

## MEDICAL MANAGEMENT/UTILIZATION MANAGEMENT OVERVIEW

Pima Health System (PHS) is committed to maintaining a Medical Management/Utilization Management (MM/UM) Program which is in accordance with the Federal Balance Budget Act (BBA), Arizona Administrative Codes, Arizona Revised Statutes (ARS), and Arizona Health Care Cost Containment System (AHCCCS) guidelines. The MM/UM Program is an integrated management strategy that is responsible for planning, organizing, directing and providing health care services in a cost effective manner. The MM/UM Program is under the direction of the PHS Chief Medical Officer and the PHS Medical Management Manager.

The MM/UM Division's goals and objectives are:

- To empower members to participate in their individual healthcare decisions;
- To improve healthcare delivery;
- To provide and promote easy access for members to receive high quality care;
- To avoid excessive, inappropriate diagnostic and treatment costs;
- To constantly monitor the effectiveness of services provided to members;
- To continuously assess clinical and financial outcomes.

PHS provides high quality healthcare services to our members in a cost effective manner through the judicious use of resources to control inappropriate hospital admissions, monitor length of stay, and provide for efficient use of ancillary services.

The major components of the MM/UM Program are:

- Prior Authorization (does not apply to emergency services);
- Concurrent Review;
- Retrospective Review;
- Utilization Data Analysis and Data Management/ Provider Profiling.

## PRIOR AUTHORIZATION OVERVIEW

Prior Authorization (PA) is a process by which the PHS PA staff determines in advance whether a service that requires prior approval will be covered, based on the initial information received. **Prior authorization does not guarantee payment.** Reimbursement for services is based on the accuracy of the information received with the original PA request, on whether or not the service is substantiated through concurrent and/or medical review, and on whether the claim meets claims submission requirements.

PA review for PHS covered services with certain limitations is based on the following:

- Verification of the member's eligibility with PHS;
- Verification of the provider's contracted status with PHS;
- Verification that the requested service is a PHS covered service requiring PA;
- Determination if the requested service is medically necessary;
- Determination if the requested service is covered by another payer (commercial insurance, Medicare, other agency).

**Prior Authorization is available to providers and members seven (7) days a week, twenty-four (24) hours a day at 520-243-8062.**

PA requests must be submitted in a timely manner to allow for processing. Authorization timelines are:

- Routine is a request for which PHS 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.
- Expedited is a request for which PHS must provide a decision as soon as possible because using the routine timeframes could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function. The provider can indicate, or PHS can make the determination of the critical status of the request. PHS must make a decision and provide notice as quickly as the member's health condition requires, but not later than 3 working days following the receipt of the authorization request. **NOTE: Providers identifying a member in need of services within 24 hours may call the Prior Authorization Division and identify the service as an Expedited Request needing to speak with a PA nurse directly. The PA nurse will need to speak with the requesting provider to obtain the necessary clinical information to process the request.**

Extensions of up to 14 calendar days may be utilized if the member or provider requests an extension, or if PHS establishes a need for additional information and the delay is in the member's best interest. The member/patient and the provider will receive a letter indicating the decision timeframe has been extended to allow for additional information to be presented.

The following information must be received with the PA request form, see attached form:

1. Member/Patient name and demographics (address and phone number), DOB, and AHCCCS ID number.
2. Provider name and demographics (address, phone and fax number), and contact person.
3. Referred to provider name and location, and anticipated admission/surgery/service date.
4. ICD-9 diagnosis code(s).
5. CPT procedure code(s) or HCPCS code(s).
6. Type of request.
7. All current supporting medical documentation indicating the service being request and medical justification.

The PHS PA nurse, in collaboration with the PHS Chief Medical Officer, will review the information provided and render a decision (approval/denial) regarding coverage. Upon approval of the PA request, the PCP and/or Specialist will receive written authorization and an authorization number. If the PA request is denied, the PCP and/or Specialist and the member/patient will receive a Notice of Action indicating the reason for the denial and recommendations. It is the responsibility of the PCP and/or the Specialist to inform the member regarding the status of the PA request.

PHS has developed a list of services which require prior authorization, see attached list.

Additional PA information and tips:

**PA is *NOT REQUIRED* when the member/patient has a primary insurer (commercial insurance, Medicare, Medicare Advantage, or other agency) and PHS is the secondary insurer and the provider is referring the member/patient to a PHS contracted provider or vendor.** If the provider is referring the member/patient to a non-contracted provider then **PA IS REQUIRED**. However, if the primary insurer has denied the service(s) for the member/patient then the provider may submit to a PA request to PHS for primary coverage. The request will be reviewed for medical necessity using PHS PA guidelines.

A **referral to a PHS contracted specialist** DOES NOT require a Prior Authorization. The PCP needs to direct the member to a PHS contracted specialist, please utilize the PHS Preferred Provider List which can be located on our web site: [www.phs.pima.gov](http://www.phs.pima.gov) or if you need an updated list please contact Provider Services at 520-243-4389. It is the responsibility of the PCP to provide the specialist with a written order or an in-office referral form, and any pertinent clinical information relating to the condition the member is being referred to the specialist for. The contracted specialist may order specialized diagnostic testing/procedures and may refer the member/patient to other contracted specialists as medically necessary. The specialist can submit the PA request directly to the PHS PA Division.

PA requests for rehabilitative therapy (physical/occupational/speech) may be initiated by the PCP or a specialist. Please understand that therapy for “chronic conditions” is not a covered benefit per AHCCCS guidelines. Also, outpatient occupational and speech therapy for AHCCCS Acute plan members over the age of 21 is not a covered benefit, per AHCCCS guidelines. Clinical documentation submitted must include a complete physical examination of the member/patient and information pertaining to the nature of the condition to be treated. If a continuation of therapy services is medically necessary then the initiating PCP or specialist must submit clinical documentation indicating the continued need for therapy. **Continuation of therapy services CAN NOT be initiated by the therapy provider.**

All PA requests for Durable Medical Equipment (DME) and Medical Supplies must include a specific order for the DME or medical supplies, the member/patient’s most current height and weight, and the type or description of equipment being ordered. The PHS PA nurse is available for assistance in determining DME or medical supply needs. The provider order needs to specify the type of supply and the amount, for example: the order needs to read “4 - # 14 FR Foley Catheters” not Urinary Catheter Supplies. Also, when ordering customized DME (electric and/or custom wheelchairs, scooters) it is best to have the member/patient assessed by a PHS contracted Physiatrist or an Assistive Technology Program to ensure the member is fit with the appropriate equipment.

PA requests for Home Health need to specify the type of treatment the member/patient requires, the frequency of visits, and clinical documentation describing the medical condition for which the member/patient is being treated. The PHS PA nurse is available for assistance in arranging Home Health Services at the request of the ordering provider. **To consult with the PA nurse, call (520) 243-8062.**

Clinical documentation should contain the most current medical notes that describe the member/patient’s current medical condition, a physical examination, current treatment options/medications that have been tried, and the plan of care for the member. Please remember to include this information because failure to do so may delay the authorization process.

PHS Prior Authorization Coverage Guidelines are available by hard copy or fax. The provider needs to call the **24-Hour Prior Authorization line (520) 243-8062** to request the information needed. Currently, PHS is in the process of posting these coverage guidelines on the website. Please continue to check the website at [www.phs.pima.gov](http://www.phs.pima.gov) for new guideline additions.

### **CONCURRENT REVIEW**

Concurrent Review is a process utilized to assess the necessity of a facility (hospital, skilled nursing, rehabilitation, sub-acute hospital) admission, the appropriateness of the services the member/patient is receiving, and evaluates the quality of care. The PHS Concurrent Review Nurse (CCRN) uses the McKesson InterQual Criteria in determining the severity of the illness the member/patient presented with, the intensity of services being rendered for that illness, and the readiness for discharge or transfer to a different level of care.

It is the responsibility of all facilities to notify PHS of an admission of a PHS member/patient. Concurrent Review is initiated when the facility notifies the PHS Hospital Intake Desk of the admission. The review function is generally started by the next business day following the admission notification and continues at intervals appropriate to the member/patient condition, based on the clinical review findings. The following factors are considered during the review process:

1. Medical necessity of admission and appropriateness of the level of care.
2. Quality of care
3. Length of stay
4. Determination of whether the services meet the coverage requirements for the eligibility type
5. Discharge needs

The PHS CCRN determines the appropriateness of continued services in consultation with the Medical Management Manager and the PHS Chief Medical Officer. The PHS CCRN coordinates with the facility discharge planner regarding discharge needs for the member/patient.

### **RETROSPECTIVE REVIEW**

PHS performs retrospective review on all cases where a medical necessity determination is required after the health care services have been delivered. The primary focus for retrospective review is to facilitate claims payment, review contractual arrangements and identification of billing issues. PHS performs retrospective review utilizing the same criteria used for assessing authorization requests and concurrent review. PHS makes medical necessity determinations based on the clinical information presented at the time of the retrospective review.

### **UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT PROVIDER PROFILING**

PHS maintains a health information system that collects pertinent utilization data for identification, monitoring, analyzing, evaluating and reporting outcomes to the MM/UM Committee. The MM/UM Committee reviews the presented utilization data on an on-going basis, at a minimum of once a quarter. The data includes a comprehensive analysis of the information including identification of variances and/or trends, review of outcomes, and recommended interventions based on the findings. The PHS MM/UM Committee utilizes the data presented at the meetings to assess current medical coverage policies and make appropriate decisions regarding coverage. This is accomplished by, but not limited to, evaluating current community/national standards, AHCCCS coverage guidelines, and receiving the opinions of experts in specialty fields. The result may yield a more or less restrictive process for requesting services. The PHS MM/UM Divisions collaborates with PHS Provider Services and Member Services to identify areas within the provider network and medical coverage guidelines to improve services.

## Guidelines for Prior Authorization

NO PA NEEDED	PA REQUIRED
<ul style="list-style-type: none"> <li>◆ Adenosine Thallium Scan</li> <li>◆ All Birth Control</li> <li>◆ Arteriograms/Angiograms</li> <li>◆ Barium Swallow/Enema</li> <li>◆ Biopsy of Lung, Breast, Liver, Kidney, Bone Marrow</li> <li>◆ Blood Transfusions</li> <li>◆ Bone Density</li> <li>◆ Bone Scan</li> <li>◆ Bronchoscopy</li> <li>◆ Cardiac Catheterization</li> <li>◆ Chemotherapy</li> <li>◆ Colonoscopy</li> <li>◆ Colposcopy</li> <li>◆ CT/CAT Scan, with and without contrast</li> <li>◆ Cystoscopy <b>not done</b> in the Operating Room</li> <li>◆ Dietician, home or hospital based</li> <li>◆ EEG, except if needing 24 hour admission then authorization required</li> <li>◆ EGD/Endoscopy, with and without biopsy</li> <li>◆ EKG</li> <li>◆ Emergency Dental</li> <li>◆ EMG/NCV (nerve conduction)</li> <li>◆ Fistulograms</li> <li>◆ HIDA Scan</li> <li>◆ Holter Monitor</li> <li>◆ In Office Procedures</li> <li>◆ IVP/VCUG, kidney and urinary x-rays</li> <li>◆ Leep procedure not done in the Operating Room</li> <li>◆ MUGA Scan</li> <li>◆ Non-invasive vascular studies/Dopplers</li> <li>◆ PTCA/Angioplasty/Stent Placement</li> <li>◆ Pulmonary Function Test</li> <li>◆ Radiation Therapy</li> <li>◆ Referrals to <b>contracted specialists, except for pain management requires authorization</b></li> <li>◆ Renal Scan</li> <li>◆ Routine Lab work</li> <li>◆ Sonogram/Ultrasound, except high level</li> <li>◆ Stress Test/Thallium Stress Test</li> <li>◆ Sweat Test</li> <li>◆ X-rays</li> </ul>	<ul style="list-style-type: none"> <li>◆ Any office visits/procedures/services done by a <b>non-contracted provider</b></li> <li>◆ Bilateral Tubal Ligation</li> <li>◆ Cardiac and Pulmonary Rehab</li> <li>◆ Durable Medical Equipment (DME), ALL</li> <li>◆ Eye glasses/contacts &gt;21, post cataract</li> <li>◆ Genetic testing &amp; counseling <b>other</b> than during pregnancy</li> <li>◆ High Level ultrasounds done by Perinatologist Obstretrix UMC High Risk</li> <li>◆ Home Health Services Home Infusion Skilled Nursing</li> <li>◆ Hospice</li> <li>◆ Hospital/Nursing Home/Rehab Admissions</li> <li>◆ Medical Supplies Bowel Routine Ostomy Supplies Wound Care Trach Supplies Urinary Catheters</li> <li>◆ MRI/MRA</li> <li>◆ Oral and Enteral Nutritional Supplements</li> <li>◆ Oxygen</li> <li>◆ Pain Management Epidural Injections Facet Block Injections Follow up visits</li> <li>◆ PET scans</li> <li>◆ Prosthetics/Orthotics/Braces</li> <li>◆ Second Opinions</li> <li>◆ Sleep Studies/Apnea Studies</li> <li>◆ Surgery, both Inpatient and Outpatient Arthroscopy Fistula Insertion and Dec clotting GYN surgical procedures Laparoscopic procedures PEG Placement</li> <li>◆ Termination of Pregnancy</li> <li>◆ Therapy, both Outpatient and Home Physical (Acute and LTC) Occupational (Acute &lt;21 and LTC) Speech (Acute &lt;21 and LTC)</li> <li>◆ Total OB Care</li> <li>◆ Transplants</li> <li>◆ Vasectomy not done in the office</li> <li>◆ Video Swallow with Speech Therapy</li> </ul>

**PATIENT INFORMATION**

**REQUEST STATUS**

PATIENT NAME / AKA	DOB	AHCCCS ID	<input type="checkbox"/> <b>ROUTINE</b> WITHIN 14 DAYS  <input type="checkbox"/> <b>EXPEDITED</b> WITHIN 72 HRS
ADDRESS (Include City, State & Zip Code)	TELEPHONE #	PRIMARY LANGUAGE	

**REQUESTING PROVIDER INFORMATION**

REQUESTING PROVIDER NAME	ADDRESS	TELEPHONE #
PROVIDER SIGNATURE	CONTACT PERSON / EXTENSION	FAX #

**REFERRED TO**

REFERRED TO	DATE(S) OF SERVICE	TELEPHONE #
ADDRESS		FAX #

**SERVICE REQUEST INFORMATION**

ICD-9 CODE # (REQUIRED)	CPT/HCPC CODE # (REQUIRED)
> PERTINENT CLINICAL INFORMATION (ATTACH ALL RELEVANT MEDICAL RECORDS AND TEST RESULTS E.T.C.) > DME/SUPPLIES DESCRIPTION: ATTACH ORDERS AND LIST OF SUPPLIES AND OR THERAPY MODALITIES (WITH FREQUENCY)	
<input type="checkbox"/> SUPPORTING DOCUMENTATION ATTACHED	
<b>TYPE OF REQUEST:</b>	<b>COMMENTS FOR TYPE OF REQUEST:</b>
<input type="checkbox"/> OUTPATIENT PROCEDURE <input type="checkbox"/> INPATIENT ( <input type="checkbox"/> ELOS ) <input type="checkbox"/> PAIN MANAGEMENT <input type="checkbox"/> THERAPY ( <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST ) <input type="checkbox"/> HOME HEALTH <input type="checkbox"/> NON CONTRACTED PROVIDER <input type="checkbox"/> DME ( HT:____ / WT:____ ) <input type="checkbox"/> MEDICAL SUPPLIES ( HT:____ / WT:____ ) <input type="checkbox"/> OTHER	
AUTHORIZATION DOES NOT GUARANTEE PAYMENT OF BENEFITS NOR VERIFY ELIGIBILITY	

↓ <b>PIMA HEALTH SYSTEM USE ONLY</b> ↓					
AUTH STATUS	<input type="checkbox"/> APPROVED	<input type="checkbox"/> PEND	<input type="checkbox"/> CLOSED	<input type="checkbox"/> MODIFIED	<input type="checkbox"/> DENIED
	DATE	DATE	DATE	DATE	DATE
COMMENTS:					
UM NURSE SIGNATURE					
MEDICAL DIRECTOR REVIEW					
COMMENTS:					
MEDICAL DIRECTOR SIGNATURE / DATE					
PHS PROGRAM: <input type="checkbox"/> HCBS <input type="checkbox"/> AMBL <input type="checkbox"/> NF <input type="checkbox"/> EPSDT Medicare Eligibility: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> NO Rate Code: _____					
OTHER HEALTH INSURANCE:					
SERVICE AUTHORIZATION #:		Date(s) From:		To:	
		Eligible From:		To:	
DATE / INT RECEIVED		DATE / INT POSTED		DATE / INT FAXED	



**Pima Health System**

Authorization Request Form  
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 Tucson, Arizona 85714  
 Ph: 520-243-8062 Fax: 520-745-6592