Chapter 8

MEDICAL MANAGEMENT AND QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (MM/QM/PI)

Medical Management (MM)

CMDP uses several mechanisms to manage service utilization.

Preferred Provider Network (PPN)

CMDP recruits PCPs and specialty physicians statewide. These providers agree to provide quality medical care to CMDP members, striving to reduce duplication of services to children and working within the regulations governing service delivery to children in out-of-home care.

Prior Authorization

Obtaining prior authorization (PA) is the act of requesting a service prior to its delivery. CMDP's PA requirements help to ensure regulations governing service delivery to CMDP members are followed, care and services are coordinated and communicated to those involved, and only medically necessary services are provided. Prior authorization nurses use InterQual criteria, AHCCCS and CMDP policy, and State regulations to guide service authorizations. Inpatient concurrent review standards are based on InterQual criteria.

A prior authorization is generally requested via fax to CMDP (602-351-8529). To know whether a particular service requires prior authorization, please see the *Prior Authorization Matrix*, found online at https://dcs.az.gov/cmdp/providers. The PA forms can also be found online.

Documentation substantiating medical necessity for the service should be included with the PA form. If the patient is an eligible member and meets medical necessity criteria, a PA number will be given to the provider's office. The service requested must be a covered service that is medically necessary, and the provider must be AHCCCS and CMDP registered. The PA number should be used when submitting claims to ensure prompt processing.

If additional documentation is needed to justify medical necessity, the provider will be asked to fax the required documents to CMDP. Additional information for PA requests must be submitted to CMDP within 14 days from the initial request for service, if it is a routine request. For Urgent requests, additional information must be received within 3 days or the PA request will be denied due to lack of sufficient documentation. An extension of 14 days may be granted by CMDP, for a total of 28 days for routine or 17 days for urgent PA requests to obtain the appropriate documentation.

AzEIP

The State of Arizona defines as eligible for supports and services through the Arizona Early Intervention Program (AzEIP), a child between birth and 36 months of age who is developmentally delayed or who has an established condition which has a high probability of resulting in a developmental delay, as defined by the State

A provider can submit a request for AzEIP services for a member

- Online: https://extranet.azdes.gov/azeip/AzeipREF/Forms/Categories.aspx
  This is the fastest and most efficient method for professional referrals. To receive confirmation of the assigned AzEIP provider, please include your work email address and you will be notified.
- Contact the local AzEIP office: https://extranet.azdes.gov/AzEIP/FamilyInfo/FamilyInformation/FamilyInfo.aspx

Participation by families in AZEIP is voluntary.

- The AZEIP service coordinator is responsible for identifying the parent when the child is in the care and custody of DCS
- If the biological parent (bio parent) is available, has not had their rights severed, and is willing to participate in the process then they are the IDEA parent, and the team proceeds with the Bio family in the initial planning process.
- If the AzEIP Service Coordinator cannot locate the bio parent, then the AzEIP Service Coordinator contacts the DCS specialist.
- If after the AzEIP Service Coordinator makes three attempts on different days, at different times of day over the course of a few weeks to contact the bio parent, the AzEIP Service Coordinator may proceed with someone else who may serve as the IDEA parent. (typically the foster parent or DCSS)
- If the bio parents are available and do not want to proceed, the AzEIP Service Coordinator is required to document that decision and exit the referral.

AzEIP Prior Authorization Requests

The process for requesting AzEIP service coverage by CMDP is the same as any other PA process. AzEIP Service Coordinator would submit authorization with supporting AzEIP documentation (IFSP form) showing why it is medically necessary; a current evaluation with test score is also needed.

After submission of the AzEIP Member Service Request, authorization will be reviewed by the Medical unit, allowing up to 14 days for determination.

If, after review, the services are deemed medically necessary, CMDP recommends services start within 3 weeks of the approval date. If services are unable to start within 45 days of the members IFSP date, CMDP will work with AzEIP to find a new provider who can start therapy timely.

Elective Admissions

Elective hospital admissions require PA. All laboratory and x-ray procedures required for elective inpatient or outpatient surgery shall be done on an outpatient basis at least 72 hours prior to the scheduled surgery.

Emergency Services

Emergency services do not require PA. Notification to CMDP is requested within these identified timeframes:

- Emergency department visit within 10 days of service delivery (voluntary)
- Emergency admission within 24 hours of admission
- Ambulance transportation within 10 days of transport (nonemergency medical transport requires prior authorization)

Concurrent Review

CMDP staff conducts concurrent review weekdays between 8:00 a.m. and 5:00 p.m. Concurrent review of hospitalized members generally occurs on a daily basis by telephone between the CMDP Concurrent Review Nurse (CRN) and the utilization management/discharge planning staff of the inpatient facility. Alternately, the facility may fax the medical records directly to the CRN. CMDP has electronic access to medical records for select hospitals. The CRN may make an on-site visit, as determined necessary, based on the member's hospital stay.

Medical Services nurses use InterQual intensity of service (IS) and severity of illness (SI) criteria, AHCCCS and CMDP policy, and state regulations to guide service delivery decisions. When the CRN determines that a continued stay is no longer medically necessary, the case will be reviewed with the Medical Director, attending physician, and the member's custodial agency representative as appropriate. The attending physician may contact the CMDP Chief Medical Officer (CMO) at any time to justify a medically necessary continued stay. The Chief Medical Officer may involve a peer reviewer as needed.

Discharge Planning

The CRN also coordinates discharge planning (see Concurrent Review section above). Health Services uses InterQual standards, AHCCCS and CMDP policy, and state regulations to guide service delivery decisions. Discharge planning begins upon admission.

Care Coordination

CMDP's care coordination functions provide added support by assisting members with health risk factors or special care needs. In addition to the member's PCP, care coordination is available to help members use medical, social, or community resources effectively, with the goal of self-management of their conditions and optimal medical and cost effectiveness. Medical Care Coordinators in Health Services are responsible for carrying out the care coordination functions under the direction of the Director of Medical Services and/or the Chief Medical Officer.

Care coordination is available to all CMDP members. Typical candidates include special needs children and youth, such as:

- Members entering out-of-home placement who are known to be under-immunized or lacking immediate medical or behavioral health services
- Members with behavioral health disorders
- Medically complex or fragile infants, children, or youth
- Pregnant members
- Members with known HIV and/or sexually transmitted diseases (STDs)
- Substance exposed newborns (SENs)
- Members who are at risk of or have known developmental delays and for whom use of Developmental Tools are appropriate
- Members with serious or chronic conditions such as Asthma or Diabetes

- Members who are non-compliant with treatment or appointments
- Members receiving services through CRS or RBHA
- Members transitioning to another AHCCCS health plan (in order to coordinate services to ensure a smooth transition) or those being placed out of state.

CMDP monitors special needs members through an integrated in-house information system and through online access to the Arizona State Immunization Information System (ASIIS) to determine immunization status, forecast due/past due immunizations and to enter historical immunization data into the system. Each EPSDT tracking form is assessed for potential referral (i.e., oral health, CRS, DDD, ALTCS, AzEIP, Head Start, or other specialty referrals). Information on members and ordered referrals may be entered into a database for monitoring and follow up. These are tracked to ensure that the appointment has occurred. Members who are noncompliant are identified and custodial agency representatives are contacted. If you have a CMDP member who would benefit from this care coordination, please contact Health Services.

Medical Director Review

A CMDP Medical Director is involved in all cases when a Medical Services staff member questions the appropriateness of care, or when services do not or no longer meet medical necessity for authorization or certification criteria. Only a Medical Director can deny, reduce, suspend, or terminate services. Any provider delivering care to a CMDP member may contact a Medical Director by calling CMDP Medical Services.

The Medical Directors and CMDP staff also work with a contracted dental consultant. The CMDP Dental Consultant assists in identifying high quality, cost-effective, and appropriate dental and orthodontic services for CMDP members.

Retrospective Claims Review

Claims are selected for retrospective review according to written criteria. A nurse and/or Medical Director review claims data reflecting high cost, questionable billing practices or excessive utilization. CMDP may recoup money paid inappropriately, after notice to the involved provider. The provider has the opportunity to appeal CMDP's recoupment decision.

Provider Education

CMDP may prepare periodic provider profiles, based on claims or other data, comparing individual provider utilization to other providers statewide for selected categories of service. The purpose of this provider profiling is to provide feedback to providers about their practice patterns related to services delivered to CMDP members. If services provided are contrary to CMDP standards compared to other physicians of the same specialty, the Medical Director may discuss this with the provider to determine alternatives.

CMDP also distributes a quarterly newsletter to update providers about CMDP procedures and other helpful tips.

Quality Management/Performance Improvement (QM/PI)

CMDP maintains a Quality Management/Performance Improvement (QM/PI) program and committee.

The committee is chaired by the CMO and meets quarterly. The committee includes members from both inside and outside CMDP, including preferred provider network PCPs. Annually, CMDP evaluates its QM/PI program to determine its effectiveness, what quality initiatives are appropriate, and what systemic changes are needed to improve plan performance.

If you would like to join the QM/PI Committee, please contact the CMDP CMO or the Director of Medical Services in the Health Services unit at (602) 351-2245.

Peer Review and Quality of Care Concerns

The peer review process is conducted as a supportive process to improve quality of medical care and services provided to CMDP members. The peer review process is under the leadership of the QM/PI Committee Chairperson (CMO). It is conducted under applicable state and federal laws, and protected by the immunity and confidentiality provisions of these laws. All members of the Peer Review Subcommittee are licensed physicians in Arizona. They review all issues involving licensed health care professionals who have delivered or want to deliver services to CMDP members.

CMDP providers are responsible for delivering medically necessary services to members, in compliance with AHCCCS and other appropriate guidelines. CMDP reviews potential quality of care issues using the peer review process. The Peer Review Subcommittee evaluates potential quality of care issues and makes recommendations. These recommendations may include, but are not limited to, corrective action plans, external peer review, and/or provider disciplinary action.

The peer review process is also applied to the credentialing of providers. CMDP utilizes a modified credentialing procedure, which is detailed in CMDP's Credentialing Policy. Questions regarding the peer review process should be directed to Medical Services.

Customer Satisfaction

As part of the QM/PI program, CMDP conducts periodic member and provider satisfaction surveys. The results are used to identify areas where improvement is needed.

Medical Record Audits

CMDP Medical Services nurses periodically conduct medical record and EPSDT audits for compliance with the standards found in the AHCCCS Medical Policy Manual and CMDP policy. This information is used to conduct performance improvement projects, review referral patterns and PA requests, and may identify opportunities to educate providers and their office staff about CMDP policies and standards.