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OVERVIEW

The ONECare 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 ONECare'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. ONECare does not provide financial incentives for MM decision makers to encourage decisions that result in underutilization. ONECare 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 ONECare 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 ONECare. Criteria used by ONECare 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:

- **CMS Guidelines**
- **Milliman Care Guidelines**
- **AHCCCS Guidelines**
- **American College of Obstetrics and Gynecology**
- **The American Academy of Pediatrics**
- **Official Disability Guidelines (ODG)**
- **Care1st Guidelines /ONECare Guidelines**
- **ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd edition**

These criteria are used only as a guideline and individual needs and local standards of practice are taken into consideration when making decisions. ONECare utilizes board certified physicians to make medically necessary decisions. When necessary, ONECare utilizes outside resources to have board certified physicians review cases for medical necessity, with the expertise that is necessary.

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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.

AUTHORIZATION FORMS

PAs for medical services (including in-office injectables) are requested on the *Treatment Authorization Request (TAR) Form*. Requests for Non-Formulary drugs are submitted on the *Pharmacy Prior Authorization Form*. The *TAR* and the *Pharmacy Authorization Form are* available on the ONECare 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.

PRIOR AUTHORIZATION TIPS

- Please refer to the Prior Authorization Guidelines for procedures that require PA in addition to the visit.
- Please direct members to contracted providers, vendors and facilities. Services requested for a non-contracted provider require prior authorization.
- 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 ONECare 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 ONECare members that are received from primary care and specialty care physicians will be processed according to status within the following designated time frames:

1. For standard pre-service organization determinations, ONECare makes the determination as expeditiously as the member's health condition requires,

but no later than 14 days after receipt of the request for the organization determination.

2. For expedited pre-service organization determinations, ONECare makes the determination as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request for the organization determination.
    a. The 72-hour timeframe begins as soon as the request is received by any department within ONECare.
    b. If additional information is needed from a provider, the Prior Authorization Representative contacts the provider in question within 24 hours of receipt of the organization determination request, to request the additional information.
3. ONECare does not deny services ordered by contracted providers due to lack of information.

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 for a determination based on medical necessity. If three documented attempts have been made by the ONECare PA Department on a pended authorization to get further information from a provider and no additional information has been submitted, the CMO will make a determination to approve, modify, or deny the authorization based on the medical information sent by the provider.

REFERRAL/PRIOR AUTHORIZATION PROCESS FROM PCP TO SPECIALIST

1. Select a ONECare specialist contracted with ONECare.
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-10 and/or CPT codes, and office fax number of the requesting provider for all services that require an authorization. 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 TAR and supporting documentation to the ONECare Prior Authorization Department.
6. For urgent requests, the PCP may call the Prior Authorization Department.

7. The Prior Authorization 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 approved TAR Form 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 standards, when an appointment is requested by a PCP.
2. For Specialists that require an authorization, 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 prior authorization number, as long as the member remains eligible with ONECare.
3. Use the prior authorization number for billing purposes.
    - The PA number is valid for a consultation and two follow-up visits unless otherwise noted on the TAR.
    - The prior authorization number for a consultation is valid for 90 days or longer.
    - Authorizations for follow up visits are valid for 120 days when given with a consultation, as long as the member retains eligibility with ONECare.
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 Prior Authorization Department.
    - The Specialist must attach a legible consult note or clearly written documents to support the request along with appropriate ICD-10 and CPT code and name of the contracted facility where service is to be rendered.
    - Upon receipt of the TAR, the PA Department will review and make a decision as necessary. An authorization number will be issued and noted on the TAR and faxed back to the specialist. Authorization numbers for procedures remain valid for 90 days; after that time, the request must be re-submitted to ONECare.

NOTE: Claims may not be reimbursed if authorization is not obtained prior to date of service or if the member is not eligible with ONECare on the date of service. To verify member eligibility, providers should contact the Member Services Department or our website. It is the responsibility of the providers to verify eligibility prior to rendering routine services.

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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 as outlined above.

ELECTIVE INPATIENT CARE

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

- Complete the TAR, which must contain all supporting documentation including ICD-10 codes, CPT codes, and office fax number of the requesting provider.
- Fax the TAR to the PA Department.
- 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.
- The PA Department will return the TAR with the authorization number via fax.
- 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

ONECare 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 ONECare contracted DME Provider.

Please include the following information when faxing your request:

1. Member information
    - Name
    - ONECare 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).

HOME HEALTH CARE AND HOME INFUSION

- Home Health Care and Home Infusion is obtained by directly contacting a ONECare contracted provider.
- If a ONECare 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 ONECare PA Guidelines for imaging services which require prior authorizations.
- Select a ONECare 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 ONECare contracted laboratory site.
- If specimen is collected in office, contact the contracted laboratory for pick-up.

ORTHOTICS AND PROSTHETICS

When referring a ONECare 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)

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

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CASE MANAGEMENT

The ONECare Case Management (CM) program is a collaborative program 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 members with high cost, high volume, medically complex and high-risk health care experiences. The ONECare case managers complete a Health Risk Assessment on all ONECare members within the first 90 days of enrollment and annually.

Our objectives include:

- Increasing member engagement with the PCP and PCP-referred specialists
- Increasing member understanding and use of plan benefits
- Increasing member awareness of community resources available to help improve their quality of life
- Decreasing unnecessary emergency room utilization
- Decreasing unnecessary hospital visits and admissions
- Optimizing members health outcomes

Case Management is available to all members and includes an initial and ongoing assessment of risks, needs and benefits, and the development of an individualized care plan for all members accessing these services. Potential candidates for CM include, but are not limited to the following:

- Members or populations with complex, chronic or co-morbid medical conditions (e.g., diabetes, asthma, end-stage renal disease, organ transplant, chronic hepatitis C) or social needs
- Members recently discharged from a hospital
- Members requiring care coordination
- High utilizes of services such as pharmacy or emergency departments (either by cost or volume)
- Special populations (e.g., aged, blind, disabled, HIV-positive, substance abusers, pregnant women, special needs children, members with behavioral health needs)

Case management process

- Screening and identification of members with high risk health problems or situations
- Identifying and implementing effective interventions, including exploration of alternative resources that could be accessed to meet members' healthcare needs
- Working collaboratively with members' practitioners and providers as well as with other disciplines inside and outside the plan to achieve positive outcomes

Coordinating care for defined conditions/diseases to attain optimal clinical outcomes for the members and to improve their quality of life/

- Providing education, support, and monitoring for the member, member's family, and others involved in care
- Encouraging members to self manage their conditions effectively and develop and sustain behaviors that may improve the member's quality of life
- Working to ease barriers to needed healthcare and psychosocial services for members with special needs or cultural or language requirements

Candidates for further targeted case management are identified by:

1. Member self-referral into care management programs
2. The medical management team and managements' review of hospital records regarding ER visits and/or inpatient admissions
3. Data provided by the member to the care coordinator while completing or reviewing the health risk assessment
4. A referral from the ONECare medical director, Medical Management managers, Prior Authorization staff, Concurrent Review staff, Marketing staff, DDD coordinator, Member Services staff, or Case or Disease Management staff
5. A referral from a primary care or specialist physician
6. A referral from a facility case manager or social worker
7. A referral from an external agency working with the member, including AHCCCS, CMS, DDD a RBHA, or home health agency.
8. A referral from a member or someone associated with the member, such as a family member, friend, or neighbor
9. Case manager review of member's health care utilization data from a pharmacy, hospital, or lab, as well as internal claims data
10. Predictive modeling information allowing care management leadership to identify members at high risk for increased utilization of the healthcare system due to poorly controlled medical conditions.

To refer a patient for case management, please contact our Team at 602.778.8345 X 8301.

DISEASE MANAGEMENT

ONECare provides Disease Management programs to assist practitioners in managing members diagnosed with targeted chronic illnesses. Conditions included in disease management initiatives are those that frequently result in exacerbations and hospitalizations (high-risk) that require high usage of certain resources, and that have been shown to respond to coordinated management strategies.

Disease management activities include interventions such as:

- Assessment of member's risk and needs
- Education about disease, medications and self management
- Adherence monitoring
- Assistance with finding or coordinating resources and/or exploring alternative resources
- Working to ease barriers for members with special needs or cultural or language requirements

Potential candidates for Disease Management are identified thought:

- Administrative data such as medical and pharmacy claims
- Laboratory data
- HEDIS data
- Self reported data through health risk assessments
- Provider referrals
- Member and family self referrals
- Internal referrals from ONECare staff members

Disease management programs are structured around nationally recognized evidence-based guidelines. The guidelines are posted on the ONECare website: https://www.care1st.com/az/providers/diseasemanagement.asp

A paper copy of the guidelines is available to providers upon request.

Please contact our Team at 602.778.8345 X 8301 for more information and assistance.

CONCURRENT REVIEW

ONECare 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 ONECare'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 or DRG basis depending upon the specific contractual terms between ONECare and the hospital. 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 documented evidence to substantiate payment. ONECare uses the Milliman Care 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

ONECare reserves the right to perform retrospective review of care provided to its member for any reason. 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

ONECare 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 may contact Provider Network Operations.