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Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

May 20, 2010

William Hagan, CEO
Arizona Physicians IPA, Inc.
3141 N. 3rd Avenue
Phoenix, AZ 85013-4345

RE: Notice to Cure - Grievance System (Extensions and Retro-Review Process)

Dear Mr. Hagan:

The Division of Health Care Management is issuing a Notice to Cure to Arizona Physicians IPA, Inc. (APIPA) regarding management of the grievance system process under contract YH09-0001.

Claim Dispute Extensions

On February 25, 2010, APIPA submitted a corrective action plan (CAP) to address AHCCCS' concern with its grievance process, specifically the excessive number of extensions requested each month. Item number three in the CAP indicated that APIPA would decrease the volume of extensions to no more than 25% of all disputes by March 10th. The monthly grievance report that was submitted for the March data on May 3rd indicated the following:

Number of Claim Disputes Received	2,338
Total Current Inventory as of End of Month	1,882
Extensions Requested	2,364

Therefore, APIPA did not meet its self imposed March 10th goal. Additionally, APIPA reported on May 4th that in April 2010 a total of 1,111 extensions were requested. Although this is an improvement from the previous month, the goal still has not been obtained.

Although contractors may request an extension from a provider when a decision can not be made within the 30 days allotted in the Claim Dispute process, it is not acceptable that APIPA needs to request them for the majority of the cases received. This leads us to believe that APIPA is not adequately staffed to process disputes according to the terms of its contract with AHCCCS. Paragraph 16 (Staffing Requirements) of the Acute Care Contract reads as follows:

The Contractor must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The Contractor's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS policy requirements, including the requirement for providing culturally competent services. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by AHCCCS, up to and including actions specified in Section D, Paragraph 72, Sanctions, of the Contract.

Therefore, please submit a corrective action plan by COB June 3, 2010 that addresses how APIPA will meet the following goals:

- Adjudicate 95% of claim disputes no later than 30 days after the provider files the claim dispute with APIPA or within timeframes agreed to by APIPA and the provider. For disputes filed with APIPA on or after June 1, 2010, APIPA must adjudicate 99% of claim disputes no later than 45 days from the date of receipt.

- Reduce claims dispute extension requests so that the number of extensions requested does not exceed 25% percent of the total claims dispute inventory. Extensions may not exceed 15 additional days.

Retro Review Process

In December, 2009 APIPA initiated a new process for conducting a retrospective review for members seen either in the Emergency Department or admitted and discharged to an acute facility during non business hours. AHCCCS received complaints from several hospitals regarding this process including, but not limited to the following:

- APIPA issuing claim denials due to lack of authorization before a clinical review was conducted.
- APIPA clinical staff stating that the hospital had no "appeal rights" because two physicians at APIPA had looked at the record and denied the care based on clinical criteria.
- Not reviewing medical records as part of the claim dispute process.

During a meeting with AHCCCS on March 22nd, APIPA acknowledged that they were denying claims rather than pending the claims for medical review and that the retrospective review was not occurring prior to the claim being denied. APIPA committed at that meeting to correcting the situation immediately by pending claims until the retrospective review was completed. On April 30th AHCCCS was informed that the situation had not been corrected at which time APIPA committed to fixing the claim issue by May 11th. To assure that the issues would be addressed comprehensively, on May 6th AHCCCS provided technical assistance to APIPA regarding regulatory requirements as they relate to concurrent review, retrospective review, claims and the claim dispute process. APIPA was given a copy of the presentation and it is also attached here as documentation of the guidance that was provided.


APIPA's failure to coordinate the retrospective review process with the claim process placed an undue burden on hospitals and the appeal process. Due to this failure, APIPA must submit a corrective action plan by June 3, 2010 which addresses the following:

- Update the hospital communication log to remove reference to administrative denials. The log must be submitted for AHCCCS review.
- Pend claims for retrospective review as opposed to denying these claims.
- Update processes to acknowledge that claims received within 10 days is considered notification for a hospital stay.
- Develop a communication plan to keep all impacted hospitals up to date regarding the retro review process.
- Complete all reviews that are currently older than 30 days by June 30th.
- Update the claim dispute process to include medical review on all disputes that state the service was medically necessary.

Following the review of both corrective action plans, AHCCCS may conduct random and periodic audits of both the claim dispute process and timeliness of retrospective reviews.

If you have any questions regarding this matter, please contact Rodd Mas at 602-417-4072.

Sincerely,


Michael Veit
Contracts and Purchasing Administrator

C: Kate Aurelius
Rodd Mas
Shelli Silver
Maureen Wade

**AHCCCS - APIPA
Concurrent/ Retrospective
Review, Claims
and Claim Disputes**

May 6, 2010

Concurrent Review

- **Concurrent Review** is the process of reviewing an institutional stay **at admission and throughout the stay** to determine medical necessity for an institutional level of care. Contractor reviewers assess the appropriate use of resources, levels of care (LOCs) 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.

-AMPM, Chapter 1000, Definitions

Concurrent Review

- 42 CFR Ch. IV, “Except as required under 456.127” (preadmission reviews)” the review of each recipient’s admission to the hospital is conducted (a) Within one working day after admission, for an individual who is receiving Medicaid at that time; or (b) Within one working day after the hospital is notified of the application for Medicaid, for an individual who applies while in the hospital

Concurrent Review and Disagreements in Medical Criteria

- 42 CFR 456.123 (e) If the committee or subgroup making the review...finds that the admission is not needed, it notifies the recipient's attending physician and gives him an opportunity to present his views before it makes a final decision on the need for the continued stay; (f) If the attending physician does not present additional information or clarification of the need for the admission, the decision of the ...subgroup is final; and (g) If the attending presents additional information or clarification, at least two physician members of the committee review the need for the admission. If they find that the admission is not needed, their decision is final.”

Concurrent Review and Disagreements in Medical Criteria

- 42 CFR 438.210...”Consult with the requesting provider when appropriate....any decision to deny a service authorization request...be made by a health care professional who has the appropriate clinical expertise in treating the enrollee’s condition or disease.
- The preamble to the BBA allows for interpretation of the “expertise in treating the enrollee’s condition or disease”- Please reference AZ regs on Medical Director’s and consider defense of decision in hearing.

Denial of Continued Stay or Admission- “to NOA or Not to NOA?”

- If the member *received* the care (usually post discharge reviews) , the member does **NOT** need to be noticed. There is nothing for the Member to Appeal.
- 42 CFR 456.136 Notification of Adverse Decision....written notice of any adverse final decision on the need for continued stay [see 456.124 for initial review denials- language is the same] ...is sent to the hospital administrator; the attending physician; the recipient; and if possible the next of kin or sponsor

Denial of Continued Stay or Admission- “to NOA or Not to NOA?”

- 456.137...the committee makes a final decision on a recipient's need for continued stay and gives notice ...of an adverse final decision within 2 working days after the assigned continued stay review dates, except...If the committee makes and adverse final decision on a recipient's need for continued stay before the assigned review date, the committee gives notice...within 2 days working days after the date of the final decision.
- Review 456.126 for time limits for final decision and notification of adverse decisions for initial admission reviews

New Topic and New Timeframes

Retrospective Review

Retrospective Review

- **Retrospective Review** means the process of determining the medical necessity of a treatment/service post delivery of care.
- 42 CFR 438.114...Emergency and Poststabilization services....cannot refuse to cover services base on the ED/Hosp not notifying the enrollee's MCO of the screening and treatment within 10 calendar days
- Notification includes a claim or notification of the MCO through the concurrent review process

Retrospective Review

- Two options
 - Pre Claim submission
 - Post Claim submission

Retrospective Review

- Retrospective review can be pre-claim e.g. unable to conduct concurrent review in the timeframe of 1 working day due to admit and discharge over weekend/ holiday- The key is that upon notification of admission the review is conducted before receipt of claim and staff could communicate with the facility in the same manner as the “review” process for concurrent review (attending to review committee)

Retrospective Review

- Retrospective review can be post-claim receipt ...notification on a Monday of weekend admit/discharge and review does not get done before Wednesday but the claim hits the system electronically- system pends claim as system shows review pending but has notification in system and the claim decision to pay, deny, or partial pay waits on clinical decision on medical necessity
- e.g. notification of admission is day 8 via claim...claim system does not see auth./ review and pends claim for medical review- staff could communicate with the facility in the same manner as the “review” process for concurrent review (attending to review committee), request documentation or conduct electronic review and make a clinical determination of medical necessity but the 10 day notification has occurred and therefore the service cannot be denied for lack of notification

Retrospective Review

- Do not confuse these processes that occur *prior* to issuing any claim payment decision with what occurs once you have sent the facility a claim decision.
- All you have done to this point is approved or denied clinical care based on your criteria for medical review

Application of Criteria

- **The Contractor has implemented and monitors a comprehensive inter-rater reliability program to ensure consistent application of criteria for clinical decision making. [AMPM Chapter 1000; 42CFR438.236]**
- This standard applies to all decision makers and all aspects of clinical review:
 - Prior authorization, Concurrent review, retrospective review, post-payment claim review or claim dispute review for medical appropriateness

New Topic and New Timeframes

Claims

Claims

- The Claim comes into APIPA
 - Review System for previous clinical review
 - If authorization or denial has been previously entered into the system process claim according to the authorization or denial

Claims

- The Claim comes into APIPA.
 - Review System for previous clinical review
 - If no previous clinical review has been performed and;
 - The hospital has not notified the Contractor of the hospitalization and;
 - The claim was received more than 10 days of the date of service.
 - The claim can be denied.

Claims

- The Claim comes into APIPA
 - Review System for previous clinical review
 - If no previous clinical review has been performed and;
 - The hospital has not notified the Contractor of the hospitalization and;
 - The claim was received within 10 days of the date of service.
 - The claim must be pended. Follow post claims retro review process outlined above in slide 12.

Claims

- Pended claims- Retro Review completed
 - With in 30 days of receipt, process the claim in accordance with the auth or denial in the system that was entered as a result of the retro review.

New Topic and New Timeframes

Claim Disputes

Claim Disputes

- All Disputes must be reviewed based on the factual and legal basis of the request.
 - If the factual and legal basis for the dispute is the claim did not pay based on the contracted rate, the contract would need to be reviewed
 - If the factual and legal basis for the dispute is that the medical decision made was inappropriate, the medical decision would need to be reviewed.

New Topic and New Timeframes

State Fair Hearing Requests

State Fair Hearing requests

- All Hearing requests must be reviewed based on the factual and legal basis of the request.
 - If the factual and legal basis for the Hearing request is the claim did not pay based on the contracted rate, the contract would need to be reviewed
 - If the factual and legal basis for the Hearing request is that the medical decision made was inappropriate, the medical decision would need to be reviewed.

Questions????