

SECTION IX: Medical Operations

OVERVIEW

The Care1st Medical Management (MM) program ensures that members get the right care from the appropriate service provider at the right place and at the right time. The framework of Care1st's MM Program drives the processes used to identify utilization patterns such as recidivism, adverse outcomes, and under/over utilization which may indicate quality of care issues. The program is further designed to identify and manage care for high risk members to ensure that appropriate care is delivered by accessing the most efficient resources. Finally, the MM program identifies opportunities to promote preventive health measures to decrease acute and chronic health care conditions. Care1st does not provide financial incentives for MM decision makers to encourage decisions that result in underutilization. Care1st does not reward practitioners, or other individuals involved in utilization review, for denying a service.

PRIOR AUTHORIZATION AND REFERRAL PROCESS

Prior authorization (PA) is a process by which Care1st determines in advance whether a service that requires prior approval will be covered, based on the initial information received. PA may be pended until the receipt of required clinical documentation to substantiate compliance with criteria used by Care1st. Criteria used by Care1st to make decisions are available upon request.

The MM Department uses clinically sound, nationally developed and accepted criteria for making medical necessity decisions. Clinical criteria utilized in decision making include, but is not limited to:

- AHCCCS Guidelines
- Milliman Care Guidelines
- Official Disability Guidelines (ODG)
- American College of Obstetrics and Gynecology
- The American Academy of Pediatrics
- CMS Guidelines
- Care1st Guidelines

PA is not a guarantee of payment. Reimbursement is dependent upon the accuracy of the information received with the original PA request, whether or not the service is substantiated through concurrent and/or medical review, eligibility, and whether the claim meets claims submission requirements.

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AUTHORIZATION FORMS

PAs for medical services (including in-office injectables) are requested on the *Treatment Authorization Request (TAR) Form*. Requests for nonformulary drugs are submitted on the *Pharmacy Prior Authorization Form*. To request a Total OB authorization, submit a completed *ACOG Form*. The *TAR* and the *Pharmacy Authorization Form* are available on the Care1st website www.care1st.com/az under the *Forms* section of the Provider menu. The Prior Authorization Guidelines and Formularies are also available on our website under the provider link. Providers without internet access may contact Provider Network Operations for a copy to be mailed or faxed to your office.

Requests for dental services that require authorization are submitted to Advantica (formerly known as Bridgeport Dental Services) via Advantica's website www.advanticadental.com or via mail using the *ADA Form or Advantica's Prior Authorization Form*. Dental prior authorization requests made via mail should be sent to:

Advantica
Suite 14
Prior Auth Department
9735 Landmark Parkway Drive
St. Louis, Missouri 63127

The "At a Glance Guidelines" identifies dental prior authorization and claim submission requirements and is available on Advantica's website or by contacting Advantica at 800.429.0495.

PRIOR AUTHORIZATION NUMBER SUBMISSION ON CLAIM

A PA number is issued by the PA Department for approved treatment authorization requests. The PA number must be included on the claim in order for claims adjudication and payment to occur.

- 1. UB-04 – place PA number in field 63
- 2. CMS 1500 – place PA number in field 23

A denial will occur if the PA number is not included.

PRIOR AUTHORIZATION TIPS

- Please refer to the Prior Authorization Guidelines for procedures that require PA in addition to the visit. Prior authorization is required for some services when Care1st is the secondary payer.
- Please direct members to contracted providers. All services requested for a non-contracted provider require prior authorization.

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- For Specialties that require authorization for the initial consultation and/or follow-up visits, all visits and in-office procedures performed must fall within the authorization date range approved.
- Your PA request will be processed more expeditiously if you fax the completed TAR with all supporting documentation and medical records. Allow sufficient time to process your request (especially on Friday afternoons following hospital discharges).
- Please contact Care1st for the status of your PA request before sending a duplicate request.
- Provide the past year's medical records and/or any supporting documents to justify request. Failure to submit supporting documents may delay processing.
- Provide laboratory results such as cultures and sensitivities, cholesterol panels, or any other pertinent lab results to expedite the medical necessity reviews for both medical and pharmacy requests.
- PA is required on all non-formulary drugs. A 5 day supply of medication following a hospital or ED discharge can be obtained by calling MedImpact at 800.788.2949.

AUTHORIZATION TIME FRAMES

Inpatient and outpatient referral requests for Care1st members that are received from primary care and specialty care physicians will be processed according to status within the following designated time frames:

Urgent - Processed and returned no later than 3 working days from date received by the PA Department as long as all necessary supporting medical documentation is included for review. Please remember not to use urgent for requests for member or provider convenience.

NOTE: Care1st reserves the right to downgrade urgent requests.

Routine- Processed and returned with authorization number within 14 working days from the date received by the PA Department.

Pended- Requests will be pended upon receipt for up to 28 working days if appropriate supporting documentation is not included with the request. Failure to submit supporting documentation will delay the processing of your request.

Note: Clean referrals are those referrals that contain adequate documentation and/or information to medically support the request, such as patient history to date, current symptoms, attempted treatments, etc. If the information submitted is not adequate, it will be pended in order to afford the opportunity for the MM staff to obtain additional medical information.

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Urgent referrals received by telephone will be directed to a nurse or to the CMO when mandated in order to make an immediate decision. The provider will be instructed to follow up with a faxed copy of the request at a later time.

1. All referrals are triaged to determine whether the level of service is urgent or routine.
2. Urgent referrals will be triaged to see if it is an Urgent request and will be downgraded to routine if determined not to be urgent. Urgent referrals are not for provider convenience and should only be used for urgently needed treatments. The requesting provider's office will be contacted with the authorization determination.
3. Routine requests will be processed within 14 business days from receipt of the request unless there is not adequate information to make a determination. Providers will be notified of the determination via facsimile within one working day of making the decision.
4. For routine requests that are pended for more information, the PA Department will make three attempts to obtain any outstanding medical information that is required to make a determination based on medical necessity. This will increase the amount of time it takes to process the request and may take up to 28 days to complete the process. If three documented attempts to obtain additional information from the requesting provider have been unsuccessful, the CMO will make a determination to approve, modify, or deny the authorization based on the medical information submitted by the provider.

REFERRAL PROCESS FROM PCP TO SPECIALIST

1. Select a contracted specialist.
2. Refer to the PA Guidelines to determine if an authorization is required.
3. If PA is NOT required, the PCP may contact the contracted specialist and schedule an appointment.
4. If PA is required, complete the TAR, which must contain all supporting documentation including ICD-9 and/or CPT codes, and office fax number of the requesting provider. Supporting documentation should include physician progress notes, lab results, diagnostic test results and reports, consultant notes, or any other medical documentation from the medical record that is pertinent to the service being requested that will assist in making the decision.
5. Fax the completed TAR and supporting documentation to the PA Department.
6. For urgent requests, the PCP may call the PA Department.

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7. The PA Department will return the TAR, with the authorization number, by fax.
8. After the approved TAR has been received, contact the specialist and schedule the member's appointment. After the appointment has been made, send copy of approved TAR to the authorized specialist.
9. Notify the member of the time, date, and location of the scheduled appointment.

SPECIALIST RESPONSIBILITIES

1. Schedule appointments for members in accordance with appointment availability standards when an appointment is requested by a contracted PCP.
2. If a member fails to appear for a scheduled visit the specialty care provider may reschedule the appointment within ninety (90) days without obtaining another PA number, as long as the member remains eligible with Care1st.
3. Use the PA number for billing purposes.
 - The PA number is valid for a consultation and two follow-up visits unless otherwise noted on the TAR.
 - The PA number for a consultation is valid for ninety (90) days.
 - Authorizations for follow up visits are valid for ninety (90) days when given with a consultation, as long as the member retains eligibility with Care1st.
4. Verify member eligibility prior to all appointments (see note below).
5. Provide scheduled services.
6. Provide a copy of the consultation notes to the member's PCP.
7. If the Specialist plans to perform a surgery or a special procedure, a TAR must be completed and faxed to the PA Department.
 - The specialist must attach a legible consult note or clearly written documents to support the request along with appropriate ICD-9 and CPT codes.
 - Upon receipt of the TAR, the PA Department will review and approve the procedure as necessary. An authorization number will be issued and noted on the TAR then faxed back to the specialist. Authorization numbers for procedures remain valid for ninety (90) days. After that time, the request must be re-submitted to Care1st.

NOTE: Claims will not be reimbursed if authorization is not obtained prior to date of service or if the member is not eligible with Care1st on the date of service. To verify member eligibility, providers should contact the Member Services Department, Care1st Interactive Voice Response (IVR) System, AHCCCS, or use MediFAX. It is the responsibility of the providers to verify eligibility prior to rendering services.

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The IVR should also be utilized for verifying authorization numbers. Follow the prompts on the IVR and you'll be able to quickly obtain your authorization number for a request that has been submitted.

REFERRAL PROCESS FROM SPECIALIST TO ANOTHER SPECIALIST

When a specialist needs to refer a member to another specialist, it is not necessary for the member to be referred back to the PCP. The referring specialist should follow the guidelines in outlined above.

REFERRALS TO DENTAL PROVIDERS MEMBERS 0-20 YEARS OF AGE:

1. Prior authorizations, claim submissions and claim inquiries are submitted to Advantica. For additional information see Section VI Covered Services.
2. Members between the ages of 0-20 years may schedule their own appointment with any contracted general dentist.
3. General Dentists treating patients under the age of 4 must obtain prior auth before performing all restorative services.
4. Members under 4 years of age may self refer to a pedodontist.
5. The dental "At a Glance Guidelines" provides detailed information regarding prior authorization requirements and claim submission requirements regardless of the cost of the total treatment plan. For the most current "At a Glance Guidelines" or detailed information on the clinical guidelines and criteria visit the Advantica web site www.advanticadental.com or contact Advantica at 800.429.0495. All dental offices must verify member eligibility prior to rendering services.
6. After dental services are provided, the dentist is responsible for sending a printed report to the PCP to be included in the member's medical record.

MEMBERS 21 YEARS OF AGE AND OLDER:

Effective October 1, 2010 AHCCCS covers medical and surgical services related to dental (oral) care. Covered dental services for members 21 yrs of age and older must be related to the treatment of a medical condition such as acute pain (excluding TMJ), infection, or fracture of the jaw. Covered dental services include a limited problem focused examination of the mouth, required x-rays, care of fractures of the jaw or mouth, giving anesthesia and pain medications and/or antibiotics. Certain pre-transplant services and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered only after a

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transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

SPECIALTY CARE DENTAL REFERRALS:

A General Dentist or Pediatric Dentist may refer a patient directly to a specialist in the network, except for Endodontic and Periodontal services, which require prior authorization from Advantica. The Prior Authorization Form must include a narrative, x-rays and perio charting.

MEDICALLY NECESSARY DENTURES (COVERAGE LIMITED TO AGES 0-20)

Medically necessary dentures are defined as partial or full dentures and services that are determined to be the primary treatment of choice for an essential part of an overall treatment plan designed to alleviate a preexisting medical condition as determined by the PCP in consultation with the dental provider. Dentures require prior authorization. Refer to the “At a Glance Guideline” and Clinical Guidelines for further details.

Members who have clinical evidence of significant weight loss (documented in medical records) or evidence of malnutrition may also qualify. These conditions include:

- Organ transplantation
- Malocclusion
- Malabsorption
- Diagnosis of malignancy
- Diabetes
- Dialysis
- Any condition that could be improved by these dental services will be assessed on a case by case basis.

RETROSPECTIVE REVIEW FOR DENTAL

Care1st & Advantica reserve the right to perform retrospective review of care provided to its member for any reason. All emergent care provided without PA is subject to retrospective review. Additionally, care is subject to retrospective review when claims are received for services not authorized.

ELECTIVE INPATIENT CARE

For Care1st members who require elective inpatient care (acute hospital), the admitting physician should:

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1. Complete the TAR, which must contain all supporting documentation including ICD-9 codes, CPT codes, and office fax number of the requesting provider.
2. Fax the TAR to the PA Department.
3. For urgent requests, the PCP may call the PA Department. NOTE: Medical information will be required over the phone to justify medical necessity for approval of the service being requested.
4. The PA Department will return the TAR with the authorization number via fax.
5. After the approved TAR has been received, contact the hospital and schedule the member's hospitalization and send approved TAR Form to the authorized facility.

Providers who provide services on a fee-for-service basis for inpatients must use the applicable hospital's PA number on the claim.

EMERGENCY DEPARTMENT CARE

Care1st does not require PA for a member to receive emergency services. Members may seek care at any emergency department in the event of an emergency.

REFERRALS TO ANCILLARY PROVIDERS

Providers should follow the instructions outlined above under "Referral Process from PCP to Specialist", considering the following:

DURABLE MEDICAL EQUIPMENT

Covered durable medical equipment (DME) must be medically necessary and prescribed by a PCP or specialist. DME can be obtained by directly contacting the Care1st contracted DME Provider.

Please include the following information when faxing your request:

1. Member information
 - Name
 - AHCCCS identification number
 - Phone number
 - Address
 - Diagnoses
 - Weight
2. Amount, type and size of equipment desired including HCPC code
3. Completed and signed Certificate of Medical Necessity (for oxygen and motorized wheelchair).
4. Recent room air oxygen content (RA O₂) must be 88% or less, if the request is for oxygen

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The following limitations apply:

- 8. Reasonable repairs or adjustments of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of repair is less than the cost of rental or purchase of another unit. The equipment must be considered medically necessary by Care1st.
- 9. The rental of such equipment shall terminate no later than the end of the month in which the member no longer needs the medical equipment as certified by the authorized provider or when the member is no longer eligible or enrolled with Care1st (except during transitions of care as specified by the Care1st Medical Director).
- 10. If the duration of medically necessary rental equipment exceeds the cost of purchase, the Care1st Medical Director shall make the determination of rental or purchase of said equipment.

HOME HEALTH CARE AND HOME INFUSION

- Home Health Care and Home Infusion is obtained by directly contacting a Care1st contracted provider.
- If a Care1st member requires long term Home Health Care or Home Infusion a referral to the Case Management Division is made by the PA Department.

OUTPATIENT RADIOLOGY SERVICES

- Refer to the Care1st PA Guidelines for imaging services which require prior authorizations.
- Select a Care1st contracted provider from the Radiology Grid.
- Contact the contracted provider to schedule an appointment.
- It is the responsibility of the imaging service provider to verify member eligibility prior to rendering services.

OUTPATIENT LABORATORY SERVICES

- Complete laboratory requisition and direct member to a Care1st contracted laboratory site.
- If specimen is collected in office, contact the contracted laboratory for pick-up.
- PCPs and Specialists may perform in-office labs based on the Clinical Laboratory Improvement Amendments (CLIA) test complexity categorization provisions utilized by AHCCCS. In order for a lab to be payable, AHCCCS must allow the lab to be performed in POS 11. Practices with CLIA certifications must ensure that each CLIA certification

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is on file at AHCCCS for each provider and that each provider has an agency code of 200 noted on the AHCCCS PR020 Licenses/Certifications screen. All other laboratory services must be performed by Sonora Quest.

ORTHOTICS AND PROSTHETICS

When referring a Care1st member for orthotic/prosthetic services, the provider's office must submit a TAR along with supporting documentation and appropriate HCPC code(s). Once approved, the orthotic/prosthetic provider will contact the member for fitting and delivery.

REHABILITATION SERVICES (OCCUPATIONAL/PHYSICAL/SPEECH THERAPY)

10. Select a contracted provider for referral and fax a completed TAR to the PA Department for review and approval.

11. Outpatient Occupational Therapy and Speech Therapy for members 21 years and older is not an AHCCCS covered benefit.

12. Outpatient physical therapy visits for members 21 years and older are limited to 15 visits per contract year (10/1-9/30)

NUTRITIONAL SUPPLEMENTS FOR ELIGIBLE EPSDT MEMBERS

Members receiving oral nutritional supplements are tracked through the PA process or through ongoing reports received from the nutritional vendor. PCPs are required to complete the "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" Form. The "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" form may be found at <http://www.azahcccs.gov/shared/downloads/MedicalPolicyManual/Chap400.pdf>, pp. 90-91.

- Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or specialist. Providers requesting oral nutritional supplements should submit the completed medical necessity form to the nutritional vendor or to PA for review and approval.
- The PCP or specialist must document that nutritional counseling has been provided to the member. The documentation must include alternatives that have been tried.
- The completed medical necessity form must indicate the criteria that are met. At least two criteria must be met. The criteria includes:
 - The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more.
 - The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent).

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- The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment).
- The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

CASE MANAGEMENT

The Care1st Case Management program is designed to be a collaborative process between Case Managers, members and providers which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet the members' health care needs. The Case Management Program is developed to specifically address the needs of the member with high cost, high volume, medically complex and high-risk health care experiences.

Our objectives include:

- Increasing member engagement with the PCP and PCP-referred specialists
- Decreasing unnecessary hospital visits and admissions
- Increasing member understanding and use of plan benefits
- Increasing member awareness of community resources available to help improve their quality of life
- Providing licensed professional support for transplant and high risk OB members
- Decreasing unnecessary emergency room utilization

The Case Management program identifies possible case management clients by reviewing health surveys, receiving referrals from internal or external sources, reviewing inpatient admission, readmission, and ED usage reports. The goal is to identify areas of risk and intervene early to affect the best outcome for the acutely or chronically ill, injured, or high-risk OB members.

Case Managers assess the client's medical condition and psychosocial needs in conjunction with the PCP. A comprehensive program is then developed to identify benefits and community resources available to meet the member's needs.

Once the member has been deemed appropriate for the Case Management program and has agreed to be enrolled, the Case Manager develops a plan of care. The development of this plan involves identification of problems, interventions, and goals to be addressed within the case. Appropriate referrals are made to community resources if needs are identified outside the benefits of the health plan. The Case Manager then makes periodic calls to the member, monitors the case, evaluates the effectiveness of interventions and revises the plan as appropriate until all goals are met or the case is closed.

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Diagnoses/conditions which are often enrolled in Case Management include, but are not limited to:

- Asthma (severe)
- Cancer
- CHF
- COPD
- Diabetes
- ER Frequent Users
- Hemophilia
- Hepatitis C
- HIV/AIDS
- Transplant

To refer a patient for case management, please contact our Team at 602.778.1800 X 8301.

DISEASE MANAGEMENT

The Care1st Disease Management program focuses on members with chronic conditions such as asthma and diabetes. Disease Management assists members in reaching their optimal health through partnering with the member, the PCP, and the specialist(s) involved in the member's care. When not managed through coordinated strategies, these conditions frequently result in hospitalizations and/or medical complications that require greater utilization of resources and higher costs.

Members are identified by:

- Diagnoses codes
- Ancillary data, including laboratory studies with specific lab values
- Medication history
- Hospitalizations
- Health Plan Employer Data and Information (HEDIS)
- Physician Profile

The disease management process is as follows:

1. The disease management nurse makes initial contact with identified member via telephone and completes a comprehensive initial assessment.
2. The disease management nurse determines from the assessment if the member is placed into the program. Areas considered for enrollment are:
 1. Elevated lab values
 2. Need for education
 3. Need for follow-up with primary care physician
 4. Need for specialist referrals
 5. Need for equipment

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3. Interventions utilized to manage members enrolled in the program are as follows:
 - Educating members about the disease, its symptoms and effective tools for self-management
 - Assisting members with enrollment in existing education classes if available
 - Educating members on medications
 - Assisting members with appointments with primary care physician
 - Assisting members with referrals to specialists
 - Assisting members in obtaining equipment covered under the plan
4. Members in the program will be followed at 1, 3, and 6 month intervals or more frequently to monitor effectiveness of interventions.

Please contact our Team at 602.778.1800 X 8301 for more information and assistance. National guidelines for asthma and diabetes are also available on our website under Disease Management in the Provider drop down menu.

PHARMACY MANAGEMENT

FORMULARY

The Care1st formularies, including updates, are communicated and made available on our website www.care1st.com/az. Providers may also contact Provider Network Operations for a copy. Please ensure that your office is prescribing medications listed on the current formularies. Before submitting the Pharmacy Prior Authorization Request Form for a non-formulary medication, consider all formulary alternatives. Prior authorization requests and supporting documentation are faxed to 602.778.1838.

MedImpact is our Prescription Benefit Manager and they manage all prescription drug transactions and pharmacy networks for all lines of business.

DRUG UTILIZATION MANAGEMENT TOOLS

For certain drugs, there are additional requirements for coverage. These requirements ensure appropriate drug therapy is utilized by the most cost effective means. A team of physicians and pharmacists develop the specific requirements. Examples of these utilization management tools include:

Prior Authorization is the process by which certain drugs are reviewed against healthcare management guidelines prior to allowing the prescription to be filled. If prior approval is not received, then the drug may not be covered.

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Quantity Limits are designed to identify the excessive use of drugs which may be dangerous in large quantities and to highlight the potential need for a different type of treatment. Quantity limits define the amount of the drug that is covered per prescription or for a defined period of time (for example, per month).

Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary. The aims are to control costs and minimize risks. Also called step protocol.

Step-therapy allows coverage only after specific preferred medications are tried first. When applied to a pharmacy plan, step-therapy requires one or more prerequisite, clinically equivalent drugs (in many cases less expensive) to be tried before certain “step-therapy” drugs will be covered.

An example of step-therapy in action follows:

A high blood pressure medication not on our preferred drug list has a generic equivalent that is more cost-effective. Prerequisite medications and their corresponding step-therapy medications are FDA-approved and are used to treat the same conditions.

If a drug requires prior authorization, a Pharmacy Authorization Request Form should be completed by the prescribing physician/physician’s representative. The required information must be provided in order for the request to be considered. Only pertinent clinical documentation should accompany the request.

The prior authorization request may be faxed to Care1st at 602-778-1838 or phoned in at 602-778-1800 (Options 5, 5). The turn-around time for review will be determined by the urgency of the request once all required information is received by the Pharmacy Department.

Urgent requests: 24 hours

Routine requests: 72 hours

Determinations for coverage will be faxed to the requesting provider and mailed for the patient (member)/guardian. Step therapy requests are handled the same as prior authorization requests. All pertinent information regarding previous drug therapy should be included.

Requests for uses outside the accepted indications (off-label use) will require documented clinical support (e.g., published clinical trials, nationally accepted

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practice guidelines) concluding that the treatment is safe and effective for the requested diagnosis, patient age, and dosage regiment requested.

SPECIALTY MEDICATIONS PURCHASING PROGRAM

Specialty injectable drugs may be obtained through our contracted vendor, BioScrip. Please use the following procedure to procure mail-order specialty drugs:

Prior Authorization Process

- Complete the Pharmacy Prior Authorization Request Form and fax to us at 602.778.1838.
- Once approved, the Pharmacy Department will fax back the approval to the practice.
- The practice then completes the BioScrip request form (form is provided by the Pharmacy Team at the time of approval) and faxes the script and the completed BioScrip form to BioScrip at 866.488.5809. The phone number for BioScrip is 877.316.8921.
- BioScrip completes the order and ships the medication.

Prior authorization requests must first come to the health plan before an order is placed. If prior authorization is not obtained before the order is placed, the plan decision and patient care may be delayed.

* This program does not include vaccines. In addition, all unclassified drugs (i.e. J3490, J9999) require prior authorization and will be evaluated by the Prior Authorization Dept on a case by case basis for approval and reimbursement. Contact Pharmacy Prior Authorization at 602.778.1800 (Options 5, 5) if you have any questions.

CONCURRENT REVIEW

Care1st provides for continual reassessment of all acute inpatient care. Concurrent review includes both admission certification and continued stay review. Concurrent review is performed by nurses who work closely with the medical director in reviewing documentation for each case. Other levels of care such as partial day hospitalization or skilled nursing care may also require concurrent review at Care1st's discretion. Review may be performed on-site or may be done via telephone or fax. Authorization for payment of inpatient services is generally on a per diem basis. The authorization is given for the admission day and from then on, on a day-to-day basis contingent upon the inpatient care day satisfying the criteria for that level of care for that day. This would include the professional services delivered to the inpatient on that day. Any exceptions to this (i.e. procedures, diagnostic studies, or professional services provided on an otherwise medically necessary inpatient day which do not appear to satisfy criteria) will require

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documented evidence to substantiate payment. Care1st uses the Milliman Care Guidelines® and the AHCCCS NICU/Nursery/Stepdown utilization guidelines to ensure consistency in hospital-based utilization practices. A copy of individual guidelines pertaining to a specific case is available for review upon request. Providers are notified when there are denials given for a specific day.

RETROSPECTIVE REVIEW

Care1st reserves the right to perform retrospective review of care provided to its member for any reason. All emergent care provided without prior authorization is subject to retrospective review. Additionally, care is subject to retrospective review when claims are received for services not authorized. There may also be times, during the process of concurrent review (especially telephonic) that the Concurrent Review Nurse is not satisfied with the concurrent information received based on the Milliman Care Guidelines®. When this occurs the case will be pended for a full medical record review by the Chief Medical Officer.

PRACTICE GUIDELINES

Care1st utilizes practice guidelines, criteria, quality screens and other standards for certain areas of medical management, disease management, and preventive health. Our guidelines follow nationally accepted standards and are reviewed and approved by our Medical Management Committee, which is comprised of both clinical staff and network physicians. Updates occur annually or more frequently if needed. If you have questions on our guidelines or would like a hard copy of our guidelines mailed to your office you may contact Provider Network Operations.