 2. The MM committee shall review relevant metrics and reports,
531 and meet quarterly to discuss performance, outliers, and
532 opportunities for improvement for HCS UM activities and AdSS
533 UM activities.
- 534 3. The Division's HCS shall address the need for improvement of

535 UM activities conducted by the AdSS through quarterly meetings
536 with the AdSS and through the UM Subcommittee.

537 4. The Division shall oversee the AdSS, utilizing the following
538 methods to ensure compliance with policy:

- 539 a. Annual Operational Review of each AdSS;
- 540 b. Review and analyze deliverable reports submitted by the
541 AdSS; and
- 542 c. Conduct oversight meetings with the AdSS for the purpose
543 of:
 - 544 i. Reviewing compliance,
 - 545 ii. Addressing concerns with access to care or other
546 quality of care concerns,
 - 547 iii. Discussing systemic issues, and
 - 548 iv. Providing direction or support to the AdSS as
549 necessary.

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551 **SUPPLEMENTAL INFORMATION**

- 552 1. AHCCCS DFSM is responsible for the administration of utilization
553 management functions for acute physical and behavioral health
554 services for Division Members enrolled in the Tribal Health Program.
- 555 2. The intent of the discharge planning process is to improve the
556 management of inpatient admissions and the coordination of post
557 discharge services, reduce unnecessary hospital and institutional
558 stays, ensure discharge needs are met, and decrease readmissions.

559

560 Signature of Chief Medical Officer:

561

562 **~~1020 UTILIZATION MANAGEMENT~~**

563

564 ~~REVISION DATE: 1/25/2023 7/20/2022~~

565 ~~EFFECTIVE DATE: August 4, 2021~~

566 ~~REFERENCES: A.R.S. § 13-3994, A.R.S. § 31-501, A.R.S. § 36-551, A.R.S. §~~
567 ~~38-211, A.A.C. R9-22-101, A.A.C. R9-28-201, 42 CFR 412.87, 42 CFR Part~~
568 ~~437, 42 CFR Part 438, 42 CFR 447.26, 42 CFR 456.125, 42, CFR Part 457,~~
569 ~~45 CFR Parts 160 and 164.~~

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572 **~~PURPOSE~~**

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574 ~~This policy outlines the oversight responsibilities of the Division of~~

575 ~~Developmental Disabilities (Division) to ensure effective treatment services,~~

576 ~~coordination of care to achieve optimal health outcomes for members served~~
577 ~~by the Division and identify opportunities for improvement in utilization~~
578 ~~management. This policy is specifically targeted to the Division's roles and~~
579 ~~responsibilities related to utilization management and oversight of the AdSS.~~

580

581 **DEFINITIONS**

582 1. ~~"Behavioral Health Inpatient Facility (BHIF)" means a health~~
583 ~~institution, as specified in A.A.C. R9-10-101, that provides~~
584 ~~continuous treatment to an individual experiencing a behavioral~~
585 ~~health issue that causes the individual to:~~

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

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

591 c. ~~Be a danger to self;~~

592 d. ~~Be a danger to others;~~

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

- 595 ~~f. Be an individual with a grave disability as specified in~~
596 ~~A.R.S. § 36-501.~~
- 597 ~~2. "Behavioral Health Residential Facility (BHRF)" means, as~~
598 ~~specified in A.A.C. R9-10-101, is a health care institution that~~
599 ~~provides treatment to an individual experiencing a behavioral~~
600 ~~health issue that:~~
- 601 ~~a. Limits the individual's ability to be independent, or~~
602 ~~b. Causes the individual to require treatment to maintain or~~
603 ~~enhance independence.~~
- 604 ~~3. "Care Management" means a group of activities performed to~~
605 ~~identify and manage clinical interventions or alternative~~
606 ~~treatments for identified members to reduce risk, cost, and help~~
607 ~~achieve better health outcomes. Distinct from Support~~
608 ~~Coordination, Care Management does not include the day-to-day~~
609 ~~duties of service delivery.~~
- 610 ~~4. "Concurrent Review" means the process of reviewing an~~
611 ~~institutional stay at admission and throughout the stay to~~
612 ~~determine medical necessity for an institutional Level of Care~~

613 ~~(LOC). Reviewers assess the appropriate use of resources, LOC,~~
614 ~~and service, according to professionally recognized standards of~~
615 ~~care. Concurrent review validates the medical necessity for~~
616 ~~admission and continued stay and evaluates for Quality Of Care~~
617 ~~(QOC).~~

618 ~~5. "Denial" means the decision to deny a request made by, or on~~
619 ~~behalf of, an individual for the authorization and/or payment of a~~
620 ~~covered service.~~

621 ~~6. "Emergency Medical Condition" means a medical condition~~
622 ~~manifesting itself by acute symptoms of sufficient severity~~
623 ~~(including severe pain) such that a prudent layperson who~~
624 ~~possesses an average knowledge of health and medicine could~~
625 ~~reasonably expect the absence of immediate medical attention to~~
626 ~~result in:~~

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

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

- 631 ~~c. Serious dysfunction of any bodily organ or part as specified~~
632 ~~in 42 CFR 438.114(a); or~~
- 633 ~~d. Serious physical harm to another individual (for behavioral~~
634 ~~health conditions).~~
- 635 ~~7. "Health Care Acquired Condition (HCAC)" means a Hospital~~
636 ~~Acquired Condition (HAC) which occurs in any inpatient hospital~~
637 ~~setting and is not present on admission (Refer to the current~~
638 ~~Centers for Medicare and Medicaid Services (CMS) list of~~
639 ~~Hospital-Acquired Conditions).~~
- 640 ~~8. "Institution for Mental Disease (IMD)" means a hospital, nursing~~
641 ~~facility, or other institution of more than 16 beds that is primarily~~
642 ~~engaged in providing diagnosis, treatment, or care of individuals~~
643 ~~with mental diseases (including substance use disorders),~~
644 ~~including medical attention, nursing care and related services.~~
645 ~~Whether an institution is an institution for mental diseases is~~
646 ~~determined by its overall character as that of a facility~~
647 ~~established and maintained primarily for the care and treatment~~
648 ~~of individuals with mental diseases, whether or not it is licensed~~

649 ~~as such. An institution for Individuals with Intellectual Disabilities~~
650 ~~is not an institution for mental diseases as specified in 42 CFR~~
651 ~~435.1010.~~

652 ~~9. "Institutional Setting" means:~~

653 ~~a. A nursing facility as specified in 42 U.S.C. 1396 r(a);~~

654 ~~b. An Institution for Mental Diseases (IMD) for an individual~~
655 ~~who is either under age 21 or age 65 or older;~~

656 ~~c. A hospice (free-standing, hospital, or nursing facility~~
657 ~~subcontracted beds) as specified in A.R.S. § 36-401;~~

658 ~~d. A Behavioral Health Inpatient Facility (BHIF) as specified in~~
659 ~~A.A.C. R9-10-101;~~

660 ~~e. A Behavioral Residential Setting (BHRF) as specified in~~
661 ~~A.A.C. R9-10-101.~~

662 ~~10. "Inter Rater Reliability (IRR)" means the process of monitoring~~
663 ~~and evaluating qualified healthcare professional staff's level of~~
664 ~~consistency with decision making and adherence to clinical~~
665 ~~review criteria and standards.~~

666 ~~11. "Other Provider Preventable Condition (OPPC)" means a~~

667 ~~condition occurring in the inpatient and outpatient health care~~
668 ~~setting which the Division and AHCCCS has limited to the~~
669 ~~following:~~

- 670 ~~a. Surgery on the wrong member,~~
- 671 ~~b. Wrong surgery on a member,~~
- 672 ~~c. Wrong site surgery.~~

673 ~~12. "Peer Reviewed Study" means prior to publication, is a medical~~
674 ~~study that has been subjected to the review of medical experts~~
675 ~~who:~~

- 676 ~~a. Have expertise in the subject matter of the study,~~
- 677 ~~b. Evaluate the science and methodology of the study,~~
- 678 ~~c. Are selected by the editorial staff of the publication,~~
- 679 ~~d. Review the study without knowledge of the identity or~~
680 ~~qualifications of the author, and~~
- 681 ~~e. Are published in the United States.~~

682 ~~13. "Prior Authorization (PA)" means a process by which the AdSS~~
683 ~~authorizes, in advance, the delivery of covered services based on~~
684 ~~factors including but not limited to medical necessity, cost~~

685 ~~effectiveness, compliance with this policy and as specified in~~
686 ~~A.A.C. R9-201, and any applicable contract provisions. PA is not~~
687 ~~a guarantee of payment as specified in A.A.C. R9-22-101.~~

688 ~~14. "Provider Preventable Condition (PPC)" is a condition that meets~~
689 ~~the definition of a health care acquired condition or another~~
690 ~~provider preventable condition as defined by the State of~~
691 ~~Arizona.~~

692 ~~15. "Responsible Person" means the parent or guardian of a minor~~
693 ~~with a developmental disability, the guardian of an adult with a~~
694 ~~developmental disability or an adult with a developmental~~
695 ~~disability who is a client or an applicant for whom no guardian~~
696 ~~has been appointed. A.R.S. § 36-551.~~

697 ~~16. "Retrospective Review" means the process of determining the~~
698 ~~medical necessity of a treatment/service post-delivery of care.~~

699 ~~17. "Service Plan (SP)" means a complete written description of all~~
700 ~~covered health services and other informal supports which~~
701 ~~includes individualized goals, family support services, peer and~~
702 ~~recovery support, care coordination activities and strategies to~~

- 703 ~~assist the member in achieving an improved quality of life.~~
- 704 ~~18. "Special Health Care Needs (SHCN)" means serious and chronic~~
- 705 ~~physical, developmental, or behavioral conditions requiring~~
- 706 ~~medically necessary health and related services of a type or~~
- 707 ~~amount beyond that required by members generally; that lasts~~
- 708 ~~or is expected to last one year or longer and may require~~
- 709 ~~ongoing care not generally provided by a primary care provider.~~
- 710 ~~19. "Subcontracted health plan" means an organization with which~~
- 711 ~~the Division has contracted or delegated some of its~~
- 712 ~~management/administrative functions or responsibilities.~~
- 713 ~~20. "Support Coordination" means a collaborative process which~~
- 714 ~~assesses, plans, implements, coordinates, monitors, and~~
- 715 ~~evaluates options and services to meet an individual's health~~
- 716 ~~needs through communication and available resources to~~
- 717 ~~promote quality, cost-effective outcomes.~~
- 718 ~~21. "Telehealth" means healthcare services delivered via~~
- 719 ~~asynchronous, remote patient monitoring, teledentistry, or~~
- 720 ~~telemedicine (interactive audio and video).~~

721

722 **POLICY**

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

724 ~~1. The Division's Health Care Services (HCS) shall provide oversight~~
725 ~~and identifies trends, best practices and opportunities for~~
726 ~~improvement in utilization management through the following:~~

727 ~~a. HCS shall meet with the AdSS' Medical Management (MM)~~
728 ~~staff on a quarterly basis to review utilization data, trends,~~
729 ~~performance, and implementation of action plans.~~

730 ~~b. HCS shall review and approve annual AdSS' Medical~~
731 ~~Management Program Plan, Work Plan and Evaluation to~~
732 ~~ensure goals, service quality and outcomes reflect member~~
733 ~~needs and Division goals.~~

734 ~~2. The Division shall work in collaboration with AHCCCS Division of~~
735 ~~Fee for Service Management (DFSM) to monitor health outcomes~~
736 ~~of members enrolled in the Tribal Health Program (THP).~~

737 ~~3. The Medical Management (MM) Committee shall review~~
738 ~~utilization data and findings to make recommendations to~~

739 ~~improve performance and achieve better outcomes. The MM~~
740 ~~Committee responsibilities include:~~
741 ~~a. The review of validated data provided by the Utilization~~
742 ~~Management (UM) subcommittee and any other relevant~~
743 ~~data;~~
744 ~~b. The review of tracking and trending utilization data on an~~
745 ~~on-going basis to:~~
746 ~~i. Identify under-utilization and/or over-utilization of~~
747 ~~services;~~
748 ~~ii. Identify opportunities for early intervention;~~
749 ~~iii. Mitigate adverse outcomes;~~
750 ~~iv. Identify opportunities for improvement and best~~
751 ~~practices;~~
752 ~~v. Review of performance data related to integrated~~
753 ~~care, such as support coordination activities, access~~
754 ~~to services, and actions undertaken to resolve~~
755 ~~barriers to care; and~~
756 ~~vi. Review of the utilization data, performance and~~
757 ~~opportunities for improvement with the AdSS at least~~

758 ~~quarterly.~~

759 ~~4. The UM Subcommittee shall provide a quarterly tracking and~~
760 ~~trending report, including data provided by the AdSS, to the MM~~
761 ~~Committee.~~

762 ~~5. The UM Subcommittee shall meet at least 10 times per year.~~

763
764 ~~**C. CONCURRENT REVIEW**~~

765 ~~1. The Division shall provide oversight of concurrent review~~
766 ~~services conducted by the AdSS. The Division shall monitor~~
767 ~~and review, at least annually, the AdSS' hospital and~~
768 ~~institutional stays to ensure that treatment and lengths of~~
769 ~~stay meet member needs and are provided in accordance~~
770 ~~with clinical standards of care.~~

771 ~~2. The Division shall provide oversight of the AdSS who are~~
772 ~~required to implement the following:~~

773 ~~a. Pre-certification prior to a planned hospital or~~
774 ~~institutional admission based on medical necessity~~
775 ~~and appropriateness of proposed care. After hospital~~

776 ~~or institutional admission occurs authorization of the~~
777 ~~continued stay is based on medical necessity~~
778 ~~established during the concurrent review process.~~

779 ~~b. Clinical documentation includes relevant medical~~
780 ~~information to be reviewed when making hospital~~
781 ~~length of stay decisions. Information may include:~~
782 ~~symptoms, diagnostic test results, diagnoses, and~~
783 ~~required services. The clinical review shall include~~
784 ~~the information used for determining the length of~~
785 ~~stay.~~

786 ~~c. The admission review and subsequent concurrent~~
787 ~~reviews shall occur within the timeframes and~~
788 ~~frequency set forth below:~~

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

- 794 ii. ~~If the hospital or institution does not provide~~
795 clinical information with the notification of
796 admission, the AdSS shall request the
797 member's medical records pertinent to the
798 admission within one business day;
- 799 iii. ~~Continued stay authorizations for hospital and~~
800 institutional stays shall specify a date by which
801 the next medical review shall be done based on
802 the member's clinical information and criteria
803 guidelines.
- 804 3. ~~The Division shall notify providers of the option to request~~
805 a peer to peer discussion with the appropriate AdSS or the
806 AHCCCS DFSM Medical Director when additional
807 information is requested or when the admission or
808 continued stay is denied.
- 809 4. ~~HCS shall ensure the concurrent review process is clearly~~
810 documented and includes the following elements:
811 a. ~~Medical necessity of admission, level of care and~~

- 812 ~~appropriateness of the service setting, criteria used~~
813 ~~for decision determination;~~
- 814 ~~b. Quality of care, services and setting meeting the~~
815 ~~member needs;~~
- 816 ~~c. Projected length of stay, based on approved clinical~~
817 ~~criteria;~~
- 818 ~~d. Continued stay authorization with identification of~~
819 ~~next review date;~~
- 820 ~~e. Denials or reduction in level of service;~~
- 821 ~~f. Requests for peer-to-peer review and disposition of~~
822 ~~the request;~~
- 823 ~~g. Proactive discharge planning starting on the day of~~
824 ~~admission and ongoing throughout the~~
825 ~~hospital/institutional stay to ensure continuity of care~~
826 ~~and linkage to required treatment services and~~
827 ~~supports at discharge;~~
- 828 ~~h. Identification of utilization patterns, such as~~
829 ~~readmissions, extended length of stays.~~
- 830 ~~5. The Division's support coordinator shall participate~~

831 ~~proactively in discharge planning for its members admitted~~
832 ~~to inpatient settings from the day of admission.~~

833 ~~6. Support coordination shall manage discharge planning to~~
834 ~~ensure a safe discharge back to the community and~~
835 ~~facilitate active engagement from the health plans, health~~
836 ~~care and behavioral healthcare providers, allied treatment~~
837 ~~providers, supports and services to meet the~~
838 ~~comprehensive needs of the member.~~

839 ~~7. The support coordinator shall collaborate with AHCCCS~~
840 ~~DFSM, as appropriate for THP enrolled members.~~

841 ~~8. HCS shall review the AdSS' notification of an Institution of~~
842 ~~Mental Disease (IMD) placement exceeding 15 days and~~
843 ~~report it to AHCCCS.~~

844 ~~9. The AdSS' Medical Management Committee shall annually~~
845 ~~approve the medical criteria used for concurrent review,~~
846 ~~which shall be adopted from the national standards.~~
847 ~~Subsequently it shall be approved by the Division's MM~~
848 ~~Committee.~~

- 849 ~~10.—The Division shall ensure criteria for physical health and~~
850 ~~behavioral health coverage and medical necessity decisions~~
851 ~~are clearly documented and based on reasonable medical~~
852 ~~evidence or the consensus of relevant health care~~
853 ~~professionals.~~
- 854 ~~11.—The Division shall review the AdSS submission of the~~
855 ~~quarterly Inpatient Hospital Showings Report and sends it~~
856 ~~to AHCCCS after ensuring the report is signed by the AdSS’~~
857 ~~Chief Medical Officer attesting that:~~
- 858 ~~a.—a. A physician has certified to the necessity of~~
859 ~~inpatient hospital services,~~
- 860 ~~b.—The services were periodically reviewed and~~
861 ~~evaluated by a physician,~~
- 862 ~~c.—Each admission was reviewed or screened under a~~
863 ~~utilization review program, and~~
- 864 ~~d.—All hospitalizations of members were reviewed and~~
865 ~~certified by medical utilization staff.~~
- 866 ~~12.—The Division shall collaborate with AHCCCS DFSM to review~~
867 ~~the Inpatient Hospital Showings Report for Division~~

868 ~~members enrolled in THP.~~

869

870 **~~D. DISCHARGE PLANNING~~**

871 ~~1. The Division shall ensure the discharge planning process~~

872 ~~for members receiving inpatient services has proactive~~

873 ~~discharge planning to identify and assess the post-~~

874 ~~discharge bio-psychosocial and medical needs of the~~

875 ~~member to arrange necessary services and resources for~~

876 ~~appropriate and timely discharge from a facility.~~

877 ~~2. The support coordinator shall proactively engage with the~~

878 ~~interdisciplinary planning team which includes the~~

879 ~~hospital/institutional staff, the AdSS UM staff, HCS nurses,~~

880 ~~health care and behavioral healthcare providers, allied~~

881 ~~treatment providers, supports and services in discharge~~

882 ~~planning to meet the comprehensive needs of the member.~~

883 ~~3. The Division support coordinator shall engage within the~~

884 ~~interdisciplinary planning team to support discharge~~

885 ~~planning from the day of admission and during the~~

886 ~~inpatient stay and after discharge to ensure all the~~
887 ~~necessary treatment, services and supports are available~~
888 ~~to sustain recovery, health, wellness, and well-being upon~~
889 ~~discharge to the community.~~

890 ~~a. If the discharge cannot be affected because of the~~
891 ~~lack of a resource including return to home or~~
892 ~~community-based setting, the support coordinator~~
893 ~~shall identify the needed resource to support~~
894 ~~discharge from the hospital or institutional setting or~~
895 ~~resolve member issues and service concerns timely~~
896 ~~at the lowest level through the identification of care~~
897 ~~coordination strategies, resources, and clinical~~
898 ~~consultation.~~

899 ~~b. If a covered behavioral health service required after~~
900 ~~discharge is temporarily unavailable for individuals in~~
901 ~~an inpatient or residential facility who are discharge-~~
902 ~~ready, the member may remain in that setting until~~
903 ~~the service is available. The support coordinator shall~~
904 ~~work with the Behavioral Health Complex Care~~

905 ~~Specialist, as needed and/or seek assistance to~~
906 ~~elevate the issue for resolution of the barrier in~~
907 ~~accordance with established procedures.~~

908 ~~4. The support coordinator shall ensure care management,~~
909 ~~intensive outpatient services, provider support~~
910 ~~coordination, and/or peer service are available to the~~
911 ~~member while waiting for the appropriate covered physical~~
912 ~~or behavioral health services.~~

913 ~~a. The HCS shall compile a census report identifying the~~
914 ~~number of members who remain in discharge~~
915 ~~pending status due to the lack of community~~
916 ~~resources for review by the MM Committee including~~
917 ~~the barrier, type of resources needed, date of~~
918 ~~projected discharge and date of discharge.~~

919 ~~5. The Division shall ensure discharge planning is performed~~
920 ~~by a qualified healthcare professional and initiated on the~~
921 ~~initial concurrent review, updated periodically during the~~
922 ~~inpatient stay, and continues through post-discharge to~~

- 923 ~~ensure a timely, effective, safe, and appropriate discharge.~~
- 924 ~~6. Division staff participating in discharge planning shall~~
- 925 ~~ensure the member/responsible person, as applicable:~~
- 926 ~~a. Is involved and participates in the discharge planning~~
- 927 ~~process;~~
- 928 ~~b. Understands the written discharge plan, instructions,~~
- 929 ~~and recommendations provided by the facility; and~~
- 930 ~~c. Is provided with resources, referrals, and possible~~
- 931 ~~interventions to meet the member's assessed and~~
- 932 ~~anticipated needs after discharge.~~
- 933 ~~7. The Division shall ensure discharge planning, coordination,~~
- 934 ~~and management of care includes, but is not limited to:~~
- 935 ~~a. Follow up appointment with the PCP and/or specialist~~
- 936 ~~within seven business days;~~
- 937 ~~b. Coordination and communication by the Division with~~
- 938 ~~inpatient and facility providers for safe and clinically~~
- 939 ~~appropriate discharge placement, and community~~
- 940 ~~support services;~~

- 941 ~~c. Communication of the member's treatment plan and~~
942 ~~medical history across the various outpatient~~
943 ~~providers, including the member's outpatient clinical~~
944 ~~team, other entities/contractors, and FFS providers~~
945 ~~when appropriate;~~
946 ~~d. Prescription medications;~~
947 ~~e. Medical equipment;~~
948 ~~f. Nursing services;~~
949 ~~g. End of Life Care related services such as Advance~~
950 ~~Care Planning;~~
951 ~~h. Practical supports;~~
952 ~~i. Hospice;~~
953 ~~j. Therapies;~~
954 ~~k. Referral to appropriate community resources;~~
955 ~~l. Referral to Disease Management or Care~~
956 ~~Management (if needed);~~
957 ~~m. A post-discharge follow-up call is made by the~~
958 ~~District nurse to the member/responsible person~~
959 ~~within three business days of discharge to confirm~~

- 960 ~~the member's well-being and progress of the~~
961 ~~discharge plan;~~
962 ~~n. Additional follow up actions as needed based on the~~
963 ~~member's needs;~~
964 ~~e. Proactive discharge planning when the Division is not~~
965 ~~the primary payer.~~

968 ~~**D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION**~~

969 ~~1. The Division's support coordinator and Health Care~~
970 ~~Services staff shall work in conjunction with the Division's~~
971 ~~Network Administrator to provide needed support to~~
972 ~~homeless clinics to identify available providers and assist~~
973 ~~in obtaining PA to ensure timely delivery of services that~~
974 ~~are included in the member plan of care.~~

975 ~~2. The Division shall not require PA for tribal members~~
976 ~~utilizing Indian Health Services (IHS)/638 Tribal providers~~
977 ~~and facilities. Non-IHS/638 providers or facilities~~
978 ~~rendering covered services shall obtain PA. PA is not a~~

- 979 ~~guarantee of payment as specified in A.A.C. R9-22-101.~~
- 980 ~~3. The AdSS Medical Management committee shall determine~~
- 981 ~~PA criteria and is approved by the Division's Medical~~
- 982 ~~Management committee.~~
- 983 ~~4. The Division shall provide oversight of the PA process~~
- 984 ~~conducted by the AdSS, including adherence to benefit~~
- 985 ~~coverage and timeliness of PA requests.~~
- 986 ~~5. The Division shall provide oversight to ensure that all PA~~
- 987 ~~activities are performed in accordance with AdSS Medical~~
- 988 ~~Manual Policy 1020 including, but not limited to:~~
- 989 ~~a. The AdSS shall clearly document its criteria for~~
- 990 ~~decisions on coverage and medical necessity for both~~
- 991 ~~physical and behavioral health services and be based~~
- 992 ~~on reasonable medical evidence or a consensus of~~
- 993 ~~relevant health care professionals.~~
- 994 ~~b. The AdSS shall utilize Arizona licensed PA staff that~~
- 995 ~~includes a nurse or nurse practitioner, physician or~~

996 ~~physician assistant, pharmacist or pharmacy~~
997 ~~technician, or licensed behavioral health professional~~
998 ~~with appropriate training to apply the AdSS' medical~~
999 ~~criteria or make coverage decisions.~~

1000 ~~c. The AdSS shall implement a system that allows~~
1001 ~~providers to submit PA requests via telephone, fax,~~
1002 ~~and/or electronically through email.~~

1003 ~~d. Any AdSS network provider who requests~~
1004 ~~authorization for a service shall be notified of the~~
1005 ~~option to request a peer to peer discussion with the~~
1006 ~~AdSS Medical Director when additional information is~~
1007 ~~requested by the Division or when a PA request is~~
1008 ~~denied.~~

1009 ~~e. The AdSS shall coordinate the discussion with the~~
1010 ~~requesting provider when appropriate.~~

1011 ~~f. The AdSS shall identify and communicate to~~
1012 ~~providers and members/Responsible Person the~~
1013 ~~services that require and do not require PA and the~~

1014 ~~relevant medical criteria required for authorization~~
1015 ~~decisions.~~

1016 ~~g. The AdSS shall respond to requests for initial and~~
1017 ~~continuous determinations for standard and~~
1018 ~~expedited authorization requests as defined in Policy~~
1019 ~~1000, Chapter Overview of this Policy Manual,~~
1020 ~~Division Operations Manual policy 414, 42 CFR~~
1021 ~~457.1230(d), and 42 CFR 438.210(b).~~

1022 ~~h. The AdSS shall respond as expeditiously as the~~
1023 ~~member's condition requires but no later than 72~~
1024 ~~hours after receipt of an expedited service request~~
1025 ~~pursuant to 42 CFR 438.210(d)(2)(i). The expedited~~
1026 ~~authorization request shall meet federal standards,~~
1027 ~~because a delay in processing could seriously~~
1028 ~~jeopardize the member's life, health, or ability to~~
1029 ~~attain, maintain or regain maximum function. If the~~
1030 ~~PA request does not meet the criteria for an~~
1031 ~~expedited request, the requesting provider will be~~

1032 ~~notified and given the opportunity to provide~~
1033 ~~additional clinical information to support the~~
1034 ~~expedited request status. However, if the additional~~
1035 ~~clinical information does not support an expedited~~
1036 ~~request, the PA request will be processed as a~~
1037 ~~standard request within the specified timelines.~~

1038 ~~i. The AdSS shall communicate information to~~
1039 ~~members/Responsible Person and providers in~~
1040 ~~multiple ways including but not limited to~~
1041 ~~newsletters, the AdSS' websites, the Member~~
1042 ~~Handbooks, and provider manuals.~~

1043 ~~j. Medical criteria shall be available to~~
1044 ~~members/Responsible Person upon request.~~

1045 ~~k. The AdSS shall consistently apply medical criteria~~
1046 ~~through inter-rater reliability.~~

1047 ~~l. The AdSS shall authorize services in a sufficient~~
1048 ~~amount, duration, and scope to achieve the purpose~~
1049 ~~for which the services are furnished.~~

- 1050 ~~m. The AdSS MM Committee and the Division MM~~
1051 ~~Committee shall review and approve any changes to~~
1052 ~~medical criteria and shall be communicated to~~
1053 ~~providers at least 30 business days prior to~~
1054 ~~implementation of the change.~~
- 1055 ~~6. The Division shall require PA for the following Medical and~~
1056 ~~Behavioral Health Services:~~
- 1057 ~~a. Behavioral Health Residential Facility;~~
 - 1058 ~~b. Non-emergency Acute Inpatient Admissions;~~
 - 1059 ~~c. Level I Behavioral Health Inpatient Facility and RTC~~
1060 ~~Admissions;~~
 - 1061 ~~d. Elective Hospitalizations;~~
 - 1062 ~~e. Elective Surgeries;~~
 - 1063 ~~f. Medical Equipment;~~
 - 1064 ~~g. Medical Supplies;~~
 - 1065 ~~h. Home Health;~~
 - 1066 ~~i. Home and Community Based Services;~~
 - 1067 ~~j. Hospice;~~
 - 1068 ~~k. Skilled Nursing Facility;~~

- 1069 ~~l. Therapies Rehabilitative/Habilitative;~~
- 1070 ~~m. Medical and/or behavioral health services;~~
- 1071 ~~n. Nursing facility;~~
- 1072 ~~o. Emergency alert system services;~~
- 1073 ~~p. Rehabilitative/Habilitative Physical/Occupational~~
- 1074 ~~Therapy for members twenty one (21) years of age~~
- 1075 ~~and older;~~
- 1076 ~~q. Behavior Analysis Services;~~
- 1077 ~~r. Augmentative and Alternative Communication (AAC)~~
- 1078 ~~services, supplies, and accessories;~~
- 1079 ~~s. Non-Emergency Transportation;~~
- 1080 ~~t. Select Medications.~~
- 1081 ~~7. The Division shall not require PA for these services:~~
- 1082 ~~a. Services performed during a Retroactive Eligibility~~
- 1083 ~~Period;~~
- 1084 ~~b. When Medicare or other commercial insurance~~
- 1085 ~~coverage is primary;~~
- 1086 ~~c. Emergency Medical Hospitalization < 72 hours;~~
- 1087 ~~d. Emergency Admission to Behavioral Health Level 1~~

- 1088 ~~Inpatient facility, however, notification of the~~
1089 ~~admission to the health plan shall occur within 72~~
1090 ~~hours;~~
- 1091 ~~e. Some Diagnostic procedures, e.g., EKG, MRI, CT~~
1092 ~~Scans, Xrays, Labs; check the member's health~~
1093 ~~plan's prior authorization requirements;~~
- 1094 ~~f. Dental Care—emergency and non-emergency, check~~
1095 ~~the member's health plan's PA requirements;~~
- 1096 ~~g. Eyeglasses for members < 21 years old;~~
- 1097 ~~h. Family Planning Services;~~
- 1098 ~~i. Physician and/or Specialty Consultations and Office~~
1099 ~~Visits;~~
- 1100 ~~j. Behavioral Analysis Assessment;~~
- 1101 ~~k. Prenatal Care;~~
- 1102 ~~l. Emergency Transportation;~~
- 1103 ~~m. Non-Emergency Transportation of less than 100~~
1104 ~~miles;~~
- 1105 ~~n. Emergency room visit.~~

1107 **E. ~~INTER-RATER RELIABILITY~~**

1108 ~~1. The Division shall provide oversight of inter-rater reliability (IRR)~~
1109 ~~done by the AdSS to ensure the consistent application of review~~
1110 ~~criteria in making medical necessity decisions which require PA,~~
1111 ~~concurrent review, and retrospective review. Each AdSS plan is~~
1112 ~~monitored to ensure the following:~~

1113 ~~a. Adoption of policy and procedures for conducting inter-~~
1114 ~~rater reliability;~~

1115 ~~b. All staff, including medical directors, making medical~~
1116 ~~necessity decisions in PA, concurrent review and~~
1117 ~~retrospective review shall have IRR testing as part of the~~
1118 ~~orientation process and at least annually thereafter;~~

1119 ~~c. A process for corrective action shall be developed and~~
1120 ~~implemented for all staff who do not meet the minimum~~
1121 ~~passing compliance standard of 90%.~~

1122 ~~2. The Division shall conduct IRR testing for the following HCS~~
1123 ~~functions:~~

- 1124 a. ~~Skilled Nursing Services,~~
1125 b. ~~Second Level Medical Review.~~
- 1126 3. ~~At least annually, the IRR testing results from the AdSS plans,~~
1127 ~~the District Support Coordination and the Division medical~~
1128 ~~directors are presented to the Medical Management Committee~~
1129 ~~for review and approval.~~

1130

1131 **F. ~~RETROSPECTIVE REVIEW~~**

- 1132 1. ~~The Division shall oversee the retrospective review of~~
1133 ~~medical necessity of a treatment or service post delivery of~~
1134 ~~care done by the AdSS plans.~~
- 1135 2. ~~The AdSS plans shall be monitored for the following:~~
- 1136 a. ~~Policy and procedure that reflect:~~
- 1137 i. ~~The identification of health care professionals~~
1138 ~~with appropriate clinical expertise who are~~
1139 ~~responsible for conducting retrospective~~
1140 ~~reviews,~~

- 1141 ii. ~~Which services require retrospective review,~~
- 1142 iii. ~~Timeframe(s) established by the AdSS plans~~
- 1143 ~~for completion of the retrospective review.~~
- 1144 3. ~~The Division shall ensure criteria for making medical~~
- 1145 ~~necessity decisions is clearly documented and based on~~
- 1146 ~~reasonable medical evidence or a consensus of relevant~~
- 1147 ~~health care professionals.~~
- 1148 4. ~~The Division shall ensure there is a process for consistent~~
- 1149 ~~application of review criteria.~~
- 1150 5. ~~Guidelines for Provider Preventable Conditions (PPC), other~~
- 1151 ~~Provider Preventable Conditions (OPPC), Health Care~~
- 1152 ~~Acquired Conditions (HCAC) include:~~
- 1153 a. ~~Payment for services related to Provider Preventable~~
- 1154 ~~Conditions is prohibited, as specified in 42 CFR~~
- 1155 ~~447.26,~~
- 1156 b. ~~A member's health status may be compromised by~~
- 1157 ~~hospital conditions and/or medical personnel in ways~~

1158 ~~that are sometimes diagnosed as a “complication.” If~~
1159 ~~it is determined that the complication resulted from~~
1160 ~~an HCAC or OPPC, any additional hospital days or~~
1161 ~~other additional charges resulting from the HCAC or~~
1162 ~~OPPC will not be reimbursed.~~

1163 ~~c. If it is determined that the HCAC or OPPC was a~~
1164 ~~result of an error by a hospital or medical~~
1165 ~~professional, the AdSS shall conduct a Quality of~~
1166 ~~Care (QOC) investigation and report it in accordance~~
1167 ~~with AdSS Medical Manual Policy 960.~~

1168
1169 ~~**G. CLINICAL PRACTICE GUIDELINES**~~

1170 ~~1. The Division shall collaborate with the AdSS to ensure the clinical~~
1171 ~~practice guidelines (CPGs) developed by the AdSS meet the~~
1172 ~~individualized needs of the Division members.~~

1173 ~~2. The AdSS shall develop, adopt and disseminate CPGs for physical~~
1174 ~~and behavioral health services, in accordance with 42 CFR~~

- 1175 ~~457.1233(c) and 42 CFR 438.236 that:~~
- 1176 ~~a. Are based on valid and reliable clinical evidence or a~~
- 1177 ~~consensus of health care professionals in that field;~~
- 1178 ~~b. Have considered the individualized needs of the Division's~~
- 1179 ~~members;~~
- 1180 ~~c. Are adopted in consultation with contracted health care~~
- 1181 ~~professionals and National Practice Guidelines or developed~~
- 1182 ~~in consultation with health care professionals and include a~~
- 1183 ~~thorough review of peer reviewed articles in medical~~
- 1184 ~~journals published in the United States when national~~
- 1185 ~~practice guidelines are not available;~~
- 1186 ~~d. Are disseminated by the AdSS to all their affected~~
- 1187 ~~providers and, upon request, to members/Responsible~~
- 1188 ~~Person and potential members;~~
- 1189 ~~e. Provide a basis for consistent decisions for utilization~~
- 1190 ~~management, member education, coverage of services,~~
- 1191 ~~and any other areas to which the guidelines apply.~~

1192 ~~3. The AdSS MM Committee shall evaluate the practice guidelines~~
1193 ~~through a MM multi-disciplinary committee to determine if the~~
1194 ~~guidelines remain applicable, represent the best practice~~
1195 ~~standards, and reflect current medical standards every two~~
1196 ~~years.~~

1197 ~~4. The Division shall review the AdSS' approved CPGs and~~
1198 ~~document the review and adoption of the practice guidelines as~~
1199 ~~well as the evaluation of efficacy of the guidelines in the MM~~
1200 ~~Committee meeting minutes.~~

1201
1202 ~~H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING~~
1203 ~~TECHNOLOGIES~~

1204 ~~1. The Division shall collaborate with the AdSS to ensure new~~
1205 ~~medical technologies and new uses of existing technologies to~~
1206 ~~meet the individualized needs of the Division members. The~~
1207 ~~AdSS shall be monitored for the following:~~

1208 ~~a. Implementation written procedures for evaluating new~~
1209 ~~technologies and new uses of existing technology that~~

1210 ~~include an evaluation of benefits for physical and~~
1211 ~~behavioral healthcare services, pharmaceuticals, and~~
1212 ~~devices;~~

1213 ~~b. The procedures shall include both a mechanism for MM~~
1214 ~~Committee review on a quarterly basis and a timeframe for~~
1215 ~~making a clinical determination when a time sensitive~~
1216 ~~request is made. A decision in response to an expedited~~
1217 ~~request shall be made as expeditiously as the member's~~
1218 ~~condition warrants and no later than 72 hours from receipt~~
1219 ~~of the request.~~

1220 ~~2. The AdSS shall include coverage decisions by Medicare~~
1221 ~~intermediaries and carriers, national Medicare coverage~~
1222 ~~decisions, and Federal and State Medicaid coverage decisions in~~
1223 ~~its evaluation.~~

1224 ~~3. The AdSS shall evaluate published or unpublished information~~
1225 ~~sources that may establish that a new medical service or~~
1226 ~~technology represents an advance that substantially improves~~
1227 ~~the diagnosis or treatment of members, as specified in 42 CFR~~

1228 ~~412.87.~~

1229 ~~4. The AdSS shall have a process for documenting the coverage~~
1230 ~~determinations and rationale in the MM Committee meeting~~
1231 ~~minutes.~~

1232

1233 ~~I. DIVISION OVERSIGHT RESPONSIBILITIES~~

1234 ~~1. The Division MM Committee shall monitor utilization~~
1235 ~~management activities.~~

1236 ~~2. The MM Committee shall review relevant metrics and reports,~~
1237 ~~and meet quarterly to discuss performance, outliers, and~~
1238 ~~opportunities for improvement for HCS UM activities and AdSS~~
1239 ~~UM activities.~~

1240 ~~3. HCS shall address the need for improvement of UM activities~~
1241 ~~conducted by the AdSS through quarterly meetings with the~~
1242 ~~AdSS and through the UM Subcommittee as well as the~~
1243 ~~Division's Operational Review.~~

1244

SUPPLEMENTAL INFORMATION

1. The Division is responsible for the oversight of the AdSS' administration of utilization management activities for all services provided to members of the Division.

2. AHCCCS DFSM is responsible for the administration of utilization management functions for acute physical and behavioral health services for Division members enrolled in the Tribal Health Program.

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

Signature of Chief Medical Officer: 
Anthony Dekker (Jan 20, 2023 08:46 MST)

Anthony Dekker, D.O.