1020 - UTILIZATION MANAGEMENT

EFFECTIVE DATES: 10/01/94, 11/01/05, 10/01/08, 03/01/11, 01/01/11, 04/01/12, 02/01/15, 03/01/15, 10/01/15, 04/05/17, 07/01/17, 10/01/18, 10/01/19, 10/01/20, 10/01/21, 10/01/22, 10/01/23, 10/01/24

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I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), DES DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), DES DDD Tribal Health Program (DDD THP), Tribal ALTCS, TRBHA; and all FFS populations, excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100). This Policy specifies requirements for Contractors and FFS Programs to develop an integrated processes or systems that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care from preventative care to hospice, including advance care planning at any age or stage of illness. The Contractor is responsible for adhering to all requirements for medical management as specified in Contract, Policy, 42 CFR Part 457, and 42 CFR Part 438. For FFS Programs, refer to AMPM Policy 810 for further information on Utilization Management.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including:

CONTRACTOR	**DESIGNATED REPRESENTATIVE (DR)**	**HEALTH CARE DECISION MAKER (HCDM)**
MEMBER	**MEDICAL MANAGEMENT (MM)**	**PRIMARY CARE PROVIDER (PCP)**
PRIOR AUTHORIZATION	**QUALITY OF CARE (QOC)**	**UTILIZATION MANAGEMENT (UM)**

III. POLICY

The Contractor shall ensure an integrated Utilization Management (UM) program that includes Utilization Data Analysis and Data Management, Concurrent Review, Discharge Planning, Prior Authorization (PA) and Service Authorization, Inter-Rater Reliability, Retrospective Review, Clinical Practice Guidelines and New Medical Technologies and New Uses of Existing Technologies. The UM program shall report to the Contractor's Medical Management (MM) committee and shall involve a designated senior-level physician and behavioral healthcare practitioner in the implementation of physical and behavioral healthcare aspects.

A. CLINICAL CRITERIA FOR UTILIZATION MANAGEMENT DECISIONS

The Contractor shall have written criteria which are objective, evidence-based, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Criteria shall include:

1. Written UM decision-making criteria that are objective and based on medical evidence.
2. Written policies for applying the criteria based on member needs.
3. Written policies for applying the criteria based on an assessment of the local delivery system.
4. Involves appropriate providers in developing, adopting, and reviewing criteria.
5. Reviews the criteria and procedures for applying the criteria annually and updates the criteria when appropriate.

B. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

The Contractor shall have in effect mechanisms to review utilization and detect both underutilization and over utilization of services, as specified in 42 CFR 457.1240(b), 42 CFR 457.1240(f), 42 CFR 457.1201(n)(2), and 42 CFR 438.330(b)(3). The Contractor shall develop and implement processes to collect, validate, analyze, monitor, and report the utilization data.

Annually and on an as needed basis, the Contractor's UM program shall review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified. The evaluation shall include a review of the impact on both service quality and outcome. The UM program shall determine, based on its review, if action (new or changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address both over and underutilization of services shall be integrated throughout the organization. All such strategies shall have measurable outcomes that are reported in the Contractor's MM committee minutes.

C. CONCURRENT REVIEW

The Contractor shall have policies, procedures, processes, and criteria in place that govern the utilization of services during short-term and long-term hospital and institutional stays to ensure that the member continues to receive reasonable, appropriate care in the right health care setting to meet the members healthcare needs. The Contractor shall have procedures for review of medical necessity prior to a planned institutional admission (pre-certification) and for determination of the medical necessity for continuation of institutional care (concurrent review).

1. Policies and procedures for the concurrent review process shall:
   a. Include relevant clinical information considered when making hospital length of stay decisions. Relevant clinical information may include but is not limited to:
      i. Symptoms,
      ii. Diagnostic test results,
      iii. Diagnoses, and
      iv. Required services.
   b. Specify timeframes and frequency for conducting concurrent review and decisions:
      i. Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed, and
      ii. Admission reviews shall be conducted within one working day after notification is provided to the Contractor by the hospital or institution (this does not apply to pre-certifications) as specified in 42 CFR 456.125.
   c. Provide a process for review that includes but is not limited to:
      i. Necessity of admission and appropriateness of the service setting,
      ii. Quality of care,
      iii. Length of stay,
      iv. Whether services meet the member needs,
      v. Discharge needs, and
      vi. Utilization pattern analysis.
   d. Establish methodology for Contractor participation in proactive discharge planning for services available upon discharge for all members in institutional settings.

2. Criteria for decisions on coverage and medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals:
   a. Medical criteria shall be approved by the Contractor MM committee. Criteria shall be adopted from national standards. When providing concurrent review, the Contractor shall compare the member's medical information against medical necessity criteria that describes the condition or service,
   b. Initial institutional stays are to be based on the Contractor adopted criteria, the member's specific condition, and the projected discharge date, and
   c. Continued stay determinations are to be based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay shall be assigned a new review date each time the review occurs. The Contractor shall ensure that each continued stay review date is recorded in the member's record.

3. The Contractor shall submit, as specified in Contract, the inpatient hospital showings report, signed by the Contractor's Medical Director to attest that a physician has certified to the necessity of inpatient hospital services:
   a. The services were periodically reviewed and evaluated by a physician,
   b. Each admission was reviewed or screened under a utilization review program, and
   c. All hospitalizations of members were reviewed and certified by their medical utilization staff.

D. DISCHARGE PLANNING

The FFS providers are responsible for discharge planning for FFS members, in accordance with the member's treatment or service plan, as applicable.

The Contractor shall have policies and procedures in place that govern the process for proactive discharge planning and coordinating services the Contractor furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays, as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(i).

The intent of the discharge planning process is to improve the management of inpatient admissions and the coordination of post-discharge services, reduce unnecessary institutional and hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge.

The Contractor shall develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member to arrange necessary services and resources for appropriate and timely discharge from a facility.

In the event that a covered behavioral health service is temporarily unavailable for individuals in an inpatient or residential facility who are discharge-ready and require covered, post-discharge behavioral health services, policies and procedures shall be in place which stipulate the process for allowing the member to remain in that setting until the service is available or ensure Contractor care management, intensive outpatient services, provider case management, and/or peer service are available to the member while waiting for the appropriate covered behavioral health service.

The Contractor shall conduct interdisciplinary staffing with the inpatient team for care coordination efforts once the member has been identified as awaiting discharge to the appropriate level of care. The Contractor's Chief Medical Officer (CMO) or Medical Director notification and involvement is required for members experiencing a delay in discharge from institutional settings or the Emergency Department (ED).

A proactive assessment of discharge needs shall be conducted prior to admission when feasible, or as soon as possible upon admission.

Discharge planning shall be performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continued post-discharge to ensure a timely, effective, safe, and appropriate discharge.

1. Contractor staff participating in the discharge planning process shall ensure the member/Health Care Decision Maker (HCDM), Designated Representative (DR), as applicable:
   a. Is involved and participates in the discharge planning process,
   b. Understands the written discharge plan, instructions, and recommendations provided by the facility, and
   c. Is provided resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.

2. Discharge planning, coordination, and management of care shall include but are not limited to:
   a. Follow-up appointment with the Primary Care Provider (PCP) and/or specialist within seven business days, unless member is discharged to a facility/institution in which they are evaluated by a health care professional based on the needs of the member,
   b. Coordination and communication by the Contractor with inpatient and facility providers for safe and clinically appropriate discharge placement, and community support services,
   c. Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team, other Contractors, and FFS Programs when appropriate,
   d. Prescription medications,
   e. Medical equipment,
   f. Nursing services,
   g. End of life care related services such as advance care planning,
   h. Informal Supports,
   i. Hospice,
   j. Therapies (Refer to AMPM Policy 310-X for limitations),
   k. Referral to appropriate community resources,
   l. Referral to Contractor disease management or Contractor care management (if needed),
   m. A post-discharge follow-up call to the member/HCDM/DR within three business days of discharge to confirm the member's well-being and the progress of the discharge plan according to the member's assessed and anticipated clinical (behavioral and physical health) and social needs. If the member is discharged to a facility/institution in which they are evaluated by a healthcare professional based on the needs of the members, the three day follow up call is not required,
   n. Additional follow-up actions as needed based on the member's needs, and
   o. Proactive discharge planning when the Contractor is not the primary payer.

E. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

All FFS Providers shall follow PA requirements specified in AMPM Policy 820.

The Contractor shall have Arizona licensed PA staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply the Contractor's medical criteria or make medical decisions. Qualifications of staff members who may authorize long-term care Home and Community-Based Services (HCBS) that are not considered skilled are specified in AMPM Policy 1630.

Information regarding emergency services is specified in AMPM Policy 310-F.

The Contractor shall develop and implement a system that includes at least two modes of delivery for providers to submit PA requests such as telephone, fax, and/or electronically through a portal on the Contractor's website.
The Contractor shall ensure providers who request authorization for a service are notified of the option to request a peer-to-peer discussion with the Contractor's Medical Director when additional information is requested by the Contractor or when the PA request is denied. The Contractor shall allow at least 10 business days from the date the provider has been made aware of the denial for the provider to request a peer-to-peer and coordinate the discussion with the requesting provider when appropriate.

The Contractor shall develop and implement policies and procedures, coverage criteria and processes for approval of covered services, which include required timeframes for authorization determination.

1. Policies and procedures for approval of specified services shall:
   a. Identify and communicate to providers, other Contractors, FFS Programs when appropriate, and to members/HCDM/DR for services that require and do not require PA and the relevant clinical criteria required for authorization decisions,
      The Contractor shall:
      i. Specify methods of communication with members/HCDM/DR including but not limited to newsletters, Contractor website, and/or Member Handbook,
      ii. Specify methods of communication with providers other Contractors, and FFS Programs including but are not limited to newsletters, Contractor website, and/or provider manual, and
      iii. Provide for communication of changes in the coverage criteria to members/HCDM/DR, TRBHAs, Tribal ALTCS and providers 30 business days prior to implementation of the change.
   b. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Informs providers how criteria are made available to providers, Tribal ALTCS and TRBHAs through the Contractor provider manual and Contractor website. Criteria shall be available to members/ HCDM/DR upon request,
   c. Authorize services in a sufficient amount, duration, or scope to achieve the purpose for which the services are furnished,
   d. Ensure consistent application of review criteria,
   e. Specify timeframes for responding to requests for initial and continuous determinations for standard, expedited and medication authorization requests as specified in ACOM Policy 414, 42 CFR 457.1230(d), and 42 CFR 438.210(b),
   f. Provide for consultation with the requesting provider, other Contractors, or FFS Programs when appropriate, and
   g. Review all PA requirements annually. The review shall be reported through the Contractor's MM Committee and shall include the rationale for changes made to PA requirements and shall be documented in the MM Committee meeting minutes.

2. The Contractor shall develop and implement policies for processing and making determinations for PA requests for medications as specified in ACOM Policy 414. The Contractor shall allow for at least a four-day supply of a covered outpatient prescription drug to be provided to the member in an emergent situation as specified in 42 CFR 457.1230(d) and 42 CFR 438.3(s)(6).

3. Contractor criteria for decisions on coverage and medical necessity for both physical and behavioral health services shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.
   a. The Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the setting, diagnosis, type of illness or condition of the member,
   b. The Contractor shall place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome,
   c. The Contractor has written procedures for using board-certified professionals in making medical necessity determinations, and
   d. The Contractor provides evidence that it uses board-certified professionals for medical necessity determinations.

4. The Contractor shall use and document all relevant information when making coverage decisions. Information used for determining coverage may include, but is not limited to:
   a. Office and hospital records,
   b. History of presenting problem,
   c. Physical exam results,
   d. Treatment plans and progress notes,
   e. Patient psychosocial history,
   f. Information on consultations with treating practitioner,
   g. Evaluations from other health care practitioners and providers,
   h. Operative and pathological reports,
   i. Rehabilitation evaluations,
   j. Printed copies of the criteria related to the request,
   k. Information regarding benefits for services or procedures,
   l. Information regarding the local delivery system,
   m. Member characteristics and information,
   n. Information from family codes, and
   o. Diagnosis codes.

5. The Contractor shall have criteria in place to ensure issuance of timely authorization decisions for requests for services, including those service requests for a member with possible or actual Medicare or other third-party coverage. The fact that the Contractor is or may be the secondary payer does not negate the Contractor's obligation to render a determination regarding coverage within the timeframes specified in ACOM Policy 414. The absence or presence of an individual's third-party liability coverage is unrelated to the Contractor's obligation to timely evaluate medical necessity and coverage of a requested service even when the potential third party has not issued a determination or when the third party has denied the service request. Third party liability and coordination of benefit issues are separate and distinct from the Contractor's independent responsibility to timely issue an authorization determination as specified in state and federal provisions. Moreover, a denial of the service request by a third party is not to be used as a basis for the Contractor's determination of medical necessity or coverage; the Contractor shall independently and timely evaluate the member's service request. In instances where the third party has approved a service request through medical necessity review, the Contractor shall not apply a secondary PA and shall coordinate benefit coverage with the third party. When a third party has approved a service request as medically necessary, the Contractor shall not apply a secondary prior authorization. Additional information regarding Contractor payment and cost sharing responsibilities are as specified in ACOM Policy 201 and ACOM Policy 434.

F. INTER-RATER RELIABILITY

The Contractor shall have in place a process to ensure consistent application of review criteria in making medical necessity decisions which include PA, concurrent review, and retrospective review as specified in 42 CFR 457.1230(d) and 42 CFR 438.210(b). Inter-rater reliability testing of all staff involved in these processes shall be performed at least annually. A corrective action plan shall be developed and implemented for staff who do not meet the minimum compliance standard of 90%.

G. RETROSPECTIVE REVIEW

For FFS Programs, refer to AMPM Policy 810 for further information on utilization management.

The Contractor shall have policies and procedures for review of medical necessity of a treatment/service post-delivery of care. The Contractor shall conduct retrospective review which is guided by the following:

1. Policies and procedures that:
   a. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,
   b. Describe services requiring retrospective review, and
   c. Specify time frame(s) established by the Contractor for completion of the review.

2. Criteria for decisions on medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

3. A process for consistent application of review criteria as specified in 42 CFR 457.1230(d) and 42 CFR 438.210(b)(2)(i).

4. Provides electronic or written notification of the decision within 30 calendar days of the request.

5. Guidelines for Provider-Preventable Conditions
   a. Payment for services related to Provider-Preventable Conditions is prohibited, as specified in 42 CFR 447.26,
   b. A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication". If it is determined that the complication resulted from a Health Care-Acquired Condition (HCAC) or Other Provider-Preventable Condition (OPPC), any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed, and
   c. If it is determined that the HCAC or OPPC was a result of a mistake or an error by a hospital or medical professional, the Contractor shall conduct a Quality of Care (QOC) investigation and report the occurrence and results of the investigation to the AHCCCS/Quality Management.

H. CLINICAL PRACTICE GUIDELINES

The Division of Fee-For-Service Management (DFSM) is responsible for the establishment of practice guidelines for FFS programs.

1. The Contractor shall develop or adopt and disseminate practice guidelines for physical and behavioral health services that:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field as specified in 42 CFR 457.1233(c) and 42 CFR 438.236(b)(1),
   b. Have considered the needs of the Contractor's members served as specified in 42 CFR 457.1233(c) and 42 CFR 438.236(b)(2),
   c. Are adopted in consultation with contracted health care professionals and National Practice Guidelines as specified in 42 CFR 457.1233(c) and 42 CFR 438.236(b)(3), or
   d. Are developed in consultation with health care professionals and network providers, and include a thorough review of peer-reviewed articles in medical journals published in the United States when national practice guidelines are not available,
   e. Are disseminated by the Contractor to all affected providers, practitioners, and, upon request, to members/ HCDM/DR and potential members, and
   f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply as specified in 42 CFR 457.1233(c) and 42 CFR 438.236(d).

2. The Contractor shall evaluate the practice guidelines through a MM committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards every two years as specified in 42 CFR 457.1233(c) and 42 CFR 438.236(b)(4).

3. The Contractor shall document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines in the MM committee meeting minutes.

I. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

The Division of Fee-For-Service Management (DFSM) coordinates within the AHCCCS administration, including the DFSM Medical Director and CMO on evaluation of new medical technologies and new uses of existing technologies for members enrolled with an FFS program.

The Division of Fee-For-Service Management (DFSM) establishes rules, guidelines, policies, and procedures related to coverage, payment, utilization management, and oversight that allows for the FFS member's medical or behavioral health needs to be met.

1. The Contractor shall develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology, The review of new technologies and new uses of existing technology includes an evaluation of benefits for medical and behavioral healthcare services, pharmaceuticals, and devices. The policies and procedures shall include both a mechanism for committee review on a quarterly basis and a timeframe for making a clinical determination when a time sensitive request is made. A decision in response to an urgent request shall be made as expeditiously as the member's condition warrants but no later than 72 hours from receipt of the request.

2. The Contractor shall include, in their review, coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, peer-reviewed literature, and Federal and State Medicaid coverage decisions.

3. The Contractor shall evaluate published or unpublished information sources to establish that a new medical service or technology represents an advance that substantially improves the diagnosis or treatment of members as specified in 42 CFR 412.87.

4. The Contractor shall establish:
   a. Coverage rules, practice guidelines, payment policies, policies and procedures, utilization management, and oversight that allows for the member's medical needs to be met,
   b. A process to evaluate for changes in coverage rules and practice guidelines that are based on the evaluation of trending requests. Additional review and assessment are required if multiple requests for the same technology or application of an existing technology are received,
   c. A process for documenting the coverage determinations and rationale in the MM committee meeting minutes, and
   d. A process for seeking input from relevant specialists and professionals who have expertise in the technology.