1000 CHAPTER OVERVIEW

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The standards and requirements included in this Chapter are applicable to AHCCCS Acute Care and Arizona Long Term Care Systems (ALTCS) Contractors, the Department of Economic Security, Division of Developmental Disabilities (DES/DDD), the Comprehensive Medical and Dental Program (CMDP), the Regional Behavioral Health Authorities (RBHAs), and Children's Rehabilitative Services (CRS). If requirements of this Chapter conflict with specific contract language, the contract will take precedence. For purposes of this Chapter, the above listed organizations and agencies will be referred to as "Contractors".

At least annually, the Medical Management (MM) Unit will conduct reviews of each Contractor's compliance with the requirements of this Chapter. The MM Unit is located within the Division of Health Care Management (DHCM).

The Chapter provides the necessary information to Contractors to ensure compliance with Federal, State and AHCCCS requirements related to medical management activities.

Definitions

The words and phrases in this Chapter have the following meanings, unless the context explicitly requires another meaning. Refer to Chapter 900 of this manual for other applicable definitions.

1. **Assess or Evaluate** means to study or examine methodically and in detail, typically for purposes of explanation and interpretation.

2. **Authorization Request (Expedited)**, under 42 C.F.R. 438.210, means a request for which a provider indicates or a Contractor determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest.

3. **Authorization Request (Standard)**, under 42 C.F.R. 438.210, means a request for which a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest.

4. **Care Management** is a group of activities performed by the Contractor 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.

5. **Case Management** is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

6. **Catastrophic Reinsurance** is a stop-loss mechanism to provide Contractors with partial reimbursement for specified service costs incurred by a member. This risk-sharing program is available when the provisions delineated in the Reinsurance Processing Manual, AHCCCS Medical Policy Manual (AMPM) and contract is met.

7. **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, Level of Care (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.

8. **Delegated Entity** is a qualified organization, agency, or provider that holds a subcontract to perform delegated management/administrative functions or responsibilities for the Contractor.

9. **Disease Management** is an integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

    a. Identifying and proactively monitoring high-risk populations
    b. Assisting members and providers in adhering to identified evidence-based guidelines
    c. Promoting care coordination
    d. Increasing and monitoring member self-management, and
    e. Optimizing member safety

10. **Goal** means a desired result the Contractor envisions, plans, and commits to achieve within a proposed timeframe.

11. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights. Grievances do not include "Action(s)" as defined in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

12. **Measurable** means a gauge to determine definitively whether or not a goal has been met or progress has been made.

13. **Medical Management (MM)** means an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from prevention to end of life care).

14. **Methodology** means the planned process, steps, activities or actions taken by a Contractor to achieve a goal or objective or to progress toward a positive outcome.

15. **Monitoring** means the process of auditing, observing, evaluating, analyzing and conducting follow-up activities, and documenting results.

16. **Retrospective Review** means the process of determining the medical necessity of a treatment/service post delivery of care.

17. **Utilization Management** applies to a Contractor's process to evaluate and approve or deny health care services, procedures or settings based on medical necessity, appropriateness, efficacy and efficiency. Utilization management also includes processes for prior authorization, concurrent review, retrospective review and case management.

Refer to:

- Chapter 500 of this Manual for additional information regarding care coordination requirements,

- Chapter 800 of this Manual for Fee-For Service (FFS) quality and utilization management, and

- Chapter 900 of this Manual for member rights and responsibilities, medical records and communication of clinical information and additional related definitions.

REFERENCES

1. 42 C.F.R. 438.200 *et seq* (Quality Assessment and Performance Improvement Including Health Information Systems)
2. 42 C.F.R. Part 456, Subparts A through J (Utilization Control)
3. 45 C.F.R. Part 164 (Health Insurance Portability and Accountability Act [HIPAA] Privacy Requirements)
4. Arizona Revised Statutes (A.R.S.) § 36-2903 (Duties of the Administration)
5. A.R.S. § 36-2917 (Review Committees)
6. Title 9 of the Arizona Administrative Code, Chapter 22 (9 A.A.C. 22), Article 5 (General Provisions and Standards)
7. 9 A.A.C. 22, Article 12 (General Provisions and Standards for Service Providers)
8. 9 A.A.C. 28, Article 5 (Program Contractor and Provider Standards)
9. 9 A.A.C. 28, Article 11 (General Provisions and Standards for Service Providers)
10. 9 A.A.C. 31, Article 5 (General Provisions and Standards)
11. 9 A.A.C. 31, Article 12 (General Provisions and Standards for Service Providers)
12. 9 A.A.C. 34 (Grievance System), and
13. AHCCCS Contracts.