COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT SCENARIO # D24D

1) INTERACTION OF THE CM (CM) WITH THE MEMBER AND OTHERS AS APPLICABLE

PAS information was reviewed after CM received daily enrollment roster and noted that member rolled on to CHS Roster. Initial telephone contact was made with Roger and Joyce within three working days of receipt of the enrollment roster. The CM scheduled the initial assessment within seven working days of receipt of the roster at a time convenient for Roger and Joyce. The CM introduced herself, welcomed them to the program, and set the stage for a sound working relationship based on mutual respect and trust. The CM explained that the role of the CM is to help Roger get the best health care possible within program guidelines, based on medical necessity. She explained that CMs work with doctors and providers to coordinate care, and are readily available to answer questions and address members' day-to-day concerns.

The CM provided Roger and Joyce with the CHS Member Handbook, business card, list of CHS contracted physicians, specialists and pharmacies. The Notice of Privacy Practices was provided and explained. The Authorization to Share Health Information was completed, with Joyce identified as the guardian. Joyce provided the CM with a copy of the guardianship letter. Member's rights and responsibilities were reviewed with Joyce in Roger's presence. Roger and Joyce were also given AHCCCS approved information on initiating Advanced Directives, and the CM encouraged Roger to receive the annual influenza and pneumonia vaccinations, if medically possible. The CM reviewed the covered services with Joyce and explained the cost effectiveness of services. The CM went into more detail explaining the SDAC model and family attendant care options as Joyce was very interested in these. Joyce currently has a full time job and the neighbors are checking in on Roger during the day while she is at work. Joyce stated she feels it is unsafe to leave Roger alone at any time and that the neighbors have decided to re-locate to a different area of the state. The CM informed Joyce about general supervision and how it is assessed and the criteria that must be met in order to authorize it. The CM also assured Roger and Joyce that BH services are available locally. Joyce was directed to choose a CHS contracted PCP for her brother from the list of physicians provided. The CM informed them she would contact the PCP of their choice to inquire whether they were accepting new patients at this time. If the new PCP was accepting new patients, the CM would send a new enrollment letter to the PCP including Roger's enrollment date, DOB, address, phone number, and any other insurance information. The CM informed Joyce that she would also be receiving a letter informing her of the change in PCPs. She would be instructed to request the medical records from Roger's previous PCP to be sent to the new PCP and to schedule an appointment with the new PCP within seven to ten days of receipt of the letter. The County Resources Directory was also provided to Joyce.

To begin Roger's assessment, the CM explained that a HCBS Member Needs Assessment Tool, a Uniform Assessment Tool, and the CHS Assessment Form would be completed during the assessment. These tools aid the CM in gathering information about the member's needs and identifying what home based services the member requires in order to remain in the home setting safely. The CM explained she makes a preliminary determination of services needed and then all information is reviewed with the Assessment Review Team for discussion. She explained the Assessment Review Team process and who is involved. The Assessment Review Team consists of two or three CMs with more than ten years experience, the CM/MUM RN Liaison, and the CM RN Supervisor. This team, along with the CM, discusses the information gathered during the assessment and other previous assessment information if any. The team discusses the member's situation, identifies the member's needs and makes a determination of services based on the CM's assessment information provided. The CM informed Roger and Joyce that CHS CMs follow this process for any new CHS members that require HCBS services and for any member identified as needing and/or requesting a change in current services whether for an increase or decrease. She told Joyce she would be receiving a phone call from her within two days of the Assessment Review Team meeting informing her of the services that would be authorized and that the Service Plan would be mailed for her signature. She informed Joyce that if she disagreed with the services authorized, she may note that on the Service Plan and the services would be reviewed by the CM Supervisor and CHS Medical Director. The NOA process was discussed with Joyce. The CM also completed the Behavioral Health Screening form at this time and informed Joyce this form indicates the need for Behavioral Health services for Roger. The Contingency (Back up) Plan was explained and developed. The CM explained gaps in service and member preference and how to report gaps in service if they should occur, including the 800# at AHCCCS set up for this purpose.

Joyce explained since Roger's recent move here after their mother's death, she has noticed an increase in negative behaviors. She explained their mother was able to care for him at home with some support, but Joyce is now having difficulty even with some prior behavior management training. She said Roger is resistive to care, refuses to bathe, change clothes, and take his medications. Roger has also had an increase in verbal and physical aggression, using profanity, throwing objects, and has recently struck out at her twice. He is fabricating and has recently tried to leave the house without supervision. Joyce noticed that Roger is isolating himself more in his bedroom and he says it's because he is bored and doesn't have anything to do but watch television. Joyce told the CM she tries to reward good behavior with cigarettes, but it just is not working.

Joyce also informed the CM that Roger continues to have seizures about twice a week. She is concerned that he may fall and hurt himself or hurt himself with his increased aggressive behaviors. To provide Joyce an opportunity to make an informed decision, the CM discussed homed based services versus alternative behavioral placements and the share of cost. Joyce said she would like to keep Roger home with her rather than looking for a behavioral setting at this time.

2) ASSESSMENT OF MEMBER'S STATUS AND NEEDS:

Physical status assessed as follows:

Transfer/Mobility: No difficulty with transfers or mobility reported or assessed. High risk for falls related to current seizure activity. Reevaluate in ninety days.

Bathing, Dressing and Grooming: Member is resistive to personal care, refuses to bathe, change clothes, and take medications.

Eating: No difficulty in eating reported or assessed. Reevaluate in ninety days.

Toileting: No difficulty with toileting reported or assessed. Reevaluate in ninety days.

Change in ADL function: No physical changes indicated. Reevaluate in ninety days.

Communication: No difficulty in communicating. Reevaluate in ninety days.

Summary of physical needs assessed as follows:

-Monitor for safety and risk of falls due to seizures. Joyce and Roger to follow up with PCP on history of seizure activity and current seizures.

-Needs general supervision when family/informal Support System not available related to potential for injury, impaired judgment, elopement risk, increased aggressive behaviors.

Psychological status assessed as follows:

-Address grieving and adjustment problems due to death of mother, symptoms of depression, and recent relocation to another state to live with Joyce.

-Address verbal and physical aggression, agitation, uncontrolled anger and fabrications.

Summary of psychological needs assessed:

-Needs psychiatric evaluation for verbal and physical aggression, agitation, uncontrolled anger, and fabrications.

-Needs counseling, to address loss of mother, symptoms of depression, self-isolation, and adjustment problems regarding recent relocation. Evaluation should include possible benefit of family, as well as individual, counseling.

-Needs general supervision when family/informal support system is not available.

Environmental status assessed as follows:

Roger lives with sister. He has own room. No other environmental needs assessed.

Socialization status assessed as follows:

Roger has nothing to occupy his time. He spends most of the day in his room. He has impaired judgment.

Summary of socialization needs assessed:

-Needs habilitation services.

-Needs supportive employment if appropriate.

-Needs access to SMI day program.

Community support/public assistance status assessed as follows:

Roger and Joyce need as much information as possible on community supports and public assistance, as they are new to the area.

Summary of community support/public assistance needs assessed:

-Provide Roger and Joyce with list and contacts of community/public assistance programs and groups.

3) CARE PLAN/SERVICES DEVELOPED TO MEET THE NEEDS OF THE MEMBER, INCLUDING DESIRED OUTCOMES THAT ARE MEMBER-SPECIFIC AND MEASURABLE

Physical:
-Provide Roger and Joyce a list of CHS contracted PCPs and Specialists.
-If current PCP is not contracted, pick from list provided within three days and report to CM.
-Send new PCP notification letter after calling to confirm availability. Joyce to make appointment within seven to ten days of receipt of letter.
-Roger and Joyce to discuss current and past seizure activity with PCP at first visit, as well as the upper respiratory infections, and possible need for adjustment of medications and/or referral to neurologist.
-Recommend Respite care two hours twice a week until Abrio (habilitation provider) is in place, to be effective immediately.
-Contact Abrio within two days to arrange for habilitation evaluation, and complete authorization.
-Offer Smoking Cessation Program after negative behaviors have stabilized.
-Provide general supervision while Joyce is at work to be effective immediately for redirection and prompts, elopement risk, and to prevent injury from un-witnessed falls due to seizure activity, impaired judgment, and aggressive behavior. Goal is for member to remain free from injury for thirty days due to impaired judgment, aggressive behaviors, and un-witnessed falls.

Behavioral Health:
-Contact PCP to determine medical necessity and coordinate behavioral health services, including psychiatric evaluation for medications, medication management, and counseling for grief, depression, anger management and fabrications. Complete referrals within two days of identifying need.
-Contact and coordinate services with behavioral health providers within two days, providing member history and issues with anger management and personal/environmental stressors. Since the goal is to remain in own home, counseling may improve both Roger's and Joyce's coping skills to manage grief and other environmental stressors. Counseling will also provide education for Joyce in the use of positive reinforces other than cigarettes for rewarding positive behaviors. The Behavioral health professional will recommend frequency of visits after intake, and submit monthly progress reports to the CHS Medical/Utilization Management division and CM.
-Complete Initial BH Consultation for review and recommendations by the BH Coordinator.
-Contact local BH provider within two days to coordinate access to the Comfort Zone, a day program for individuals with SMI diagnoses.
-Contact Abrio within two days for in-home evaluation to assist with behavioral management. Goal is for member to have a decrease in verbal and physical aggressive episodes and exhibit a decrease of self-isolation tendencies within two months.

Housing/home modifications: None indicated.

Socialization:
-Contact Abrio within two days for an in-home evaluation to assess the benefit of habilitation services, including acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside in an HCBS setting. -Services needed would also include behavioral management, supported employment (if appropriate), and escorts to day programs such as the Comfort Zone. Goal is for Roger to be less resistive to care and show improved social interactions by a decrease of verbal statements of feeling bored within one month.

Community Support/Public Assistance:
- Discuss available resources with Joyce and Roger including: ViCap (volunteer group), TBI support groups, other groups as appropriate, NAMI, Cenpatico providers (explore newly available providers and services in the area), Comfort Zone, HEE booklet, County Resource Directory, and Public (financial) assistance agencies. Goal is for Joyce to have contact with at least one community support group within one month.

Service plan completed and mailed to Roger. Contingency plan completed and mailed to Roger and agency. Authorizations entered into health information system and sent to providers. Completed CA160, CA161 and CA165.


Medical
Management

COCHISE HEALTH SYSTEMS (CHS) MEDICAL MANAGEMENT # D25

Purpose: Along with the Medical/Utilization Management (M/UM) tasks of monitoring care and service delivered to members by contracted providers, the purpose of the Utilization Management (UM) program is to execute processes that assess, plan, implement, and evaluate UM activities as specified in AMPM Chapter 1000. This is done through utilization reviews that audit the effectiveness of the UM program, review medical appropriateness of services provided, and review provider performance in providing cost-effective care. CHS strives to ensure that AHCCCS covered services are delivered in a way that is consistent with current medical knowledge and standards. The UM Plan is monitored to ensure that activities do not have an adverse impact on medically appropriate care via the review of any denials, focused studies, negative utilization trends, and/or member grievances.

Overview: Utilization data is collected and analyzed in the following broad categories: prior authorization and referral management, concurrent review, retrospective review, and internal process review. Over or under-utilization will be determined by randomly selecting specific CHS services and collecting data to compare utilization patterns among providers, members, and case managers. The information gained is reviewed with CHS staff and the providers. For any identified issues or concerns, discussion and/or written communication is accomplished in consultation with the Medical Director with suggestions for a corrective action plan (CAP) if needed. Examples of specific utilization review activities follow.

Utilization Review of Pharmacy Services: The drug utilization review process is outsourced to United Drugs, our Pharmacy Benefit Manager (PBM). M/UM staff reviews and evaluates the appropriate utilization of services delivered to members. The utilization data provided by the PBM is used in the evaluation of providers during re-credentialing and in the renewal of contracts. The drug utilization program conducted by our PBM includes, but is not limited to: a) prospective review of all drugs before dispensing and all non-formulary drug requests; b) concurrent drug therapy monitoring of selected members; c) retrospective drug use review; and d) pattern analysis. The PBM provides a formal, quarterly report of these activities in written format and meets with M/UM staff to review same as needed.

Based upon the PBM's utilization data, education of prescribers and CHS professionals will be geared toward common drug therapy problems. These will be based upon utilization patterns with the aim of improving safety, generic usage, prescribing practices, adherence to formulary, and therapeutic outcomes. An analysis of these interventions and an assessment of the effect of the interventions on the quality of care will be included in next year's review.

M/UM staff reviews member medication utilization on a monthly basis. If a member has prescriptions for ten or more medications, the member's PCP is sent quarterly the member's specific pharmacy report, is asked to do a medication review, and asked to evaluate medical need and utilization. M/UM staff also review member medication cost reports monthly for medication costs of $400 plus per month. The PCP is sent the member's specific pharmacy cost report quarterly and is asked to do a medication review with an evaluation of medical need and utilization. Quarterly, PCPs are also sent "Report Cards" that compare their utilization to other physicians contracted with CHS. This is offered to physicians in hope of encouraging increased use of generic medications and reduction of costs per member per month. Information regarding variances in utilization data are reviewed during M/UM Nurses meetings and reported to the M/UM Performance Improvement Committee (M/UM PIC). Our PBM reports that CHS prescriber's use of generic medications is the highest in the State working with that PBM, indicating that our efforts have been effective in this area.

Utilization Review of E.R. Services: Data regarding utilization of ER services is gathered monthly through the use of "Doc Util" reports from our claims management system. Over utilization of E.R. services is defined as: 1) a member with three (3) or more E.R. visits within a three month period; 2) a PCP with three (3) or more members with E.R. visits within a three month period; 3) a nursing home with three (3) or more members with E.R. visits in a three month period; and/or 4) an emergency room visit diagnosis that does not indicate a sudden onset of a medical condition.

Utilization Review of Repeat Hospital Admissions: Data regarding utilization of repeat hospitalizations is also gathered monthly through the use of "Doc Util" reports from our claims management system. Data indicating over

utilization of repeat hospital admissions is defined as: 1) a member with three (3) or more admissions within a three month period; 2) a PCP with three (3) or more members with admissions within a three month period; and/or 3) a nursing home with five (5) or more members with admissions within a three month period.

Utilization Review of Durable Medical Equipment: To evaluate the appropriate utilization of DME services delivered to members, data from our claims processing system is reviewed on a monthly basis (or as needed) for specific CPT codes. This utilization data of DME is used in the evaluation of providers during re-credentialing and in the renewal of contracts. The process of obtaining DME and medical supplies is coordinated through Case Management. Case managers are required to complete a DME log on each HCBS member upon admission and update at 90-day visits as needed. These logs are maintained in the member's record. On a daily basis, M/UM nursing staff review the authorization and utilization report. When an authorization is identified as potentially inappropriate, the case manager is notified to provide background information that may support the medical necessity for service. If the service is not assessed as medically necessary, the case manager will follow up with the requesting provider or initiate a quality of care concern process as indicated. In addition, M/UM staff receives utilization reports from our contracted DME provider on at least a monthly basis. This data is also used to identify concerns or trends.

Utilization Review of HCBS: To evaluate the appropriate utilization of services delivered to HCBS members, skilled home health data is reviewed. This Utilization data is used in the evaluation of providers during re-credentialing and in the renewal of contracts. It is also used to compare authorization patterns among case managers and among the network of HCBS providers.

Utilization Review of Specialist Visits: To evaluate the appropriate utilization of services delivered to members, specialist visits are reviewed at least bi-annually using paid claims data. This utilization data is used in the evaluation of providers during re-credentialing, and in the renewal of contracts. Data indicating over utilization of specialist referrals is defined as: 1) a member with four (4) or more specialist visits within three (3) months; and/or 2) a PCP with ten (10) or more members with specialist visits within three (3) months.

Utilization Review of Behavioral Health Services: To evaluate the appropriate utilization of services delivered to members, behavioral health utilization data is reviewed at least quarterly using paid claims data. In addition, MSAS staff requires a monthly summary report and statement of goals with all requests for continuing behavioral health services. Two to three high profile members are reviewed monthly at the Behavioral Health Utilization Workgroup meeting to more closely monitor both the under and over utilization of BH services. Some records are also sent to a contracted Behavioral Health consultant to review appropriateness of treatment and progress towards goals. This utilization data is used in the evaluation of providers during re-credentialing, and in the renewal of contracts.

Utilization of Specialty and/or Ancillary Service Referrals: The Primary Care Physician (PCP) is the focal point for managing each member's medical care, including coordination of all specialty and/or ancillary services the member may require. If a referral to more specialized services is necessary, the PCP or designee will complete a referral form including clinical information and submit to CHS for authorization. The requested health care professional is responsible for keeping the PCP informed with respect to the member's care. Primary Care Physician referrals are reviewed quarterly for over/under utilization. This information may be forwarded to the PCP's office for their information and review.

Management of the overall referral process and under/over utilization of referred services is accomplished through a joint effort involving: Medical/Utilization Management, Case Management, Finance, Providers and the PCP. Support services and non-emergent transportation are authorized by Case Management, as is DME up to $500. Referral utilization reports are generated to enable CHS to identify under and over utilization issues on an ongoing basis. Formal chart audits are conducted on any physician identified as potentially under or over utilizing services. This information is communicated to the appropriate physician and to the Medical Director. A focused review and a Plan of Correction for physician utilization are included if necessary. This information is reviewed and acted upon during the re-credentialing process.

Medical Claims Review: The M/UM staff conducts retrospective reviews of certain claims prior to payment. The reviews are conducted to ensure the medical appropriateness of the services delivered and to monitor utilization patterns. All non-Medicare inpatient acute hospital claims and all outlier claims are reviewed for medical necessity and appropriateness. Other claims may receive Medical Review as deemed necessary for services that are identified

as potentially over-utilized, medical need is questionable, or procedures reported are different from those authorized. If the documentation is insufficient to support the medical necessity of the services, the claim is pended and returned for additional information. All claims that are denied due to medical necessity are reviewed by the Medical Director. Some claims are denied by M/UM Nurses, due to procedural issues, no auth, wrong provider, wrong dates of service, duplicate claims, and/or incorrect coding. The following claims are forwarded to M/UM by Finance for medical review on a daily basis: Discrepancy between Auth # and Charges/Services Billed, Inpatient claims for Non-Medicare members over $5,000 billed, all outlier claims, high dollar/high volume – Non-Medicare only, all hospice, Dialysis – Non-Medicare, Dental, DME with Medicare EOB Denials, Ambulance transportation Medicare and Non-Medicare, and all Non-Medicare Therapy claims.

Underutilization of Services: In all of the analysis activities described above, M/UM staff will also review cases for the possibility of under-utilization of service. Data indicating under utilization of services or providers is defined as: 1) a member complaint of inadequate referrals to providers; 2) a PCP with no referrals to providers within a six-month period; and/or 3) a Quality of Care concern indicating inadequate care of referrals for care. If under utilization occurs, a plan of action will be developed. Outcome Reports are completed annually to address the results of the year's collection of data.

Results from Utilization Review Activities: The ultimate goal of all of the review and analysis activities described above is to ensure that CHS members receive appropriate medical care to optimize their overall health status. This will allow them to "age in place" as long as possible, in the least restrictive setting, and to ensure they receive medically necessary, ALTCS covered services in the most cost effective manner by the most appropriate contracted CHS' providers. When problems regarding under utilization, over utilization, or inappropriate utilization of services are identified, the M/UM department takes a lead role resolving these identified problems.

Information regarding variances in utilization will be reported to the M/UM PIC. Evaluation of the quality of services provided will be reviewed during M/UM Nurse Meetings and reported to M/UM PIC on a quarterly basis. The following items will be addressed by the M/UM Manager at the M/UM PIC meetings: 1) Problem areas identified; 2) Interventions and plans of action; 3) Analysis of interventions; and 4) Changes to interventions.

Typically there are many factors that can adversely affect utilization. The first step taken when opportunities for improvement are noted is education. M/UM staff provides education to individual contractors, facilities, CHS staff, and to members. Many times, once the provider or staff is made aware of the noted trend, immediate corrective action takes place. The M/UM department continues to closely monitor utilization after a trend is corrected to be certain that the corrective action will be long-lasting.

After education is provided and the trend continues, or if the trend could impact member safety, M/UM staff requests a written plan of correction with timelines from the provider involved. In most cases, the contracted provider or facility responds quickly and appropriately, the plan of correction is accepted by M/UM staff and the Medical Director, and the M/UM staff will continue to monitor the situation to be certain that the problem has indeed been corrected. If the identified trend involves several providers and/or members, M/UM staff may consult with the Medical Director and write specific protocols and/or practice guidelines to assist in the delivery of care. These protocols and guidelines are also reviewed by the M/UM PIC for their input prior to distribution and use.

In the event that a trend is not corrected or if the contracted provider or facility does not submit an acceptable plan of correction, admissions/referrals to that facility may be suspended. If this action does not result in the submission of an acceptable plan of correction, then CHS would give notice to the provider or facility of intent to terminate the contractual agreement with them. If the unresolved trend involves a medical provider, the case is always referred to the Medical Director for intervention and resolution. If the trend is serious in nature or is determined to be repetitive, the Peer Review Committee will be requested to review the case and take action as appropriate. The M/UM staff also may refer cases outside of CHS when appropriate to involve other agencies, i.e., AHCCCS, BOMEX, AzDHS, APS, CPS, etc.

The CHS Concern Forms will be used to record issues that involve utilization that may have affected member's health, safety or well-being; and will be discussed at the M/UM PIC meetings.

See attached Sample Utilization Reports presented to M/UM PIC.

SAMPLE UTILIZATION REPORTS 2010

REPEAT ER/ADMISSIONS VISITS

Oct. 01/09-Dec. 31/09	Jan. 01/10-Mar. 31/10	April 01/10- June 30/10	July 01/10 – Sept. 30/10
# Members with 3 or more ER Visits: 5	# Members with 3 or more ER Visits: 5	# Members with 3 or more ER Visits: 7	# Members with 3 or more ER Visits: 9
# PCPs with 3 or more members with ER Visits: 1 (P Patel)	# PCPs with 3 or more members with ER Visits: 0	# PCPs with 3 or more members with ER Visits: 0	# PCPs with 3 or more members with ER Visits: 0
# NFs with 3 or more members with ER Visits: 0	# NFs with 3 or more members with ER Visits: 0	# NFs with 3 or more members with ER Visits: 0	# NFs with 3 or more members with ER Visits: 0
#ALF's with 3 or more members with ER Visits: 0	#ALF's with 3 or more members with ER Visits: 0	#ALF's with 3 or more members with ER Visits: 0	#ALF's with 3 or more members with ER Visits: 0
# Members with 3 or more Admissions: 4	# Members with 3 or more Admissions: 2	# Members with 3 or more Admissions: 0	# Members with 3 or more Admissions: 0
# PCPs with 3 or more members with Admissions: 0	# PCPs with 3 or more members with Admissions: 0	# PCPs with 3 or more members with Admissions: 0	# PCPs with 3 or more members with Admissions: 0
# NFs with 3 or more members with Admissions: 0	# NFs with 3 or more members with Admissions: 0	# NFs with 3 or more members with Admissions: 0	# NFs with 3 or more members with Admissions: 0
#ALF's with 3 or more members with admissions: 0	#ALF's with 3 or more members with admissions: 0	#ALF's with 3 or more members with admissions: 0	#ALF's with 3 or more members with admissions: 0
Members presented with Concerns: none	Members presented with Concerns: none	Members presented with Concerns: none	Members presented with Concerns: none

HOSPITAL UTILIZATION

Oct. 01/09-Dec.31/09	Jan. 01/10-Mar. 31/10	April 01/10-June 30/10	July 01/10-Sept 30/10
Total Admissions: 183 Total BH Admits: 7 Total Rehab Admits: 2 Average LOS: 5.9 Average BH LOS: 9 Average Rehab LOS: 18 Top Diagnosis: PNEUMONIA - 17 COPD 9 UTI 8 # Medicare : 153 # Non-Medicare: 30 #Behavioral Medicare: 2 #Behavioral Non-Med: 5 #Rehab Medicare: 1 #Rehab Non-Med: 1	Total Admissions: 174 Total BH Admits: 0 Total Rehab Admits: 11 Average LOS: 7.8 Average BH LOS: 0 Average Rehab LOS: 12 Top Diagnosis: PNEUMONIA - 29 CHF - 11 UTI - 10 # Medicare : 146 # Non-Medicare: 28 #Behavioral Medicare: 0 #Behavioral Non-Med: 0 #Rehab Medicare: 7 #Rehab Non-Med: 4	Total Admissions: 172 Total BH Admits: 4 Total Rehab Admits: 4 Average LOS: 8.1 Average BH LOS: 5.5 Average Rehab LOS: 18.8 Top Diagnosis: PNEUMONIA - 27 UTI – 14 SEPSIS - 8 # Medicare : 147 # Non-Medicare: 25 #Behavioral Medicare: 2 #Behavioral Non-Med: 2 #Rehab Medicare: 2 #Rehab Non-Med: 2	Total Admissions: 141 Total BH Admits: 0 Total Rehab Admits: 2 Average LOS: 6.1 Average BH LOS: 0 Average Rehab LOS: 24.5 Top Diagnosis: CHEST PAIN - 14 CHF – 8 PNEUMONIA - 9 # Medicare : 119 # Non-Medicare: 22 #Behavioral Medicare: 0 #Behavioral Non-Med: 0 #Rehab Medicare: 1 #Rehab Non-Med: 1

% OF HCBS MEMBERS RECEIVING Housekeeping, Attendant Care, and Personal Care

APRIL 10	MAY 10	JUNE 10	JULY 10	AUGUST 10	SEPT 10
HCBS MEMBERS 546 Housekeeping 4% $4,301. Attendant Care 63% $306,286. Family Attend 4% $19,644. Personal Care 1% $3495.	HCBS MEMBERS 547 Housekeeping 3% $4,284. Attendant Care 61% $309,455. Family Attend 9% $30,249. Personal Care 1% $3,440.	HCBS MEMBERS 538 Housekeeping 4% $5,359. Attendant Care 61% $323,294. Family Attend 5% $17,366. Personal Care 1% $3,572.	HCBS MEMBERS 546 Housekeeping 4% $4973. Attendant Care 60% $326,577. Family Attend 4% $20,154. Personal Care 1% $3,912.	HCBS MEMBERS 539 Housekeeping 4% $3,724. Attendant Care 56% $291,745. Family Attend 3% $15,603. Personal Care 1% $3,307.	HCBS MEMBERS 544 Housekeeping 4% $3512. Attendant Care 53% $286,353. Family Attend 7% $18,241. Personal Care 1% $3,128.

% OF MEMBERS RECEIVING HHN and HHA SERVICES

APRIL 10	MAY 10	JUNE 10	JULY 10	AUGUST 10	SEPT 10
HCBS MEMBERS 546 HHN 22% HHA 0%	HCBS MEMBERS 547 HHN 24% HHA 0%	HCBS MEMBERS 538 HHN 21% HHA 0%	HCBS MEMBERS 546 HHN 21% HHA 0%	HCBS MEMBERS 539 HHN 22% HHA 0%	HCBS MEMBERS 544 HHN 22% HHA 0%
$28,622.	$27,877.	$31,114.	$31,136.	$31,832.	27,201.

Pharmacy Utilization Review Data – Presented at M/UM PIC meetings

First quarter (Oct – Dec 09) **CYE 2010**
*Cost per member per month was $52.84 pm/pm
*High cost meds: Central Nervous System, Pain Relievers, and Endocrinology
*87.30% generic use
*Total dollars CHS paid for medication this quarter $146,160.00

Second quarter (Jan – Mar 10) **CYE 2010**
*Cost per member per month was $41.94 pm/pm
*High cost meds: Central Nervous System, Pain Relievers, and Endocrinology
*88.04% generic use
*Total dollars CHS paid for medication this quarter $114,502.00

Third quarter (Apr – Jun 10) **CYE 2010**
*Cost per member per month was $40.58 pm/pm
*High cost meds: Central Nervous System, Pain Relievers, and Endocrinology
*88.27% generic use
*Total dollars CHS paid for medication this quarter $110,423.00

Fourth quarter (Jul– Sept 10) **CYE 2010** *Cost per member per month was $40.49 pm/pm
*High cost meds: Central Nervous System, Pain Relievers, and Endocrinology
*88.89% generic use
*Total dollars CHS paid for medication this quarter $108,237.00

Outcomes/Improvements: The success of the prior auth department continues to produce significant savings by directing physicians to less costly formulary alternatives. Projected annual savings: $31,000 based on monthly savings from formulary alternatives switches and/or medications discontinued.

CHS has observed that the costs, types of medications, percentage of formulary medications used and percentage of generic use has remained stable throughout CYE 2010. An area that continues to see significant improvement is the use of generic medication. Overall, generic use by the CHS population was approximately 87% the previous year. By increasing efforts in coordination with our PBM to encourage prescribing providers to use generic medications, our generic medication use has maintained at a high level and also slightly increased to an average of 88.04% (with a fourth quarter high of 88.89%). PBM has also instituted a Prescriber Recognition Program for those prescribers who are utilizing high number of generics and communicating exceptionally well with CHS and PBM. In CYE 2010, 98% of our contracted PCP's followed the formulary 100% of the time which also contributed to significant cost savings. We will continue to evaluate the impact of this program next year.

The ongoing goal of pharmacy utilization review is to provide our members with high quality care in a cost effective manner. The current efforts of CHS in pharmacy utilization promote this goal.

COCHISE HEALTH SYSTEMS (CHS) MEDICAL MANAGEMENT # D26

Overview: Over the course of eighteen years, CHS has developed many systems of checks and balances to identify and capture unfavorable utilization patterns and implement strategies for process improvement both internal and externally. Some examples include Health Information System (HIS) edits, Pre and Post Payment review of claims, diligent monitoring efforts by staff, as well as providing member and provider education whenever needed. CHS is dedicated and prides itself in operating a plan with Program Integrity that ensures members' needs are met while maintaining fiscal responsibility.

Provider Example: There are several examples CHS could use to demonstrate our Plan's Program Integrity, such as the HCBS attendant care project, but we have chosen to outline a unique experience that served as a useful mechanism for program improvement. This example began with the identification of an unfavorable utilization pattern with a small group of psychiatrists in our network.

Prepayment Review: through our prepayment claims review process, CHS identified an issue when a provider submitted claims without prior authorization. These claims, as per our process, were sent to the Medical Utilization and Management (M/UM) Department for prepayment claims review and were subsequently denied. The primary reviewing RN in the M/UM department is also a certified professional coder and has been doing claims review for CHS for over ten years. The Providers were notified of their Claims Dispute (CD) rights when the denial was sent. The Provider initially billed code 90882, one of the highest reimbursed codes on the ADHS-BH code matrix. (NOTE: this code was subsequently identified by AHCCCS as a non-covered code). The description of this code is Environmental Intervention for Medical Management. Following the claims review, the M/UM department ran a specific provider utilization report to determine the frequency this code was being billed. Due to the utilization pattern discovered specifically with these providers, an onsite review by CHS RN Surveyors was conducted in the Tucson facility where our members were placed. The RNs found member charting notations for this services/code to be almost identical (a possible unfavorable data pattern) for all of the members being reviewed. In each case, the rendering provider documented "...environmental intervention on the patient's behalf." These notations met the codes definition almost verbatim from the Current Procedural Terminology (CPT) manual. However, after consultation with the Skilled Nursing Home where the members were residing and upon review of the medical records in question, the notation and coding did not align with the actual services rendered to the members at the facility.

Providers' Education: As the reviews were being conducted, CHS attempted to work with the Providers and office manager, including an onsite visit by CHS key staff to educate the provider and attempt to mediate the situation. In addition, CHS attempted to educate the provider with each claims denial, offering specific documentation to demonstrate the claims coding guidelines specified in the CPT Manual. During this time, the Providers resubmitted claims utilizing a different code, 99367. The particular code became effective in January 2008 in the 2008 CPT Manual and is used to bill for a Medical Team Conference with an Interdisciplinary Team. CHS COO/Provider Services Manager sent correspondence to educate the provider by reinforcing the specific CPT guidelines; however, the Providers failed to submit documentation demonstrating compliance with the guidelines set forth in the CPT manual for the use of this code. Based on claims system edits and/or medical review, the Providers' claims were denied. Again, the denials included CD process education. Following this, after multiple denials, phone calls to/from CHS, the Providers submitted a CD.

Claims Dispute: The provider's CD involved approximately twenty members, approximately fifty-eight DOS spanning several months. Once the Providers submitted the CDs, an acknowledgement letter was sent within the five-day timeframe and explained that a decision would be rendered within thirty days. Not only did the Providers submit a CD, but also sent a letter to the CHS Director and to the AHCCCS Director. The CHS Dispute and Appeals department conducted a thorough review of this case and found that in almost all instances, the Providers failed to meet the guidelines set forth in the CPT manual. The claims also failed to adhere to the rules/regulations of the Provider Participation Agreement, such as correct coding initiatives and were in breach of the CHS contract for the submission of CPT 99367. The Dispute Department conducted a twelve-month review of each member's CHS chart using Case Management and M/UM Chart information and found that the Providers did not perform the required face-to-face meeting with the member within sixty days as outlined in the CPT manual about the use of this code. In fact,

in many cases, the members had not been seen by the provider in many months, even though medications adjustments/orders were noted. Of the twenty cases and approximately fifty-eight DOS in this CD, there were very few that were overturned and paid. The initial denial decision was upheld in almost all of the claims and the Providers were advised of their rights to request a fair hearing. Through this investigation, CHS learned that the billed services were actually Staffings (Case Conferences) held at the Skilled Nursing Home each Tuesday for two hours per session. Personnel at the facility who participated in these Staffings stated that sometimes the Staffings were even shorter – the session started at approximately 10:00 AM and rarely went two full hours. The Staffing included a presentation of residents that are more recently challenging or cases the staff needed assistance on from the Specialist Provider. Files were presented for review and action taken as necessary. The members were not present during the Staffings and sometimes the session included reviews of more than ten members (estimate). These Staffings were not exclusive to CHS residents; the meetings were held for all residents at the SNF. CHS found many aspects of this case concerning and the case was forwarded to the AHCCCS Office of Inspector General.

Hearing: Following receipt of CHS' CD Decision, the provider filed a request for fair hearing and CHS forwarded all information as required by Federal, State regulations including AHCCCS policy to the Office of Hearings and Appeals. The hearing in the matter was held in Tucson on June 9, 2009. CHS was represented by the CHS Leadership Team members, Legal Counsel, and Medical Director. The primary physician Complainant and his office manager also attended and all parties testified.

Hearing Results: the Appeal was denied and the decision was in favor of Cochise Health Systems. The AHCCCS Director's Decision stated that "the Complainant failed to meet their burden of proof showing, by a preponderance of evidence.....and that the greater weight of evidence provided that the denied claims were denied for failure to hold the face to face meeting and use of proper use of CPT code 99367". The Decision was supported by the Administrative Law Judge prior to the AHCCCS Director's final ruling.

Successful Interventions: CHS has many mechanisms in place to help identify provider issues, particularly ones that evolve into unfavorable utilization patterns. The ultimate goal is to prevent any patterns developing into chronic conditions. In this example, CHS initially identified issues through the claims adjudication process where the claims were flagged based on coding edits. The claims were then reviewed by the M/UM department where claims data and member files where analyzed. These actions opened up what Cochise Health Systems refers to as "a can of worms". When the claims were disputed by the Providers, CHS discovered a significant issue / unfavorable utilization pattern. The investigations for both the CD process and in preparing for the hearing showed that the Providers billed $150.00 per member per Staffing for a total of two hours. This included all cases that were reviewed each Staffing where members were not present. In some cases, members had rarely been seen by the provider as noted by the documentation, reports produced by CHS systems, and as noted on the Notice of Claims Dispute Resolution.

Herein CHS has described an unfavorable utilization pattern that had a successful intervention. The claims were denied, processed through the Grievance System Process, and most importantly, when the case was heard by an Administrative Law Judge and subsequently evaluated by AHCCCS, the decision was favorably rendered on CHS' behalf. For CHS, the Director's Decision is most important as it validates our actions and efforts to operate and maintain a program that provides quality care to our membership while maintaining fiscal responsibility through Program Integrity for the past eighteen years. While the OIG declined to open this case for a full investigation due to the relatively small dollar amounts involved, CHS is hopeful that our reporting efforts put these Providers and this utilization pattern on the radar, so to speak, at AHCCCS since these Providers see many ALTCS clients in Pima County besides our CHS members.