810 - FEE-FOR-SERVICE UTILIZATION MANAGEMENT

EFFECTIVE DATES: 10/01/94, 08/01/19

APPROVAL DATES: 03/14/97, 10/01/98, 10/01/01, 05/01/04, 01/01/05, 10/01/08, 03/01/09, 07/01/10, 09/01/12, 03/01/14, 10/01/15, 02/07/19

I. PURPOSE

This Policy applies to Fee-For-Service (FFS) Programs as delineated within this Policy including: Tribal ALTCS, TRBHA, the American Indian Health Program (AIHP); and all FFS populations, excluding Federal Emergency Services (FES). (For FES, see AMPM Chapter 1100). This Policy provides an outline of the FFS utilization management functions.

II. DEFINITIONS

CARE MANAGEMENT

For purposes of this Policy, care management is performed by AHCCCS/Division of Fee-For-Service Management (DFSM) Case Managers.

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 care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery.

CONCURRENT REVIEW

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 quality of care.

PRIOR AUTHORIZATION (PA)

For purposes of this Policy, a process by which AHCCCS/ DFSM determines in advance whether a service that requires prior approval will be covered based on prospective review of the initial information received. PA may be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate medical necessity, medical appropriateness, and compliance with AHCCCS criteria

RETROSPECTIVE REVIEW	The process of determining the medical necessity of a treatment/service post-delivery of care.
UTILIZATION MANAGEMENT (UM)	Often referred to as utilization review, is a methodology used by healthcare professionals for assessing the medical necessity, appropriateness and cost effectiveness of professional care, services, procedures, and facilities.

III. POLICY

A. UM METHODOLOGIES

UM methodologies include, but are not limited to the following:

1. 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 on-line 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 payer (e.g. commercial insurance, Medicare, other agency).

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 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. On-line web portal:
      https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f,
      ii. Fax:
      PA - (602) 256-6591,
      UR - (602) 254-2304,
      LTC - (602) 254-2426,
      Transport - (602) 254-2431,
      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 Area),
      1-800-433-0425 (In state direct line into the PA Area),
      1-800-523-0231 (Out of state line to AHCCCS switchboard, dial Extension 74400 or ask for the PA Area), or
      iv. Mail
      AHCCCS-Division of Fee-for-Service Management
      Care Management Systems Unit (CMSU), Mail Drop 8900
      701 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. Admission/surgery service date,
      v. ICD-10 diagnosis code(s),
      vi. Applicable billing codes (CPT, CDT, HCPCS, or revenue codes),
      vii. Anticipated charges (if applicable), and
      viii. Medical justification,
   c. If the PA request is submitted through the web portal, the provider shall attach documentation using the online attachment feature. If the provider is utilizing fax, forms shall be downloaded from the AHCCCS Website, completed, and submitted as the cover sheet.
      i. AHCCCS/DFSM, upon receipt and assessment of information provided, Issues to the requesting provider and approval or a provisional PA number, or will notify the provider of a denial of coverage, and
      ii. AHCCCS/DFSM generates 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 (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, see 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. CONCURRENT REVIEW FOR HOSPITAL SERVICES

1. Concurrent Review is performed as follows:
   a. Concurrent Review is provided by AHCCCS/DFSM or an AHCCCS contracted review organization that employs licensed health care professionals to perform reviews,
   b. Concurrent 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. Concurrent Review is generally initiated the business day following receipt of inpatient notification and continues at intervals appropriate to the member's condition, based on the review findings. During review, the following are considered necessity of admission and appropriateness of service setting:
      1) Quality of care,
      2) Length of stay,
      3) Whether services meet the coverage requirements for the eligibility type,
      4) Discharge needs, and
      5) Utilization pattern analysis.

2. Concurrent Review determinations are performed as follows:
   a. When the Concurrent 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 Concurrent Review function is outsourced to a contracted review organization. These include but are not limited to Length of stay or LOC cases, and Medical necessity cases where the medical need is in question,
   c. If the Concurrent 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, and

3. Continued hospital services may be denied when:
   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.

4. Consultation with the AHCCCS CMO and/or DFSM Medical Director or contracted review organization physician may occur to review the need for a continued stay.

5. The provider and the hospital liaison are notified verbally or in writing regarding a potential denial of coverage and the denial date by the entity that has the Concurrent Review responsibility.

6. The provider has one business day to:
   a. Agree: The provider agrees that services or stay are no longer appropriate and the denial stands, or
   b. Disagree: The provider disagrees and provides information to the contracted review organization justifying medical necessity for continued stay.
      i. If the provider disagrees, one or more of the following occurs when the Concurrent Review is performed by AHCCCS/DFSM:

AHCCCS/DFSM ACTION	OUTCOME
AHCCCS/DFSM (and AHCCCS CMO and/or DFSM Medical Director, as necessary) agrees with provider	Stay is extended
AHCCCS CMO and/or DFSM Medical Director does not agree on continued stay	Stay is denied
Provider requests second review and the AHCCCS CMO agrees with the DFSM Medical Director to deny continued stay.	Stay is denied
Provider requests second review and the AHCCCS CMO and DFSM Medical Director disagree	A contracted physician advisor may be consulted and his decision to continue or deny the stay is final

ii. When the Provider disagrees, one or more of the following occurs when the Concurrent Review is performed by the contracted review organization:

CONTRACTED REVIEW ORGANIZATION ACTION	OUTCOME
Contracted review organization (and their physician advisor, as necessary) agrees with attending physician.	Stay is extended
Contracted review organization physician advisor does not agree on continued stay	Second contracted physician advisor is consulted
If the second contracted physician advisor agrees with the first physician advisor to deny continued stay	Stay is denied
If first and second contracted agency physician advisors disagree	A third contracted physician advisor is consulted and his decision to continue or deny the stay is final

iii. When the final determination is a denial of coverage, denial dates will be effective (as confirmed with AHCCCS/DFSM) according to a two business-day schedule. For example:
   1) The provider is notified by the responsible Concurrent Review entity (AHCCCS/DFSM or contracted review organization) on October 10,
   2) The responsible Concurrent Review entity allows:
      a) One business day (October 11) for the attending physician's response period, and
      b) One business day (October 12) for verbal notification of the denial to the attending physician and the hospital, and
   3) The denial date is effective October 13.

iv. When the contracted review organization is the responsible entity, the following also applies:
   1) The contracted review organization immediately notifies AHCCCS/DFSM verbally, and
   2) 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).

D. 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.

E. 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 Concurrent and/or Retrospective Review.

3. Whether the claim meets claims submission requirements.