810 – FEE-FOR-SERVICE UTILIZATION MANAGEMENT

EFFECTIVE DATES: 10/01/94, 08/01/19, 04/01/22[1]

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, 12/16/21[2]

I. PURPOSE

This Policy applies to Fee-For-Service (FFS) populations and Programs as ~~delineated~~ specified[3] within this Policy including: Tribal ALTCS, TRBHA, the American Indian Health Program (AIHP), and DDD Tribal Health Program (DDD THP)~~; and all FFS populations~~, excluding Federal Emergency Services Program (FESP). (For FESP, ~~see~~ refer to AMPM Chapter 1100). This Policy provides an outline of the ~~FFS~~ utilization management functions that are performed by AHCCCS ~~-~~Division of Fee for Service Management (DFSM).

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.~~

[1] Policy revised to apply program changes effective 04/01/22.
[2] Date presented at AHCCCS Policy Committee Meeting (APC).
[3] Changed to align with Policy standards throughout the Policy.

~~Prior Authorization (PA)~~	~~For purposes of this Policy, a process by which medical necessity, medical appropriateness, and compliance with this 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.~~

Definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.[4]

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 r~~R~~eview, and/or
3. Retrospective r~~R~~eview.
4. Care m~~M~~anagement.

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 on-line verification.
2. Provider status as an AHCCCS-registered provider.

[4] Terms which align with the Contract and Policy Dictionary, have been removed from Policy and are in the Contract and Policy Dictionary.

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[5] payer (e.g., commercial insurance, Medicare, etc. ~~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 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 On-line 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 – (TBD)[6]
      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- outside Phoenix area, direct line into the PA ~~Area~~),
         1-800-523-0231 (Out of state line to AHCCCS switchboard~~, dial Extension 74400~~ 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
         8~~7~~01 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~~S~~s~~ervice date,[7]
      v. ICD-10 diagnosis code(s),
      vi. Applicable billing codes (CPT, CDT, HCPCS, or revenue codes),

[5] Added the word primary for clarification.
[6] Added as a placeholder for new DDD THP fax line
[7] Broadened language to reflect service date

vii. Anticipated charges (if applicable), and
viii. Medical justification,

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 Fee for Service (FFS) forms 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.[8]
Upon receipt AHCCCS/DFSM will~~, upon receipt~~:
i. Issue a provisional PA number, pending ~~and~~ an assessment of the ~~-~~information provided,
~~i.~~ii. ~~I~~Issue~~s to the requesting provider~~ and approval~~, or a provisional PA number~~a request for additional information, or ~~will notify the provider of~~ a denial of coverage, and
~~ii.~~iii. ~~AHCCCS/DFSM g~~Generate~~s~~ 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, ~~see~~ 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 ~~oncurrent~~STAY REVIEW~~eview~~ ~~FOR HOSPITAL SERVICES~~[9]

1. Con~~current~~tinued stay r~~R~~eview is performed as follows:
   a. ~~Concurrent~~ Continued stay r~~R~~eview is provided by AHCCCS/DFSM or an AHCCCS contracted review organization that employs licensed health care professionals to perform reviews,
   b. ~~Concurrent~~ Continued stay r~~R~~eview 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~~ Continued stay r~~R~~eview is ~~generally initiated the business day following receipt of inpatient notification and continues~~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[10] appropriateness of ~~-~~service setting:

[8] Added clarifying language pertaining to Fax submissions.
[9] Removed language concurrent and replaced throughout policy with continued to broaden applicability.
[10] Revised language to remove and broaden applicability and to reflect current processes.

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 ~~Concurrent~~ r~~R~~eview determinations are performed as follows:
   a. When the Continued stay ~~current~~ r~~R~~eview 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 c~~Concurrent~~ontinued stay r~~R~~eview function is outsourced to a contracted review organization. These include but are not limited to l~~L~~ength of stay or level of care (LOC) cases, and m~~M~~edical necessity cases where the medical need is in question,
   c. If the ~~c~~Concurrentcontinued stay r~~R~~eview 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~~

D. CONTINUED STAY DENIAL

1. Continued ~~hospital~~ stay[11] 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 ~~CMO and/or DFSM~~ Medical Director or contracted review organization physician may occur to review the need for a continued stay.

3. The provider ~~and the hospital liaison are~~is notified ~~verbally or~~ [12]in writing regarding a ~~potential~~ denial of coverage and the denial date by the entity that has the ~~Concurrent~~continued stay r~~R~~eview 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,

[11] Removed to broaden applicability.
[12] Removed language to reflect current processes.

b) The hospital, and
c) AHCCCS/DFSM (within five business days of initiation of denial).[13]

~~3.~~4. The provider has the options of: ~~one business day to:~~
a. Submitting a request with supporting documentation to AHCCCS/DFSM for reconsideration ~~of the denial,~~ or
~~a.~~b. Following the appeals process on the AHCCCS website.

~~Agree: The provider agrees that services or stay are no longer appropriate, and the denial stands,~~

~~a. Disagree: The provider disagrees and provides information to the contracted review organization justifying medical necessity for continued stay.~~

~~b. If the provider disagrees, one or more of the following occurs when the Concurrent rReview is performed by AHCCCS/DFSM~~

~~c. AHCCCS/DFSM Action~~	~~d. Outcome~~
~~e. AHCCCS/DFSM (and AHCCCS CMO and/or DFSM Medical Director, as necessary) agrees with provider~~	~~f. Stay is extended~~
~~g. AHCCCS CMO and/or DFSM Medical Director does not agree on continued stay~~	~~h. Stay is denied~~
~~i. Provider requests second review and the AHCCCS CMO agrees with the DFSM Medical Director to deny continued stay.~~	~~j. Stay is denied~~
~~k. Provider requests second review and the AHCCCS CMO and DFSM Medical Director disagree~~	~~l. A contracted physician advisor may be consulted and his decision to continue or deny the stay is final~~

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

~~n.~~

~~o. Contracted Review Organization Action~~	~~p. Outcome~~
~~q. Contracted review organization (and their physician advisor, as~~	~~r. Stay is extended~~

[13] Moved up from below

necessary) agrees with attending physician.	
s. Contracted review organization physician advisor does not agree on continued stay	t. Second contracted physician advisor is consulted
u. If the second contracted physician advisor agrees with the first physician advisor to deny continued stay	v. Stay is denied
w. If first and second contracted agency physician advisors disagree	x. A third contracted physician advisor is consulted and his decision to continue or deny the stay is final

y. 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:
z. The provider is notified by the responsible Concurrent Review entity (AHCCCS/DFSM or contracted review organization) on October 10,
aa. The responsible Concurrent Review entity allows:
bb. One business day (October 11) for the attending physician's response period, and
cc. One business day (October 12) for verbal notification of the denial to the attending physician and the hospital, and
dd. The denial date is effective October 13.
ee. When the contracted review organization is the responsible entity, the following also applies:
ff. The contracted review organization immediately notifies AHCCCS/DFSM verbally, and
gg. The contracted review organization forwards written notification of denial of coverage to the following:
hh. The attending physician,
ii. The hospital, and
jj. AHCCCS/DFSM (within five business days of initiation of denial).[14]

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.

[14] Deleted content to reflect the current continued stay denial process.

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 ~~Concurrent~~continued stay and/or r~~R~~etrospective r~~R~~eview.

3. Whether the claim meets claims submission requirements.