

1000 CHAPTER OVERVIEW

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REFERENCES: 9 A.A.C. 34, 42 CFR 438.210

Purpose

The standards and requirements included in this chapter are applicable to the Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSS). If requirements of this chapter conflict with specific contract language, the AHCCCS medical contract with the Division will take precedence.

At least annually, the Medical Management Unit will conduct reviews of each AdSS' compliance with the requirements of this chapter. The Division's Medical Management Unit is located within the Division's Health Care Services.

The chapter provides the necessary information to the Division and its AdSS to ensure compliance with federal, state, and AHCCCS requirements to Medical Management activities.

Definitions

The Division's words and phrases in this chapter have the following meanings, unless the context explicitly requires another meaning. Refer to AHCCCS policy for other applicable definitions.

Assess or Evaluate - To study or examine methodically and in detail, typically for purposes of explanation and interpretation.

Authorization Request (Expedited) - Under 42 CFR 438.210, a request for which a provider indicates the Division determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Division must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member's best interest.

Authorization Request (Standard) - Under 42 CFR 438.210, a request for which a the Division must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member's best interest.

Care Management - A group of activities performed by AdSS to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include day-to-day duties of service delivery.

Case Management – A collaborative process that 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.

Catastrophic Reinsurance - Stop-loss mechanism to provide the Division with partial reimbursement for specified service costs incurred by a member. This risk-sharing program is available when the provisions delineated in the Reinsurance Processing Manual, Medical Policy Manual, and contract are met.

Concurrent Review - Process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care. The Division reviewers assess the appropriate use of resources, Level of Care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates quality of care.

Continuous Health Care Improvement - Integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

- A. Identifying and proactively monitoring high-risk populations,
- B. Assisting members and providers in adhering to identified evidence-based guidelines,
- C. Promoting care coordination,
- D. Increasing and monitoring member self-management, and
- E. Optimizing member safety.

Delegated Entity - Qualified organization, agency, or provider that holds a subcontract to perform delegated management/administrative functions or responsibilities for the Division.

Disease Management - An integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

- A. Identifying and proactively monitoring high-risk populations,
- B. Assisting members and providers in adhering to identified evidence-based guidelines,
- C. Promoting care coordination,
- D. Increasing and monitoring member self-management, and
- E. Optimizing member safety.

Goal - Desired result the Division envisions, plans, and commits to achieve within a proposed timeframe.

Grievance - Expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member’s rights. Grievances do not include “Action(s)” as defined in 9 A.A.C. 34.

Measurable - A gauge to determine definitively whether a goal has been met or progress has been made.

Medical Management - Integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from prevention to end of life care).

Methodology - Planned process, steps, activities, or actions taken by the Division to achieve a goal or objective or to progress toward a positive outcome.

Monitoring – Process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results.

Retrospective Review - Process of determining the medical necessity of a treatment/service post-delivery of care.

Utilization Management - Applies to a Division process to evaluate, and approve or deny health care services, procedures, or settings based on medical necessity, appropriateness, efficacy, and efficiency. Utilization management also includes processes for prior authorization, concurrent review, retrospective review, and case management.

Monitoring

The Division monitors AHCCCS acute services, for the Division's members, with the following processes:

- A. Contracts with acute health plan.
- B. Operational Reviews with each Division contracted health plan.
- C. Quarterly compliance meetings with each Division contracted health plan.
- D. Annual Medical Management plans that include narratives, evaluations, completed work plans from the previous year and new work plans for the current year.
- E. Quarterly AHCCCS deliverables (includes EPSDT reports) oversight for Division members.
- F. Division contracted health plan quarterly Utilization Management (UM) reports.
- G. The Division's Medical Management and Chief Medical Officer or designated Medical Director meetings to discuss data analysis, interventions, and corrective action plans (CAPs). Informal clarification may occur as well as defined CAPs coordinated through the Compliance Units of the Division and the AdSS.
- H. Provider manual and member handbook oversight.
- I. Health Care Services procedures.