# 1020 UTILIZATION MANAGEMENT

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REFERENCES: 42 CFR 412.87; 42 CFR 435.1010; 42 CFR 438.3;42 CFR 438.114(a); 42 CFR 438.208(b)(2)(i); 42 CFR 438.210; 42 CFR 438.210(b); 42 CFR 438.210(d)(2)(i); 42 CFR 438.236; 42 CFR 438.240(b)(3); 42 CFR 447.26; 42 CFR 456.125; 42 CFR 457.1230(c); 42 CFR 457.1230(d); 42 CFR 457.1233(c); A.R.S. § 13-3994; A.R.S. § 31-501; A.R.S. § 36- 401; A.R.S. § 36-501; A.R.S. § 36-551; A.R.S. § 38-211; A.R.S. §1902(a)(31); A.A.C. R9-10-101; A.A.C. R9-22-101; A.A.C. R9-28-201; A.A.C. R9-201; Contractor Chart of Deliverables; AMPM Policy 310; AMPM Attachment 1020-A; AMPM Attachment 1020-B; ACOM 110; ACOM 414; Div Ops 414; Provider Chapter 17; 2024 National Committee for Quality Assurance; Case Management Long Term Services and Supports; Standard 4.

## PURPOSE

This policy outlines the oversight responsibilities of the Division of Developmental Disabilities (Division) to require development of an integrated process or system that is designed 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.

## 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 Hospital-Acquired Condition (HAC) which 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. "H-NAT" means the Hourly Nursing Assessment Tool that is used to analyze and display the relationship between the Skilled Nursing task and the necessary time to complete the task.

9. "Inpatient Hospital Showings Report" means a certification that a regular program of independent professional review (including medical evaluation) of the care of recipients in intermediate care facilities pursuant to A.R.S. §1902(a)(31).

10. "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 (IMD) 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 IMD as specified in 42 CFR 435.1010.

11. "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.

12. "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 Service Provider.

13. "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,
    c. Wrong site surgery.

14. "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.

15. "Prior Authorization" or "PA" means a process by which the Division authorizes, in advance, the delivery of covered services

based on factors including but not limited to medical necessity, cost effectiveness, compliance with this policy and 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.

16. "Prior Period Coverage" means for Title XIX Members, the period of time prior to the Member's enrollment with the Division 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 Division.

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

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

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

23. "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.

## POLICY

### A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

1. The Division Utilization Management (UM) sub-committee shall report to the Division's Medical Management (MM) committee and shall involve a designated senior-level physician and behavioral healthcare Provider in the implementation of physical and behavioral healthcare aspects.

2. The Division UM sub-committee shall review and evaluate the utilization data annually and on an as needed basis, and make or approve recommendations for implementing actions for improvement when variances are identified.

3. The Division's Health Care Services (HCS) shall provide oversight and identify trends, best practices and opportunities for improvement in ~~utilization management~~ UM.

4. The Division's HCS shall review and approve annual AdSS' ~~Medical Management~~ MM Program Plan, Work Plan and Evaluation to ensure goals, service quality and outcomes reflect Member needs and Division goals.

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

6. The Division shall integrate intervention strategies throughout the Division to address both underutilization and overutilization of services.

7. The Division shall require the AdSS' UM Program to have measurable outcomes that are reported in the MM Committee minutes and shared at quarterly meetings between the Division and AdSS.

8. The Division shall work in collaboration with AHCCCS Division of Fee for Service Management (DFSM) to monitor health outcomes of Members enrolled in the Tribal Health Program (THP).

9. The Division MM Committee shall review utilization data and findings to make recommendations to improve performance and achieve better outcomes.

10. The Division MM committee shall be responsible for:

a. The review of validated data provided by the ~~Utilization Management (~~UM~~)~~ subcommittee and any other relevant data; and

b. The review of tracking and trending utilization data on an on-going basis to:

i. Identify under-utilization or over-utilization of services;

ii. Identify opportunities for early intervention;

iii. Mitigate adverse outcomes;

iv. Identify opportunities for improvement and best practices;

v. Review performance data related to integrated care, such as Support Coordination activities, access to services, and actions undertaken to resolve barriers to care; and

vi. Review the utilization data, performance and opportunities for improvement with the AdSS at least

quarterly.

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

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

## B. CONCURRENT REVIEW

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

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

3. The Division shall review the AdSS submission of the quarterly Inpatient Hospital Showings Report and send it to AHCCCS 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.

4. The Division shall collaborate with AHCCCS DFSM to review the Inpatient Hospital Showings Report for Division Members enrolled in THP.

## C. DISCHARGE PLANNING

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

2. The Division 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 Division shall identify and assess the Member's post-discharge bio-psychosocial and medical needs in order to arrange necessary services and resources for appropriate and timely discharge from a facility.

4. The Division 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 Support Coordination, Care Management, intensive outpatient services, Service Provider case management, or peer service are available to the Member while waiting for the appropriate covered physical or behavioral

health services.

5. The Division shall require an interdisciplinary staffing to be conducted with the relevant Division staff, Long Term Services and Supports (LTSS) Providers and the inpatient team per contract requirements for care coordination as indicated, once the Member has been identified as awaiting discharge to the appropriate level of care.

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

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

8. The Division 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 Division staff participating in discharge planning 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 Division shall include the following in discharge planning, coordination, and management of care:
   a. Follow-up appointment with the PCP or specialist as indicated in the discharge plan within seven Business 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 Service Providers, the relevant 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 with the Member's outpatient clinical team, other entities, and other Fee For Service ~~FFS~~ Service Providers 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 Disease Management or Care Management;

f. A post-discharge follow-up call is made to the Member or Responsible Person, within three Business Days of discharge to confirm the Member's well-being and progress of the discharge plan, unless the Member is discharged to a facility or institution in which they are evaluated by a healthcare professional.

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

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

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

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

## D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

1. The Division shall have Prior Authorization (PA) staff that include an Arizona-licensed nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or an

Arizona-licensed behavioral health professional with appropriate training. ~~to apply the AdSS' medical criteria or make coverage decisions.~~

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

3. ~~The Division shall notify Service 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 Division or when the PA request is denied.~~

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

2. The Division shall require the AdSS review all PA requirements

for services, items, or medications annually.

3. The Division shall report the AdSS PA review through the MM Committee and include the rationale for any changes made to AdSS PA requirements.

4. The Division shall document the summary of the AdSS PA requirement changes annually and the rationale for those changes in the MM Committee meeting minutes.

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

6. The Division shall require decisions regarding behavioral health covered services be compliant with mental health parity.

7. The Division 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.

8. The Division shall place limits on services based on a reasonable

expectation that the amount of service to be authorized will achieve the expected outcome.

9. ~~The Division 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.~~

9. When a third party payer has approved a service request as medically necessary, the Division shall not allow a secondary PA.

10. ~~The Division 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.~~

11. ~~The Division's Support Coordinator and HCS staff shall work in conjunction with the Division's Network Administrator to provide needed support to Members experiencing homelessness to identify available Service Providers and assist in obtaining PA to ensure timely delivery of services that are included in the~~

~~Member plan of care.~~

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

11. The Division reserves the right to review AdSS PA criteria annually as part of the Operational Review or as otherwise indicated, for concerns on any requirements as indicated.

12. The Division shall provide oversight of the PA process conducted by the AdSS, including adherence to benefit coverage and timeliness of PA requests.

13. The Division shall require PA for the following Medical and Behavioral Health Services:
    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);

j. Hospice;

k. Skilled Nursing Facility (SNF);

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

14. The Division shall not require PA for these services or circumstances:

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 health plan shall occur within 72 hours;

e. Some diagnostic procedures, e.g., EKG, MRI, CT Scans, x-rays, labs, check the Member's health plan's prior authorization requirements;

f. Dental care - emergency and non-emergency, check the Member's health plan's 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;

n. Emergency room visit.

## E. INTER-RATER RELIABILITY

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

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

3. ~~The Division shall require 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 Division shall present the IRR test results from the AdSS plans to the AdSS ~~Medical Management~~ MM Committee for review annually and upon request.

## F. RETROSPECTIVE REVIEW

1. The Division shall oversee the Retrospective Review of medical necessity of a treatment or service post-delivery of care done by the AdSS plans.

2. For retrospective decisions, the Division shall provide electronic or written notification of the decision to the Responsible Person

and Practitioners within 30 calendar days of the request.

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

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

   a. Title 42 CFR Section 447.26 prohibits payment for services related to PPCs;

   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 will not be reimbursed;

   d. If it is determined that the HCAC or OPPC was a result of an error by a hospital or medical professional, the Division

shall submit the incident report to the appropriate AdSS health plan for a Quality of Care (QOC) investigation.

~~conducts a Quality of Care (QOC) investigation and reports the occurrence and results of the investigation to AHCCCS Quality Management.~~

## G. CLINICAL PRACTICE GUIDELINES

1. The Division shall require Clinical Practice Guidelines (CPGs) are developed or adopted and disseminated 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. Have considered the individualized needs of the Division's Members;
   c. Are adopted in consultation with contracted health care professionals and National Practice Guidelines or developed in consultation with health care professionals and network Service 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 Division to ~~all their~~ affected Service Providers, Practitioners, and, upon request, to the Member or Responsible Person and Members who are not yet enrolled with the Division;

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

2. The Division shall review the AdSS' approved CPGs and document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines in the MM committee meeting minutes.

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

1. The Division shall evaluate new technologies and new uses of

existing technology.

2. The Division shall include in the review of new technologies and new uses of existing technology ~~which includes~~ an evaluation of benefits for medical and behavioral healthcare services, pharmaceuticals, and devices.

3. The Division shall collaborate with the AdSS to ensure new medical technologies and new uses of existing technologies to meet the individualized needs of the Division Members.

## I. DIVISION MONITORING AND OVERSIGHT RESPONSIBILITIES

1. The Division MM committee shall monitor the AdSS for their administration of ~~utilization management~~ UM activities for all contracted services they provide to Members served by the Division.

2. The MM committee shall review relevant metrics and reports, and meet quarterly to discuss performance, outliers, and opportunities for improvement for HCS UM activities and AdSS

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599 UM activities.
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601 3. The Division's HCS shall address the need for improvement of
602 UM activities conducted by the AdSS through quarterly meetings
603 with the AdSS and through the UM Subcommittee.

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

606 a. Annual Operational Review of each AdSS;
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608 b. Review and analyze deliverable reports submitted by the
609 AdSS; and
610 c. Conduct oversight meetings with the AdSS for the purpose
611 of:

612 i. Reviewing compliance,
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614 ii. Addressing concerns with access to care or other
615 quality of care concerns,

616 iii. Discussing systemic issues, and
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618 iv. Providing direction or support to the AdSS as

necessary.

**SUPPLEMENTAL INFORMATION**

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

2. 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: