ATTACHMENT H

PRIOR AUTHORIZATION REVIEWS, RETROSPECTIVE REVIEWS AND MEDICAL REVIEWS/CONSULTS

A. Overview and Estimated Volume

1. The descriptions below regarding types of Prior Authorizations (PA), Retrospective Reviews (RR) or Medical Reviews/Consults and Ad Hoc reviews (MRC/Ad Hoc), are an overview of each type in order to apprise Vendor of the scope of work expected.
2. All decisions by Vendor are subject to policy limitations and specific criteria developed by Vendor and DHS.
3. Upon agreement of both Vendor and DHS, the reviews types and procedures may be modified.
4. Across all review types, for SFY2017, there were 117 appeals.
5. Additional information about Arkansas Medicaid services and procedures can be found in the Arkansas Medicaid Provider Manuals, which can be accessed online at:

https://www.medicaid.state.ar.us/provider/docs/docs.aspx

B. Prior Authorization

Prior Authorization (PA) requests will be initiated in two ways:

1. A requesting provider may enter the PA request in the MMIS/InterChange Provider Portal; or

2. A provider may send the PA request directly to Vendor or DHS, and DHS will forward to Vendor any PA that should have been sent directly to Vendor. In either instance, Vendor shall input the PA request into MMIS/InterChange.

The PA types, and the estimated volume of each based on SFY2017 data, are:

Prior Authorization Review	Estimated Volume (based on SFY2017)
Inpatient and Outpatient Medical Services -Vendor shall review requests for services and procedures based on medical necessity and other factors to be determined by DHS and Vendor; -Inpatient and outpatient services include, but are not limited to, the following: •Medical and surgical procedures (7,310/20) •Assistant surgeons (249/1) •Continued inpatient stay (MUMP) – includes all acute hospital stays after the fourth (4th) day of hospitalization, with the exception of children under one (1) year of age (24,426/231) •Extension of benefits for outpatient procedures and services (32,933/3109) •Independent laboratories including molecular pathology (genetic testing) (1,301/13) •Lab, x-ray and professional services (inpatient and outpatient) (included in the above numbers) •Inpatient hospital services (included in the above numbers) •Extension of benefits for lab, x-ray, and professional services (inpatient and outpatient) (included in the above numbers)	66,219 cases 3,374 reconsiderations

Durable Medical Equipment (DME) -Vendor shall review requests for medical equipment based on medical necessity and other factors to be determined by DHS and Vendor; -DME includes, but is not limited to: • Wheelchairs (2,289/103) • Ventilators (162/11) • Hyperalimentation equipment (1,969/87) • Prosthetics, orthotics and other durable medical equipment (21,347/856)	25,767 cases 1,057 reconsiderations
Personal Care (Under 21) -Vendor shall review requests for services based on medical necessity and other factors to be determined by DHS and Vendor; -Personal care requests are limited to Medicaid beneficiaries under the age of 21 and are primarily based on the assessed physical dependency need for "hands-on" services with certain activities of daily living (ADL). These can include, but are not limited to: • Eating • Bathing • Dressing • Personal hygiene • Toileting • Ambulating -Personal care assistance is provided by a personal care aide based on a beneficiary's physical dependency needs, and does not include purely housekeeping services	927 cases 203 reconsiderations
Targeted Case Management (TCM) -Vendor shall review requests for services and procedures based on medical necessity and other factors to be determined by DHS and Vendor; -TCM is a referral for service that assists beneficiaries in accessing all medical, social, educational and other services appropriate to the beneficiary's needs, and may include, but is not limited to: • Assessing the eligible individual to determine service needs • Developing or assisting in the development of an individualized care plan, specific to the beneficiary's needs • Referral(s) to help the beneficiary obtain needed services • Monitoring and follow-up contacts • Scheduling appointments related to gaining access to medical, social, educational and other services appropriate to the beneficiary's needs • Conducting face-to-face or telephone contacts with the beneficiary and/or other individuals for the purpose of assisting in the beneficiary's needs being met	36 cases 0 reconsiderations
Physician-Administered Drugs -Vendor shall review requests for providing certain drugs by physicians based on medical necessity and other factors to be determined by DHS and Vendor; -Medical necessity hereunder is based on developed review criteria unique to the specific drug or class of drugs. Vendor shall collaborate with DHS in order to develop the review criteria	1,890 cases 0 reconsiderations

C. Retrospective Review

On a regular basis agreed to by Vendor and DHS, Vendor shall be responsible to review a random sample of claims submitted by providers of specific types set forth below. Vendor shall work with the DHS DSS Lab vendor (currently Optum) to obtain a weekly claims feed. After Vendor selects a valid random sample and makes an RR determination, Vendor shall notify the MMIS/interChange vendor (currently DXC) of the RR determinations. Vendor shall work with DHS, Optum and DXC to establish all necessary procedures and interfaces to perform these reviews.

Retrospective Review	Estimated Volume (based on SFY2017)
Arkansas Works (formerly known as the Private Option) Mid-Year Transition Requests -Requests shall be submitted by Arkansas Works carriers. Vendor shall effectively and accurately perform the review and issue an accurate medical determination based on whether the Medicaid beneficiary's medical care will best be served by traditional Medicaid, or by remaining with an Arkansas Works carrier; -As part of the medical determination, Vendor will accurately determine whether the Medicaid beneficiary is: • An individual who would "be more effectively covered through the standard Medicaid program" as described at Ark. Code Ann. §20-77-2404(3) (C); and/or • "Medically Frail" in accordance with applicable laws, rules, and regulations, including but not necessarily limited to 42 CFR 440.315.	99 cases 1 reconsideration
Emergency Room/Emergency Department (ER/ED) Retrospective Review -Vendor shall review claims based on medical necessity and other factors to be determined by DHS and Vendor; -The RR shall comply with §1867 of the Social Security Act (Prudent Lay Person), i.e., inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, must be obtained at the most accessible hospital available and equipped to furnish those services.	42,724 cases 373 reconsiderations
Hospital Admissions/Inpatient Services Retrospective Review -Vendor shall review claims based on medical necessity and other factors to be determined by DHS and Vendor; -A post-payment review of a random sample of paid claims is conducted on all admissions, including inpatient stays of four days or less, to ensure that medical necessity for the services is substantiated.	33,575 cases 465 reconsiderations
Neonatal Intensive Care Unit (NICU) Retrospective Review -Vendor shall review claims based on medical necessity and other factors to be determined by DHS and Vendor; -Vendor shall conduct Diagnosis Related Group (DRG) validation reviews on DMS-reimbursed neonate admission records to determine the appropriateness of coding, admission and length of stay, and based in part on potential co-morbidities, birth weight and other factors to be determined by Vendor and DHS.	1,140 cases 7 reconsiderations

D. Medical Reviews/Consults and Ad Hoc Reviews

Medical Reviews/Consults (MRC) and Ad Hoc reviews will be sent to Vendor by DHS after an internal

process of varying levels has been completed. Vendor's duties under this section are set out by each review/consult type. These may be also done on an ad-hoc basis.

Medical Review/Consult and Ad Hoc Reviews	Estimated Volume (based on SFY2017)
Out of State Referrals -DHS consults with Vendor Physician Advisor as needed for approval requests of services based on medical necessity and other factors to be determined by DHS and Vendor; -Physician review for professional services that are not available in-state and may include non-covered services; -Prior Out-of-State referral cases have included: •Specialty GI (Gastro-Intestinal) procedures •Specialty Transplant procedures •Specialty Brain/Neurology procedures •Certain Genetic procedures •Certain Behavioral health treatment, such as certain types of eating disorders	27 cases 0 reconsiderations
Suspended Claims -DHS consults with Vendor Physician Advisor as needed for approval of claims based on medical necessity and other factors to be determined by DHS and Vendor; -Suspended claims include those that exceed pre-established limits or issues related to pricing/questionable billing, will include both surgical and non-surgical claims and may include non-covered services	1,029 cases 0 reconsiderations
Emergency Transportation -DHS consults with Vendor Physician Advisor as needed for approval of services based on medical necessity and other factors to be determined by DHS and Vendor; -Emergency transportation claims include those related to ground and air transportation services and may include non-covered services	<10 cases 0 reconsiderations
Transplants -DHS consults with Vendor Physician Advisor as needed for approval of services based on medical necessity and other factors to be determined by DHS and Vendor; -Transplant-related services include: •Bone Marrow transplant •Covered transplant procedures •Hospital readmissions for complications related to organ/transplant complications	66 cases 8 reconsiderations
EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Extension of Benefits -DHS consults with Vendor Physician Advisor as needed for approval of medical services and procedures based on medical necessity and other factors to be determined by DHS and Vendor; -Services and procedures are based on the result(s) of an EPSDT screening and may include non-covered services	36 cases 0 reconsiderations

Emergency Medicaid Eligibility -DHS consults with Vendor Physician Advisor as needed for review of applications for Medicaid enrollment based on medical necessity and other factors to be determined by DHS and Vendor; -Application approvals are based on acute/emergent services billed for certain populations, and exclude chronic conditions -Attached is additional information about this program which is referred to as "OPPD" internally (Office of Policy and Program Development) and is overseen by the Division of County Operations (DCO)	173 cases 0 reconsiderations
Ad Hoc Review: DMS Internal PA Review Procedure -DHS consults with Vendor Physician Advisor as needed for review of medical services and procedures based on medical necessity and other factors to be determined by DHS and Vendor; -DMS Internal PA Reviews include, but are not limited to, the following: • Nutrition, including but not limited to Formula, Sole-source nutrition, Enteral nutrition, Hyperalimentation (if not included on a list of pre-approved formula/nutrition) • Hearing Aids (other than batteries or broken equipment) • Home Health (Post-surgical in-home nursing care) • Medical Supplies (extension of benefits) • Private Duty Nursing • Non-covered Services	651 cases 0 reconsiderations
Ad Hoc Review: Code Set Reviews -DHS consults with Vendor when code sets are updated, including but not limited to ICD (International Classification of Diseases), CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System)	≥3 times per year
Standard of Care Review -DHS consults with Vendor Physician Advisor as needed for review of medical services and procedures based on medical necessity, appropriateness of care, and other factors to be determined by DHS and Vendor. -Cases for review by Vendor for Standard of Care may be brought to DHS's attention by Vendor, DHS's own review or by another source	≤250 cases
Denial of Applications for Program Services -DHS consults with Vendor Physician Advisor as needed for review of program applications, based on medical necessity and other factors to be determined by DHS and Vendor. -The programs for which applications are submitted shall include, but are not limited to, the following, and shall be provided without limitation: • **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** or Katie Beckett option (under §134(a)) allows states to extend Medicaid coverage to certain disabled children so that they may receive care in their homes rather than in institutions. • **Autism Waiver**: provides one-on-one, intensive early intervention treatment for beneficiaries ages eighteen (18) months through six (6) years with a	1,117 cases 0 reconsiderations

diagnosis of autism who meet the ICF/IID (Intermediate Care Facility/Intellectual Developmental Disabilities) level of care and have a diagnosis of autism.	