

810 – FEE-FOR-SERVICE UTILIZATION MANAGEMENT

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I. PURPOSE

This Policy applies to Fee-For-Service (FFS) populations and Programs as specified within this Policy including: Tribal ALTCS, TRBHA, the American Indian Health Program (AIHP), and DDD Tribal Health Program (DDD THP), excluding Federal Emergency Services (FES) Programs. (For FES Programs, refer to AMPM Chapter 1100). This Policy provides an outline of the utilization management functions that are performed by AHCCCS Division of Fee for Service Management (DFSM).

II. DEFINITIONS

Definitions are located on the AHCCCS website at: [AHCCCS Contract and Policy Dictionary](#).

III. POLICY

A. UTILIZATION MANAGEMENT METHODOLOGIES

Utilization Management (UM) methodologies include, but are not limited to the following:

1. Prior Authorization (PA) (does not apply to emergency services).
2. Concurrent review, and/or
3. Retrospective review.
4. Care management.

B. PRIOR AUTHORIZATION

PA is issued for covered services within certain limitations, based on the following:

1. The member's AHCCCS eligibility at the time of the PA request, as confirmed through AHCCCS online verification.
2. Provider status as an AHCCCS-registered provider.

3. The service requested is an AHCCCS covered service requiring PA, refer to AMPM Policy 820 for additional information regarding PA.
4. Information received by AHCCCS/DFSM meets the requirements for issuing a PA number.
5. The service requested is not covered by another primary payer (e.g., commercial insurance, Medicare, etc.).

PA request determinations are made during regular business hours. PA requests, however, may be submitted 24 hours a day, seven days a week using the AHCCCS online web portal or when necessary, by fax as specified below.

6. The process for a provider submitting a PA request, and obtaining a PA number prior to providing an AHCCCS covered service, is as follows:
 - a. Providers may submit a PA request via:
 - i. AHCCCS Online web portal:
<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>,
 - ii. Fax:
PA - (602) 256-6591,
Utilization Review (UR) - (602) 254-2304,
Long Term Care (LTC) - (602) 254-2426,
Transport - (602) 254-2431,
DDD THP – (602)252-2298, or
 - iii. Telephone (Urgent Requests)
Urgent requests should be submitted online **and** followed up with a phone call to PA staff to notify that an urgent request has been submitted.
1-602-417-4400 (Phoenix area direct line to the PA),
1-800-433-0425 (In state outside Phoenix area, direct line into the PA),
1-800-523-0231 (Out of state line to AHCCCS switchboard 602-417-4400 or ask for the PA Area), or
 - iv. Mail
AHCCCS-Division of Fee-for-Service Management
Care Management Systems Unit (CMSU), Mail Drop 8900
801 East Jefferson Phoenix, AZ 85034,
 - b. Providers shall be prepared to submit the following information:
 - i. Caller name, provider name and provider ID,
 - ii. Member name and AHCCCS ID number,
 - iii. Type of admission/service,
 - iv. Service date,
 - v. ICD-10 diagnosis code(s),
 - vi. Applicable billing codes (CPT, CDT, HCPCS, or revenue codes),
 - vii. Anticipated charges (if applicable),
 - viii. Medical justification, and

- c. If the PA request is submitted through the AHCCCS online web portal, the provider shall attach documentation using the online attachment feature. If the provider is utilizing fax, the appropriate FFS form shall be downloaded from the AHCCCS Website, required fields shall be completed, and the FFS form shall be submitted as the cover sheet or the second page within the fax.
Upon receipt AHCCCS/DFSM will:
 - i. Issue a provisional PA number, pending an assessment of the information provided,
 - ii. Issue an approval, a request for additional information, or a denial of coverage, and
 - iii. Generate a PA confirmation letter which is mailed to the provider the next business day notifying of the authorization status.

PA is not required for FFS members receiving services from Indian Health Service/638 Tribal (IHS/638) providers and facilities. A non-IHS/638 provider or facility rendering AHCCCS covered services shall obtain PA from AHCCCS/DFSM for services specified in AMPM Policy 820.

For additional information regarding submission and documentation requirements, refer to the FFS Web page at:
<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>

For all requirements related to the grievance system, refer to A.A.C., Title 9, Chapter 34.

C. CONTINUED STAY REVIEW

1. Continued stay review is performed as follows:
 - a. Continued stay review is provided by AHCCCS/DFSM or an AHCCCS contracted review organization that employs licensed health care professionals to perform reviews,
 - b. Continued stay review begins when AHCCCS/DFSM initiates and conducts the review or notifies the contracted review organization of the admission or need for review, and
 - c. Continued stay review is conducted at intervals appropriate to the member's condition, based on the review findings. During review, the following are considered in addition to the necessity of admission and/or appropriateness of service setting:
 - i. Quality of care,
 - ii. Length of stay,
 - iii. Whether services meet the coverage requirements for the eligibility type,
 - iv. Discharge needs, and
 - v. Utilization pattern analysis.
2. Continued stay review determinations are performed as follows:
 - a. When the Continued stay review is initiated and conducted by AHCCCS/DFSM Unit, the PA staff determines the appropriateness of continued services in consultation with the AHCCCS Chief Medical Officer (CMO) and/or DFSM Medical Director as needed. AHCCCS/DFSM issues a denial notice when it is determined that the services no longer meet AHCCCS coverage criteria,

- b. There are conditions when the continued stay review function is outsourced to a contracted review organization. These include but are not limited to length of stay or Level Of Care (LOC) cases, and medical necessity cases where the medical need is in question, and
- c. If the continued stay review is outsourced to the contracted review organization, both the contracted review organization and AHCCCS/DFSM determine the appropriateness of continued services in consultation with contracted physician advisors, as necessary. If it is determined that the service no longer meets coverage criteria, the contracted review agency will initiate a recommendation of denial.

D. CONTINUED STAY DENIAL

1. Continued stay services may be denied when one of the following occurs:
 - a. A member no longer meets intensity and severity criteria,
 - b. A member is not making progress in a rehabilitative program,
 - c. A member can be transferred safely to a lower LOC, or
 - d. Services do not meet the coverage criteria.
2. Consultation with the AHCCCS Medical Director or contracted review organization physician may occur to review the need for a continued stay.
3. The provider is notified in writing regarding a denial of coverage and the denial date by the entity that has the continued stay review responsibility.
 - a. When the contracted review organization is the responsible entity, the following also applies:
 - i. The contracted review organization immediately notifies AHCCCS/DFSM verbally, and
 - ii. The contracted review organization forwards written notification of denial of coverage to the following:
 - a) The attending physician,
 - b) The hospital, and
 - c) AHCCCS/DFSM (within five business days of initiation of denial).
4. The provider has the options of:
 - a. Submitting a request with supporting documentation to AHCCCS/DFSM for reconsideration of the denial, or
 - b. Following the appeals process on the AHCCCS website.

E. RETROSPECTIVE REVIEW

AHCCCS/DFSM conducts retrospective medical reviews of specified claims for each AHCCCS eligibility category to verify appropriateness and effectiveness of service utilization. Criteria for these medical claim reviews focus on factors including, but not limited to: diagnosis, utilization pattern, selected types of surgery, hospital admissions, LOC provided, and the length of stay in conjunction with the admission criteria. Focused medical reviews are conducted and may be applied to a sample of claims or all claims, depending on the reason for conducting the review.

All transplant services are reviewed by AHCCCS/Division of Health Care Management (DHCM)/Medical Management Unit, AHCCCS Transplant Coordinator.

F. REIMBURSEMENT

PA is not a guarantee of payment. Reimbursement is based on a variety of factors including but not limited to:

1. Accuracy of the information received with the original PA.
2. Whether or not the service is substantiated through continued stay and/or retrospective review.
3. Whether the claim meets claims submission requirements.