450 – ALTCS EXTRAORDINARY CARE REVIEW PROCESS FOR MINOR MEMBERS

EFFECTIVE DATE: Upon Publishing[1]

APPROVAL DATE: 07/23/2026[2]

I. PURPOSE

This Policy applies to ALTCS E/PD and DES DDD (DDD) Contractors and Fee-For-Service (FFS) Program Tribal ALTCS[3]. This Policy establishes requirements for an extraordinary care review process for Direct Care (as specified in AMPM 1240-A) and Habilitation (as specified in AMPM 1240-E) service assessments for ALTCS-enrolled children under the age of 18. This policy is established to comply with requirements outlined in AAC R9-28-1206. The AHCCCS Division of Fee-for-Service Management will serve in the contractor role for Tribal ALTCS members.[4]

II. DEFINITIONS

Refer to the AHCCCS ACOM and AMPM Dictionary for common terms found in this Policy.

For purposes of this Policy the following terms are defined as:

ACTIVITIES OF DAILY LIVING	Activities a member shall perform daily for the member's regular day-to-day necessities, including but not limited to mobility, transferring, bathing, dressing, grooming, eating, and toileting.
EXTRAORDINARY CARE	Care that exceeds the range of activities that a spouse or a legally responsible parent of a minor child would ordinarily perform in the household on behalf of the ALTCS member if the member did not have a disability or chronic illness, and which is necessary to assure the health and welfare of the member and/or avoid out of home placement[5].
EXTRAORDINARY CARE REVIEW (ECR)	An individualized[6] review process that is available for members under the age of 18 in the event the HCDM disagrees[7] with the number of assessed hours for Direct Care Services, Habilitation Service, or both as a result of the

[1] Date policy is effective.
[2] Date policy is approved.
[3] POST PUBLIC COMMENT REVISION: Incorporated applicability to the Tribal ALTCS program
[4] POST PUBLIC COMMENT REVISION: Clarified the role of AHCCCS for Tribal ALTCS members
[5] POST PUBLIC COMMENT REVISION: Clarified additional goal of extraordinary care to maintain home placement
[6] POST PUBLIC COMMENT REVISION: Clarified the ECR is an individualized, member-specific review of needs.
[7] POST PUBLIC COMMENT REVISION: Technical clarification

age limitations or maximum hourly limits[8] set forth in the Home and Community Based Services Needs Tool (HNT).

HOME AND COMMUNITY BASED SERVICES (HCBS) NEEDS TOOL (HNT)	A standardized assessment instrument created by AHCCCS to evaluate the functional and support needs of ALTCS members who may benefit from receiving certain Home and Community Based Services (HCBS) to support Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The Home and Community-Based Needs Tool (HNT) is specific to assessment of member need for Direct Care and Habilitation Service.
INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)	Activities a member shall perform that are more complex in nature than Activities of Daily Living (ADLs) and necessary for independent living and community participation, such as managing money, preparing meals, shopping, doing laundry, and using transportation as specified in AAC Title 9 Chapter 28 Article 1.
CHANGE IN CONDITION[9]	A major decline or improvement in the member's health status that will not normally resolve itself without further intervention by staff or by implementing standard disability[10] - related clinical and/or behavioral interventions, or by which the current services are no longer effective due to the change of the member's health status and has an impact on one or more areas and requires interdisciplinary review or revision of the Person Centered Service Plan (PCSP) or Home and Community Based Services Needs Tool (HNT).

III. POLICY

ALTCS children under the age of 18 who are assessed for Home and Community Based Services (HCBS) using the HCBS Needs Tool (HNT), as specified in AMPM Exhibit 1620-17, may benefit from an Extraordinary Care Review (ECR) in instances when their Health Care Decision Maker (HCDM) disagrees with the assessed hours based on the HNT's age limitations for direct care services (as specified in AMPM 1240-A) and/or limited or lack of assessed hours for habilitation services (as specific in AMPM 1240-E)[11].

[8] POST PUBLIC COMMENT REVISION: Clarified the role of the ECR process for habilitation services throughout to align with changes to allow up to 14 hours per week, based upon individual need/medical necessity
[9] POST PUBLIC COMMENT REVISION: Remove "significant" to align with other policies that include directives related to change in a member's condition.
[10] POST PUBLIC COMMENT REVISION: Revised to more appropriately reflect the conditions and interventions for the target population
[11] POST PUBLIC COMMENT REVISION: Clarified the role of the ECR process for habilitation services throughout to align with changes to allow up to 14 hours per week, based upon individual need/medical necessity

A. ALLOWABLE CIRCUMSTANCES FOR EXTRAORDINARY CARE REVIEW

1. A HCDM may request an ECR for their child who is under the age of 18 when all the following criteria are met following the outcome of the annual Person-Centered Service Plan (PCSP), inclusive of an HNT update [12]:
   a. The HCDM disagrees with the hours assessed in the HNT because the member was not assessed for Direct Care services (as specified in AMPM 1240-A)[13] due to the [14]age limitations, and/or
   b. The member was not assessed for Habilitation or was assessed and received limited Habilitation services (as specified in AMPM 1240-E)[15] due to weekly age limitations or maximum hourly limits on the HNT[16] , and
2. The HCDM provides information to support that the child has extraordinary needs and may benefit from service hours for Direct Care services, Habilitation service, or a combination of both in excess of the Direct Care services and/or Habilitation service assessment documented on the HNT due to age limitations or habilitation service hour limits.[17].[18]An ECR is allowable outside of the annual timeframe of the PCSP if one of the following is met:[19]
   i. The child has experienced a [20]change in condition that necessitates an update to the HNT to determine a reduction or increase in assessed and authorized services and/or service hours and the HCDM has a concern with a revision due to the change in condition[21], or
   ii. The specific service need has not previously gone through an ECR review and the HCDM now has concerns.

3. An HCDM may request an ECR, in writing, to the member's Contractor when the HCDM has signed the HNT (specified in AMPM Exhibit 1620-17) indicating disagreement with the number of assessed hours, provided their rationale for the disagreement, and the criteria for an ECR has been met in subsection A.1.[22] The HDCM may request an ECR after completion of the HNT, if time is needed to review the HNT document and determine if there is interest in

[12] POST PUBLIC COMMENT REVISION: Clarified the criteria that must be met for an ECR referral and linked it to the outcome of the PCSP
[13] POST PUBLIC COMMENT REVISION: Technical addition to clarify the noted services

[14] POST PUBLIC COMMENT REVISION: Removed redundant language
[15] POST PUBLIC COMMENT REVISION: Technical addition to clarify the noted services

[16] POST PUBLIC COMMENT REVISION: Clarified the role of the ECR process for habilitation services throughout to align with changes to allow up to 14 hours per week, based upon individual need/medical necessity
[17] POST PUBLIC COMMENT REVISION: Clarified that services may be requested when they are not assessed as that is also part of the HNT

[19] POST PUBLIC COMMENT REVISION: Clarified when an ECR referral is allowable outside of the annual PCSP
[20] POST PUBLIC COMMENT REVISION: Remove "significant" to align with other policies that include directives related to change in a member's condition.
[21] POST PUBLIC COMMENT REVISION: Clarified circumstances when the HNT is updated outside of the annual PCSP
[22] POST PUBLIC COMMENT REVISION: Modified to allow for better documentation for ECR rationale and clarify the ECR request is optional by the HCDM

pursuing an ECR; however, timelines must still be met for authorization or discontinuation of services as appropriate.

a. If HCDM concerns are noted upon signing the HNT, members and their HCDMs will receive written communication and education materials about the Contractor's ECR process and how reviews are conducted.[23]
b. For HNT concerns that do not meet ECR requirements outlined in subsection A.1 or when the HCDM has concerns about the assessment but does not want to pursue an ECR, the Contractor shall issue a Notice of Adverse Benefit Determination in accordance with requirements and timelines outlined in AAC R9-34-205 and as outlined in ACOM 414. .

4. The Contractor[24] must provide reasonable accommodations and language access requirements (outlined in ACOM 405, Cultural Competency and Language Access Requirements)[25] to HCDMs who need assistance, in whole or part, with the ECR process.

5. The ECR request must include:
   a. Whether the member is seeking additional hours for Direct Care Services (as specified in AMPM 1240-A) due to age limitations, Habilitation Services (as specified in 1240-E)[26] due to weekly maximum hourly limits[27], or both, that could not be assessed on the HNT, and
   b. The HCDM's justification for the specific direct care services[28] tasks and/or habilitation hours (whichever apply) that could not be assessed and/or were limited due to weekly allowance. This information should be documented on the HNT as part of the assessment process:
      i. For direct[29] care services, task-specific details must be provided that align with the tasks in the HNT, and
      ii. The reason for the time needed to support the member with the direct care tasks and/or habilitation outcomes (whichever apply) and the rationale for why the need should be considered as extraordinary care.
   c. A way for a HCDM to provide any additional supporting medical, clinical, and school-related documentation that they believe may assist in the review of the member's ADL/IADL needs and the timeframe for providing the information[30] if they choose to do so. Submission of additional documentation is not required for the ECR request to move forward. Information provided may include but is not limited to:
      i. Therapy notes,
      ii. The member's Individualized Education Program (IEP) summary,
      iii. Behavior Treatment Plan[31] and/or treatment notes, and/or

[23] POST PUBLIC COMMENT REVISION: Moved from previous Section A.4.
[24] POST PUBLIC COMMENT REVISION: Maintained "Contractor" throughout when referencing the health plan or MCO
[25] POST PUBLIC COMMENT REVISION: Clarified expectations for accommodations and language access
[26] POST PUBLIC COMMENT REVISION: Technical addition to clarify the noted services
[27] POST PUBLIC COMMENT REVISION: Clarified the role of the ECR process for habilitation services throughout to align with changes to allow up to 14 hours per week, based upon individual need/medical necessity
[28] POST PUBLIC COMMENT REVISION: Technical addition to clarify the noted services
[29] POST PUBLIC COMMENT REVISION: Technical addition to clarify the noted services
[30] POST PUBLIC COMMENT REVISION: Added language to support creation of a timeline that aligns with the Contractor's ECR process and federal timeline requirements.
[31] POST PUBLIC COMMENT REVISION: Technical correction

iv. Other services or supports that have been tried but have not benefited the member[32].

B. CONTRACTOR EXTRAORDINARY CARE REVIEW PROCESS REQUIREMENTS

The Contractor is required to develop and implement a process to administer the ECR. The Contractor must have their process approved by AHCCCS prior to implementation, including any time a substantive change is proposed to the approved process.

1. [33]The process shall include:
   a. A purpose statement regarding the Contractor's extraordinary care review process,
   b. The Contractor's notification process to inform members of the ECR process including written member education materials, Contractor website content, who to contact for ECR questions and/or support[34], and how to contact the Contractor for questions and additional information (in accordance with standards outlined in ACOM 404, Contractor Website and Member Information)[35],
   c. When and how an ECR can be requested, including timeframes as well as information regarding how to request reasonable accommodations and language access requests.,
   d. The HNT information that must be documented and[36] submitted by the HCDM when requesting an ECR as outlined in subsection A.3.,
   e. The information that may be submitted by a HCDM for review during the ECR process as outlined in subsection A.5.c. and how to submit the information,[37]
   f. The process the Contractor will use to administer the PEDI-CAT and ASD Module when appropriate, if the HCDM chooses to participate in the supplemental assessment, and how the results of the PEDI-CAT will be shared with the ECR clinician,
   g. The type of clinicians used to conduct the ECR and meet the requirements outlined in subsection B.4. including how determinations are made regarding which clinician(s) conduct ECRs for specific members[38],
   h. Any training that the ECR clinician(s) will be required to receive prior to conducting ECRs and on a regular cadence throughout their time conducting ECRs,[39]
   i. How the HCDM will be notified of:
      1. Timeline extensions of the Contractor's decision whereby the extra time will be of benefit to the member to engage the member's care team and/or specialty clinicians in the ECR as permitted in D.5(a),
      2. The date and time for the meeting with the ECR clinician when determined clinically appropriate, and[40]
      3. The outcome of the ECR,

[32] POST PUBLIC COMMENT REVISION: Added consideration for additional documentation
[33] POST PUBLIC COMMENT REVISION: Removed redundant content
[34] POST PUBLIC COMMENT REVISION: Technical addition to clarify content
[35] POST PUBLIC COMMENT REVISION: Clarified standards for readability and plain language
[36] POST PUBLIC COMMENT REVISION: Clarified the role of the HCDM in documenting their concerns to support an ECR request
[37] POST PUBLIC COMMENT REVISION: Added to allow for submission of relevant documentation that may support the ECR process
[38] POST PUBLIC COMMENT REVISION: Added requirement for the Contractor's process
[39] POST PUBLIC COMMENT REVISION: Added requirement based on feedback from Rule Public Hearing
[40] POST PUBLIC COMMENT REVISION: Added additional circumstances when notification is warranted

j. The timeline for review and notification of the outcome to the HCDM,
k. Any template forms for providing information or notifications to the HCDM including the standardized form to document ECR decisions as directed in Section C,[41]
l. The plan and timeline for training all staff who need to be aware of the ECR process (e.g. case managers, customer service representatives, clinicians[42]
m. A description of how the ECR records shall be maintained, and
n. A description of how the required ECR data (outlined in Section D) will be collected.[43]

2. The ECR process shall be conducted by clinicians with relevant professional experience (aligning with the diagnoses and needs of the child) and current licensure or certification. Any of the below clinicians[44] may be utilized to meet this requirement:[45]
   a. Developmental pediatricians,
   b. Child and adolescent psychiatrists, ,
   c. Registered nurses with additional training in behavioral health or complex medical conditions,
   d. Licensed psychologists,
   e. Board-certified Physical Medicine and Rehabilitative physicians,
   f. Board-certified Internal Medicine physicians,
   g. Board-certified Family Medicine physicians[46],
   h. Licensed occupational or physical[47] therapists,
   i. Board-Certified Behavior Analysts, and/or
   j. Other appropriately licensed clinicians as approved by AHCCCS[48].

3. The Contractor must provide AHCCCS with the specific types of clinicians that will be utilized for their ECR process, along with minimum training requirements for positions where it is necessary (e.g. for a registered nurse who must have behavioral health[49] or complex medical condition experience and training).
   a. If the Contractor would like to utilize a clinician type not included in this policy and/or not included in the Contractor's initial ECR process submission to AHCCCS, the contractor shall submit a written request that outlines the clinician type and supporting rationale to their assigned AHCCCS Operations Compliance Officer.[50]

4. All ECR clinicians, regardless of background, must be trained on person-centered service planning, both at the start of the ECR process as well as annually thereafter. The Contractor may also require additional training for the ECR clinician as appropriate for the scope of the role. [51]

[41] POST PUBLIC COMMENT REVISION: Added clarification on template forms requiring AHCCCS approval
[42] POST PUBLIC COMMENT REVISION: Added to clearly indicate ECR clinicians must be trained on processes
[43] POST PUBLIC COMMENT REVISION: Added requirement to include data collection methodology
[44] POST PUBLIC COMMENT REVISION: Modified to state "clinicians" for consistency
[45] POST PUBLIC COMMENT REVISION: Moved language to clarify/define "relevant professional experience"
[46] POST PUBLIC COMMENT REVISION: Added practitioners
[47] POST PUBLIC COMMENT REVISION: Added practitioner
[48] POST PUBLIC COMMENT REVISION: Move statement for clarity
[49] POST PUBLIC COMMENT REVISION: Technical clarification
[50] POST PUBLIC COMMENT REVISION: Technical clarification/clear direction to Contractors
[51] POST PUBLIC COMMENT REVISION: Added due to reasonable feedback from Rulemaking Public Hearing

5. ECR clinicians shall be able to consult with other ECR-approved clinicians in instances where the member's specific case has complex, multi-factorial considerations. ECR clinicians shall also have access to the following when necessary:
   a. Individuals who can provide a whole person care perspective in addition to bringing awareness of community supports that may be available[52]:
   b. For reviews involving a member with an intellectual or developmental disability, a person that holds[53] a nationally recognized certification such as a Qualified Intellectual Disability Professional (QIDP), a NAQ-Certified Intellectual/Developmental Disability (I/DD) Specialist, or a National Association for the Dually Diagnosed Dual Diagnosis Specialist (NADD-DDS), or
      A Licensed Master Social Worker, and
   c. The member's ALTCS Case Manager[54].

6. Contractors may only use clinicians (including any consulting clinicians or experts) that are either employees or contracted by the Contractor to participate in the ECR process. Contractors must take measures to mitigate conflict of interest and ensure that clinicians/experts will have no direct benefit as a result of the outcome of the ECR (e.g. a clinician who provides services to the child may not be used for the child's ECR). Similarly, case managers that meet the requirements for an ECR-approved clinician may not serve as the ECR clinician conducting the review (e.g. for members who are on their caseload or for whom they may be related to).[55]

7. Any consultation between clinicians and/or subject matter experts (SMEs), including their credentials or areas of expertise,[56] shall be documented as part of the ECR record. A consultation is to serve for informational purposes only, with the final ECR decision remaining the responsibility of the assigned ECR[57] clinician.

8. Contractors must ensure that any service provided to a member under the age of 18 is extraordinary in nature and medically necessary. Requested services, that were not assessed due to age based or maximum hourly limitations[58], must be evaluated to determine if:
   a. Any are ordinary requirements of a legally responsible individual, such as a parent or guardian, versus those that are extraordinary and would not be needed in absence of a disability or other medical condition,
   b. The member can benefit from the services, and
   c. The services are medically necessary.

[52] POST PUBLIC COMMENT REVISION: Added clarification regarding the purpose for eliciting the input from the noted practitioners.
[53] POST PUBLIC COMMENT REVISION: Technical clarification
[54] POST PUBLIC COMMENT REVISION: Added the member's case manager to clarify they can be consulted
[55] POST PUBLIC COMMENT REVISION: Incorporated conflict of interest provisions
[56] POST PUBLIC COMMENT REVISION: Noted credentials and areas of expertise should be recorded
[57] POST PUBLIC COMMENT REVISION: Technical clarification
[58] POST PUBLIC COMMENT REVISION: Clarified the ECR is not to evaluate services already assessed by the case manager via the HNT.

9. Clinicians conducting the ECR must have full access to all relevant aspects of the member's record. If the ECR clinician has additional questions and/or requests information that the Contractor has available, the Contractor must have a process to provide the clinician with the information in a timely manner. [59]

10. ECR clinicians shall also consider the results of the Content-Balanced Pediatric Evaluation of Disability Inventory - Computer Adaptive Test (PEDI-CAT)[60] that documents the member's functional status if the HCDM chooses to complete the PEDI-CAT.
    a. When appropriate, based on the member's diagnoses, the Autism Spectrum Disorder (ASD) Module of the PEDI-CAT should also be made available to the HCDM to complete if they so choose.
    b. The Contractor must establish a process to administer this tool as part of the ECR process as well as a process to make the results available to the ECR clinician when the HCDM chooses to complete the assessment tool[61].

11. The results of a conversation between the assigned ECR clinician and the HCDM when determined clinically appropriate[62].
    a. The ECR clinician may meet with the HCDM/member via phone call or, when available, virtually (including both audio/video capabilities).[63]
    b. The Contractor must make a reasonable attempt to contact the HCDM before proceeding with the ECR utilizing all the other information available to render a decision.[64]
    c. The results of the HNT and hours that were assessed by the case manager as well as any comments/documentation regarding the HCDM and/or care team's concerns about the assessment and assessed hours,
    d. The member's PCSP[65] including unique diagnoses, needs and personal goals[66],The time and effort it takes to support the member with ADLs, IADLs, and/or skill building that supports the member in obtaining or maintaining age-appropriate skills, exceeding what a parent/caregiver of a child without disability would need for these types of tasks including circumstances when the member might need multiple individuals to support a particular task, need or skill[67],
    e. [68]The member's daily schedule to understand the hours in the day the child may be available to receive services including:

[59] POST PUBLIC COMMENT REVISION: Noted the ECR clinician must have access to the member's record
[60] POST PUBLIC COMMENT REVISION: Named specific nationally normalized assessment tool
[61] POST PUBLIC COMMENT REVISION: Clarified the Pedi-Cat is only used when the HCDM chooses to fill out the form
[62] Clarified the Pedi-Cat is only used when determined clinically appropriate
[63] POST PUBLIC COMMENT REVISION: Added minimum requirements to directly engage the HCDM as part of the ECR
[64] POST PUBLIC COMMENT REVISION: Incorporated an allowance to move forward if the HCDM is unresponsive
[65] POST PUBLIC COMMENT REVISION: Incorporated specific reference to the PCSP to support a person-centered approach
[66] POST PUBLIC COMMENT REVISION: Added personal goals to support a person-centered approach
[67] POST PUBLIC COMMENT REVISION: Added consideration for instances where members need multiple caregivers to assist in the provision of care
[68] POST PUBLIC COMMENT REVISION: Removed and combined with section below to outline considerations (other services the member receives and time spent in educational setting) related to the member's schedule.

i. Other services the member receives in addition to direct care and/or habilitation services, or
ii. Time spent in educational activities.
iii. Services cannot be:
a. Co-occurring, meaning a member cannot receive two or more services simultaneously (occurring at the same time on the same day) unless clinically appropriate in accordance with AHCCCS policy[69], or
b. Billed during the time a child is sleeping unless there is a present medical or behavioral condition that requires awake, one-to-one care and/or frequent/continuous monitoring by the caregiver during sleeping hours.

f. The risk of institutionalization or out-of-home placement if the member does not receive the services,
g. The availability of other services that may be more appropriate to address the member's needs:
i. For this to be considered, the Contractor and the ECR clinician must be certain that the alternate service(s) is readily available for the member to receive the services within the required timeframes outlined in the AHCCCS policy for the point in time the service is identified.[70]
h. Other services or supports that have been tried but have not benefited the member,
i. Other service utilization data that may include, but is not limited to:
i. Inpatient hospitalization,
ii. Emergency department visits,
iii. Crisis observation visits,
iv. Out of home placements
v. Incident Reports[71], and
vi. Other services covered by the Contractor.
j. The member's ability to benefit from the services or hours of service received.
k. The member's risk of functional ability or skills regression[72]

[73]

C. EXTRAORDINARY CARE REVIEW DECISIONS

1. Clinicians responsible for the Contractor's ECR decisions must meet the timelines outlined in Section D.1[74].

2. Clinicians shall document, in writing, their findings, rationale, and decisions for each extraordinary care review on a standardized template developed by the Contractor in accordance with this Section. When the outcome of the ECR results in approved changes to the assessed hours and/or services, the ECR clinician shall work with the case manager to update the HNT as part of the outcome decision documentation process.[75]

[69] POST PUBLIC COMMENT REVISION: Clarified the provision of co-occurring services must adhere to AHCCCS policy parameters
[70] POST PUBLIC COMMENT REVISION: Clarified what is meant by services being readily available
[71] POST PUBLIC COMMENT REVISION: Added additional data that could be considered
[72] POST PUBLIC COMMENT REVISION: Added additional consideration pertaining to regression
[73] POST PUBLIC COMMENT REVISION: Moved as a requirement under the ECR outcomes section
[74] POST PUBLIC COMMENT REVISION: Technical correction
[75] POST PUBLIC COMMENT REVISION: Incorporated requirement for ECR clinician to update the HNT

a. The revised HNT, with hours documented as determined appropriate by the ECR clinician, shall become the base for the member's next HNT/PCSP update. If a member's needs have not changed (as assessed on the HNT) during the time of reassessment, the ECR clinician decision shall be carried forward until such time the member's needs have changed and/or other requirements have been met as outlined in subsection A.1.[76]

3. In instances where a Contractor utilizes multiple clinicians for ECR decisions, the Contractor is required to outline and implement procedures for ensuring interrater reliability.

4. The ECR findings and decisions shall be entered into the member's HNT and incorporated into the PCSP.

5. The ECR outcomes will result in one of the following:
   a. Current services and service hours assessed on the HNT are appropriate so there is no change to the HNT assessment, or
   b. A change to the assessed hours and/or services is approved and the member's HNT shall be updated by the case manager with direction from the ECR clinician[77] to include the additional services and/or service hours, or
   c. Current services and service hours assessed on the HNT are appropriate so there is no change to the HNT assessment; however, there are additional services that are not a part of the HNT assessment process that the member may benefit from given their unique needs and circumstances. The HCDM may opt to decline the additional services, but that won't change the outcome of the ECR decision nor the updated/current HNT.[78] Examples include, but are not limited to:
      i. Home health and/or LHA services,
      ii. Therapies,
      iii. Applied behavioral analysis,
      iv. Other services as determined by an ECR clinician.[79]

6. ECR outcomes resulting in additional services and/or service hours shall be evaluated for cost effectiveness and cannot exceed the member's allowable cost effectiveness study (CES). However, the member's comprehensive needs must be accurately reflected in the HNT, inclusive of additional hours approved by the ECR clinician, if applicable.[80]

7. Decisions made as part of the ECR must be documented in writing, and include, at a minimum, the following information:
   a. The decision rendered for the ECR,

[76] POST PUBLIC COMMENT REVISION: Added for clarification to support efficiency of process if there is no documented change in the member's condition from visit to visit
[77] POST PUBLIC COMMENT REVISION: Incorporated requirement for ECR clinician to update the HNT
[78] POST PUBLIC COMMENT REVISION: Added clarification regarding the HCDM's right to decline services
[79] POST PUBLIC COMMENT REVISION: Technical correction
[80] POST PUBLIC COMMENT REVISION: Incorporated CES as part of the ECR outcome versus a consideration made by the ECR clinician as part of the decision-making process.

b. Evidence-based documentation and rationale that supports the review decision and outcome in subsection C.5[81], and
c. Relevant ECR[82] clinician notes and considerations based on professional expertise.

8. Rationale for approving an ECR request shall include at least one of the following:
   a. Evidence, with supporting documentation, that the member's unique needs and circumstances are extraordinary in nature and receipt of additional services or service hours may alleviate the member's complex care needs and/or improve their safety, health, and wellbeing, or
   b. An immediate threat, or a high probability of immediate danger to the life, health, property, or environment of the member or another individual due to the member's medical/mental health diagnosis, or behavioral condition, or
   c. A risk of removal from the family home by an authorized agency due to concerns regarding the member's care related to their complex condition(s), or
   d. Evidence that an out-of-home placement would not be as cost effective as increasing services to support the member in remaining safe at home, or
   e. Other evidence based clinical rationale that justifies additional services and/or the increase in service hours.

9. Rationale for denying an ECR request shall include at least one of the following:
   a. Evidence that the member's unique needs and circumstances are not extraordinary in nature and do not require additional services or service hours, or
   b. Evidence that the services and/or service hours determined on the HNT is appropriate due to the member's needs and abilities [83], or
   c. Evidence that additional services or service hours are not medically necessary, or
   d. Evidence that the member cannot benefit from additional services and/or service hours, or
   e. Other clinical rationale specific to the member's unique condition and circumstances as determined and documented[84] by the reviewer.

10. All extraordinary care review decisions must be provided to the HCDM in writing via both email and mail. If the HCDM does not have access to email, a mailed decision is sufficient.[85]

[81] POST PUBLIC COMMENT REVISION: Clarified the documentation and rationale should be specific to the review outcome/decision.
[82] POST PUBLIC COMMENT REVISION: Technical correction
[83] POST PUBLIC COMMENT REVISION: Modified to clarify decisions are individualized member needs and abilities
[84] POST PUBLIC COMMENT REVISION: Clarified rationale is individualized and specific to the member and must be supported with documentation
[85] POST PUBLIC COMMENT REVISION: Removed the step for the HCDM to request the ECR decision via email and made it a standard.

D. EXTRAORDINARY CARE REVIEW TIMELINES

1. The Contractors ECR process shall adhere to the service authorization timelines outlined in 42 CFR 437.732.[86]

2. Contractors shall provide written information about the ECR process to the HCDM at the completion of the member's HNT assessment if requested and the HCDM expresses concern about the results of the HNT assessment due to criteria specified in Section A:
   a. In instances where the criteria is not met for the ECR process, the Contractor shall issue a Notice of Adverse Benefit Determination in accordance with AAC R9-34-205 and as specified in ACOM 414, and
   b. The Contractor shall document on the HNT, the date the ECR information was provided to the member's HCDM.

3. The member's HCDM may submit a written request for an ECR in the manner outlined by the Contractor. The HCDM may also provide information outlined in subsection A.5.c. in accordance with the Contractor's processes [87].[88]
   [89][90]

4. The ECR Clinician shall review the ECR request and supporting documentation including the PEDI-CAT when determined clinically appropriate to inform the ECR process [91]
   a.
   a. The Contractor shall track this data in accordance with Section F.

5. The ECR Clinician will have seven calendar days to complete the ECR and issue a decision, in alignment with federal prior authorization timelines, based on the completion date of the HNT.
   a. The Contractor may request an extension of up to an additional 14 calendar days in instances where the extra time will be of benefit to the member to engage the member's care team and/or specialty clinicians in the ECR.
   b. In the instance that an ECR is initially declined by HCDM but later requested as allowable in policy and in accordance with the Contractor's processes, the Contractor will initiate the ECR in accordance with federal prior authorization timelines, with the starting date of the HNT completion.[92]

[86] POST PUBLIC COMMENT REVISION: Incorporated prior authorization timeline standards and, therefore, removed specific timelines outlined throughout the section
[87] POST PUBLIC COMMENT REVISION: Clarified an ECR request is optional and noted the timeline for additional documentation is determined by the Contractor
[88] POST PUBLIC COMMENT REVISION: Revised timeline for HCDM to provide supplemental information if they choose to do so
[89] POST PUBLIC COMMENT REVISION: No longer applicable with a Contractor initiated ECR process
[90] POST PUBLIC COMMENT REVISION: No longer applicable with a Contractor initiated ECR process
[91] POST PUBLIC COMMENT REVISION: Updated the ECR process including consideration of the PEDI-CAT when determined clinically appropriate.
[92] POST PUBLIC COMMENT REVISON: Clarified the timeline for the ECR starts with the completion of the HNT regardless of when the HCDM makes the request if in accordance with the Contractor's process.

[93]

6. The Contractor shall notify the HCDM of the ECR decision of completion of the review. In instances where:
   a. Additional services or service hours are approved, the Contractor's case manager shall authorize the additional services/service hours in accordance with ACOM 414[94],
   b. Services and/or service hours are not being changed, the Contractor will issue a Notice of Adverse Benefit Determination in accordance with requirements and timelines outlined in accordance with AAC R9-34-205 and as outlined in ACOM 414, and/or
   c. The ECR decision includes other services that may better meet the needs of the member, the Contractor's case manager shall schedule a follow-up discussion with the HCDM within 14 calendar days of the review decision.

7. The Contractor shall ensure that the appropriate actions determined by the ECR process are implemented within the timelines outlined in Section D.4[95].

8. The ECR and all supporting documentation shall be incorporated and maintained in the member's record.[96]

E. CONTRACTOR CASE MANAGER REQUIREMENTS

1. The Case Manager shall document HCDM feedback throughout the HNT as outlined in the AMPM Exhibit 1620-B Guidance Document. The case manager will have the HCDM document their assessment concerns on the HNT as well as indicate their preferences regarding their interest in the ECR process on the member's HNT, along with appropriate HCDM justification, initials, and signatures on the member's HNT. Decisions regarding pursuit of an ECR shall be made in writing by the HCDM and in accordance with established timelines[97].

2. For instances where a new member is assessed or where an established member who has not previously received HCBS services authorized through the HNT is assessed, the Case Manager shall authorize initially assessed hours in accordance with ACOM 414[98]:
   a. If additional hours are approved following the requested ECR process, those hours will be authorized following timelines outlined in this policy.

3. For instances where a member has previously been receiving HCBS services authorized through the HNT and the new assessment results in reduction of hours due to age and/or

[93] POST PUBLIC COMMENT REVISION: Not permitted per the federal regulations governing prior authorization timelines
[94] POST PUBLIC COMMENT REVISION: Modified to align with prior authorization requirements
[95] POST PUBLIC COMMENT REVISION: Moved for clarify and better flow
[96] POST PUBLIC COMMENT REVISION: Added clarification regarding maintaining the ECR in the member's record.
[97] POST PUBLIC COMMENT REVISION: Added further clarification regarding roles of case managers and HCDMs for HNT documentation
[98] POST PUBLIC COMMENT REVISION: Added policy citation for further clarification

weekly maximum limitations, the previously approved and authorized[99] service hours shall be maintained through the ECR process.

4. The Case Manager shall document the outcome of the ECR in the member's HNT and Person-Centered Service Plan (PCSP) in alignment with the ECR clinician's decision[100].

F. CONTRACTOR DATA AND REPORTING REQUIREMENTS

1. The Contractor shall maintain records of all ECR requests and outcomes.

2. Contractor records must include, at a minimum, the following:
   a. Member demographic information including name, AHCCCS ID number, and age at date of request,
   b. Date of the HNT, date of the ECR request, date of the ECR review, the date of the ECR decision, and the date the HCDM is made aware of the ECR decision[101],
   c. All information and documentation submitted as part of the request including the written request for the ECR and any supporting documentation provided by the HCDM, the member's care team, and/or the member's providers (e.g. therapy notes)[102],
   d. The specific clinicians assigned to each review as well as their CVs and professional qualifications,
   e. Any documentation or evidence referenced as part of the review process,
   f. The outcome of the review,
   f. Any communication about the ECR process and the outcome of the review,
   g. The date(s) that communication and follow up activities as required in Section D.4 above are completed, and
   h. Data related to the following:
      i. [103]The number of reviews completed,
      ii. The number of decisions made by category type, including:
         1) Requests approved,
         2) Requests where no services or service hours were added to the HNT but where other services outside of those covered on the HNT were recommended including capturing data when HCDMs decline recommended services[104],
         3) Requests denied,

[99] POST PUBLIC COMMENT REVISION: Added clarification regarding the allowance of authorized hours to be maintained and provided during the ECR
[100] POST PUBLIC COMMENT REVISION: Added clarification that the HNT must be updated based on ECR clinicians' decision, when appropriate
[101] POST PUBLIC COMMENT REVISION: Added clarification regarding data requested
[102] POST PUBLIC COMMENT REVISION: technical clarification
[103] POST PUBLIC COMMENT REVISION: Data request is not applicable when applying a case manager initiated ECR referral process
[104] POST PUBLIC COMMENT REVISION: Added data element to be captured and reported

4) Approval of additional direct care tasks and total additional number of hours associated with each task where additional time has been approved[105], and
5) Approval of the total additional habilitation service hours approved during the reporting period[106].

iii. The total and average increases in service hours by service as well as other services recommended outside of those covered on the HNT,
iv. The average time to conduct the reviews with data specific to each phase of the review process as well as the overall average timeframe, and
v. Analysis of any trends that support review and oversight of this process.

3. The Contractor shall report this information at the intervals required by AHCCCS utilizing Attachment A.

4. Contractors shall provide any information requested by AHCCCS to support periodic reviews and/or audits of the Contractor's extraordinary care review process.

[105] POST PUBLIC COMMENT REVISION: Added for additional clarity
[106] POST PUBLIC COMMENT REVISION: Added for additional clarity