Comagine Health
Formerly Qualis Health and HealthInsight

Provider Manual

State of Alaska
Department of Health and Social Services
Division of Health Care Services

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SECTION 1: CARE MANAGEMENT PROGRAM OVERVIEW

Purpose of the Care Management Program

The care management program is intended to ensure that Alaska Medicaid[1] recipients are provided appropriate medical services in accordance with state and federal regulations, statutes, and policies.

Definitions of Utilization Management and Case Management

Comagine Health uses the following URAC definitions of utilization management (UM) and case management (CM):

- **Utilization Management:** Evaluation of the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the provisions of the applicable health benefits plan; also known as "utilization review."
- **Case Management:** A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet consumer health needs through communication and available resources to promote quality cost-effective outcomes.

UM and CM work together for:

- Appropriate use of healthcare services
- Efficiency or cost-effectiveness
- Quality of care

Comparison of Utilization Management and Case Management

UM Services	CM Services
Reactive (responding to requests for service)	Proactive (identifying optional resources)
Focused on specific treatment/units of service	Broad, holistic approach
Limited interaction with providers and recipients	Communication with recipients and providers is key
Goal is to address medical necessity of requested services	Goal is to coordinate care across the continuum of services

[1]Unless otherwise indicated, the term Medicaid refers to both Medicaid and Denali KidCare.

About Comagine Health

Corporate Background and Experience

Comagine Health is a private, nonprofit healthcare QIO with more than 40 years of experience in providing utilization review, case management and quality improvement services. Comagine Health is one of the nation's leading population healthcare consulting organizations, helping to transform care and improve care delivery and patient outcomes. We work with clients throughout the public and private sectors to advance the quality, efficiency, and value of healthcare for millions of people every day.

Programs offered include traditional utilization management services, such as pre-service, concurrent, retrospective chart and telephonic review, coding validation, and medical consultation. Services designed for the managed care arena include the early identification of high-risk patients, specialty referral management services, consumer advocacy services, and audits of access to care.

History of Medicaid Utilization Review and the QIO Program in Alaska

Comagine Health began offering utilization review services for the Washington State Medicaid program in 1975. We expanded our utilization review services to private industry in 1979. We have been a presence in Alaska's private-sector market since 1984, when we added our first care management client. In 1985, Comagine Health was awarded the utilization review contract with Alaska Medicaid.

Mission, Vision and Values

- **Mission:** To generate, apply and disseminate knowledge to improve the quality of healthcare delivery and health outcomes
- **Vision:** To be recognized for leadership, innovation and excellence in improving the health of individuals and populations
- **Core Values:** Integrity and professionalism, collaboration, and stewardship

SECTION 2: COMMUNICATING WITH COMAGINE HEALTH

Business Hours

Comagine Health's regular business hours are Monday through Friday, 6:30 am to 5:00 pm Alaska Time, excluding scheduled holidays.

Contact Information

You can contact Comagine Health via the Comagine Health Provider Portal (CHPP), fax, telephone, mail and email.

CHPP	https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
UM Phone	(888) 240-0437, option 2
UM Fax	(800) 826-3630
CM Phone	(888) 578-2547, option 1 (907) 550-7600, option 1
CM Fax	(877) 265-9549
Mail	Comagine Health PO Box 33400 Seattle, WA 98133-0400

For detailed contact information, including staff email addresses, see Appendix C, Key Contacts for Comagine Health and Alaska DHCS, or visit our website: http://qualishealth.org/healthcare-professionals/alaska-medicaid-health-care-services/contacts

Voice Mail

Comagine Health's voice mail system is available 24 hours a day. If you call after business hours, or if no one is available to answer your call during regular business hours, you may leave a confidential voice mail. We check voice mail frequently throughout the day. We retrieve messages left outside regular business hours first thing on the next business day and return those calls by 12:00 noon Alaska Time.

Submitting UM Reviews via the Internet

Providers must submit all utilization management reviews via the CHPP web-based review system. Comagine Health offers secure web-based review capability using the CHPP, ZeOmega's browser-based product that uses the Internet to create a two-way link that can be used to exchange care management data, thus facilitating real-time online approvals. Comagine Health also maintains dedicated toll-free phone and fax numbers for Medicaid providers who do not have Internet access to request review services.

The CHPP offers immediate feedback from Comagine Health regarding your review request. Reviews submitted via the CHPP receive notification of the final determination via the CHPP, and the certification number is posted to the CHPP. By using the CHPP, you do not need to wait for a phone call or a fax document to learn of the final determination.

For requests that are not submitted through the CHPP, Comagine Health communicates the determination and the certification number to providers via phone or fax.

Comagine Health sends letter notifications for all non-certified reviews and appeal reviews within one (1) business day of the determination. These notifications are sent to the recipient, DHCS and the attending physician.

Providers must designate a Portal Administrator, who completes and submits a registration packet. Once Comagine Health receives the registration packet, we create a group account for the provider and assign a CHPP ID and password to the Portal Administrator. The Portal Administrator assigns individual IDs and passwords to provider staff members. Once trained, providers can log in to the CHPP and directly enter information for the admission (i.e., initial review, continued stay/concurrent review or retrospective review request).

To get more information about the CHPP, or to learn how to submit web-based review requests, you can:

- Download the CHPP User Guide at http://www.qualishealth.org/sites/default/files/QHPP-User-Guide.pdf
- Call Comagine Health's Alaska office at (888) 240-0437

If you do not have Internet access, call Comagine Health's Alaska office toll-free at (888) 240-0437 for instructions on submitting your review.

SECTION 3: COMPLIANCE WITH URAC UTILIZATION REVIEW STANDARDS

Comagine Health complies with URAC health utilization management (UM) standards when performing utilization reviews. These standards provide a process for conducting a utilization review that is clinically sound and respects recipients' and providers' rights. URAC standards ensure that only appropriately trained, qualified clinical personnel conduct and oversee the utilization review process; that a reasonable and timely appeals process is in place; and that medical decisions are based on valid clinical criteria. Some frequently asked questions about the process of making utilization review decisions are answered next.

Frequently Asked Questions About Utilization Review Decisions

1. Who makes utilization review decisions?

URAC Health UM Accreditation requires Comagine Health to use a three-step process to determine if a proposed medical treatment or service is medically necessary:

a. **Initial Clinical Review:** A licensed health professional, such as a registered nurse, licensed practical nurse, occupational therapist, physical therapist or social worker conducts this first critical step of the review process using InterQual® medical necessity criteria and, as applicable, contract-specific criteria. If the clinical information provided does not meet InterQual criteria or, if in the clinical reviewer's judgment, a physician should review the case, it is referred for peer clinical review.

b. **Peer Clinical Review:** A licensed physician qualified to render a clinical opinion about the proposed treatment or service performs a peer clinical review by evaluating all available information to determine whether care should be certified. When a non-certification decision is made, the attending physician can discuss the review and proposed care with a Comagine Health physician prior to final determination ("doctor-to-doctor conversation"). If the result of that conversation is not satisfactory to the attending physician, an appeal process is available. See Questions #2 and 3 in this section for more information about doctor-to-doctor conversations.

c. **Appeal Process:** A recipient or a provider may initiate an appeal. Appeal review is performed by a qualified, board-certified physician within the same specialty but not involved in the initial review decision. The process must be expedited, if requested.

2. Why are doctor-to-doctor conversations important?

Doctor-to-doctor conversations allow treating providers to discuss UM determinations with a Comagine Health physician, with the goal of resolving disagreements before the formal appeal process is initiated.

3. What are the time frames for doctor-to-doctor conversations?

Comagine Health makes doctor-to-doctor conversations available for potential non-certifications. When Comagine Health makes a non-certification decision, we send an Alaska Division of Health Care Services Denial Notice that includes information about fair hearing and appeals rights. This letter also contains a Provider Notice with instructions for the provider in the event they disagree with our determination.

Providers can have their attending physician request a doctor-to-doctor conversation to discuss a non-certification decision with Comagine Health's reviewing doctor to pursue service approval. If the case is non-certified after the doctor-to-doctor conversation, the stay is non-certified retroactively to the day medical necessity was not met. Requesting a doctor-to-doctor conversation does not affect the time

requirement for requesting an appeal. To request a doctor-to-doctor conversation, call (877) 292-2615. The request must be made within 60 days of the date of the letter.

4. What recourse is there when I disagree with a determination?
Comagine Health's written notice of non-certification decision contains instructions for initiating an appeal of the non-certification. See Section 16 of this manual for details of the appeal process. If, after an appeal, you still disagree with our determination, your appeal letter outlines the steps to request a hearing with DHCS. Section 16 has more information about this process.

5. What is considered an urgent review?
An urgent review is performed when an episode involves urgent care. An episode is considered to involve urgent care whenever the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function, or (b) in the opinion of a physician with knowledge of the recipient's medical condition, would subject the recipient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the episode.

6. How are review time frames determined?
The number of days allotted for each type of review is based on URAC Health Utilization Management Standards. It is different for urgent review than it is for non-urgent review. If the review requires additional information, clinical peer review or a peer-to-peer conversation, additional time is allotted.

7. What are the time frames for completion of urgent reviews?

When all necessary clinical information has been received and no referral for clinical peer review is needed, the time frames for completion of urgent reviews are as follows:

Review Type	Time Frame for Completion
Pre-service review—Urgent	Three (3) calendar days
Concurrent review—Urgent	Three (3) calendar days

8. What are the time frames for completion of non-urgent reviews?

When all necessary clinical information has been received and no referral for clinical peer review is needed, the time frames for completion of reviews are as follows:

Review Type	Time Frame for Completion
Pre-service review—Non-urgent	Fifteen (15) calendar days
Concurrent review—Non-urgent	Three (3) calendar days
Retrospective review	Thirty (30) calendar days

When additional information is required to complete the review, the timeline is adjusted accordingly. Comagine Health may exercise a single extension of up to 15 calendar days on

non-urgent reviews when circumstances beyond our control require an extension. When this occurs, we inform the provider, by the date on which notice of the initial decision would normally be due, of the circumstances that require the extension and the date by which we expect to reach a decision.

9. What is the three-day benchmark?

All stays that do not require pre-admission review must be reviewed if the hospital stay is expected to exceed three (3) days. This is a concurrent review, and it is referred to as the three-day benchmark. With the three-day benchmark, a review must be obtained if patient is not discharged by the third day (day of admission is day one.) The review must occur on or before day four of the stay.

10. What is the exception to the three-day benchmark?

The length of maternal and newborn stays related to childbirth is the exception to the three-day benchmark. The length of maternal and newborn stay related to childbirth is:

- Vaginal delivery: 48 hours from delivery (delivery/birth is the day after admission, and discharge is within two [2] days of delivery)
- Cesarean delivery: 96 hours from delivery (delivery/birth is the day after admission, and discharge is within four [4] days of delivery)

In some instances, maternal and newborn stays do not require review for medical necessity and may be issued administrative authorizations from the Division of Health Care Services' fiscal agent, Conduent State Healthcare. See Exhibit 17, Maternal Newborn Length of Stay, for more information.

SECTION 4: HIPAA

Business Associate Standing

Comagine Health provides care management services on behalf of its clients and is considered a "Business Associate" of these clients under the Health Insurance Portability and Accountability Act (HIPAA) "Administrative Simplification" regulations governing patient health information. These regulations include the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") and the Security Standard ("Security Rule").

DHCS Letter to Alaska Medicaid Providers

On January 01, 2019 the Division of Health Care Services (DHCS) sent a letter to Alaska Medicaid providers regarding its position on HIPAA. The text of that letter is presented on the next page.

Date: January 1st, 2019

To: Alaska Medicaid Provider

From: State of Alaska Department of Health and Social Services
Division of Health Care Services and Comagine Health

Re: Health Insurance Portability and Accountability Act (HIPAA) Uses and Disclosures of Protected Health Information General rules of 45 CFR 164.502(a)(1)(ii), (iii) and 45 CFR 164.502(e)(i); and Uses or Disclosures to Carry out Treatment, Payment, or Health Care Operations 45 CFR 164.506.

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Department of Health and Social Services (DHSS) is considered a covered entity. As a covered entity, all of the Divisions within DHSS, such as the Division of Health Care Services (DHCS), may contract with organizations to support the Divisions in the performance of their duties. These organizations are referred to under the HIPAA Privacy rules as business associates.

Comagine Health is considered a **Business Associate** for DHCS.

As a Business Associate, Comagine Health is permitted to receive Protected Health Information (PHI) in order to conduct their contracted work. Also, as a Business Associate of DMA, Comagine Health is allowed under HIPAA to obtain PHI related to Medicaid or Chronic and Acute Medical Assistance (CAMA) patients from providers and others without obtaining written authorization from the patient. This is allowed when Comagine Health is conducting functions that are related to treatment, payment, or health care operations (TPO).

Comagine Health's goal is to continue to conduct operational activities for the DHCS program while complying with the applicable HIPAA regulations.

If there are any questions regarding this issue, please contact one of the following representatives for further clarification:

- Susan Dunkin, DHCS, at (907) 269-3638
- Yvette Stratton, Comagine Health, at (206) 288-2443

SECTION 5: PROVIDER BILLING CONCERNS

Claim Discrepancies

We encourage you to thoroughly examine discrepancies in claims for accuracy prior to contacting Comagine Health. To review claims, log on to the Conduent State Healthcare provider portal at www.medicaidalaska.com or call Conduent Provider Inquiry at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

You may call Comagine Health to investigate discrepancies that have caused or have the potential to cause a claim to fail. Some examples of such discrepancies are:

- The date(s) on the Comagine Health review does not match the certified admission or discharge date on the claim
- Admitting or principal diagnosis and/or all procedure code(s) on the Comagine Health review do not match the code(s) on the claim
- Incorrect recipient Medicaid Identification number indicated on the Comagine Health review
- Case ID number used for billing does not match the case ID number on the Comagine Health review. (Be sure to note the case ID number on the claim.)

Certification Modifications

Sometimes information changes between the time the certification is completed and the time of billing. If information updates are necessary and the case has not been closed, you can request these updates using the CHPP. If the review is already closed in the CHPP, call Comagine Health to request the updates.

After we make your requested changes, we provide you with confirmation. For changes requested via the CHPP, we provide confirmation via the CHPP. For changes requested via other means, we provide telephone confirmation. We also communicate these changes to the fiscal agent.

Changing diagnosis, procedure, dates of service, or eligibility may result in further review. We notify you if additional review is required.

Contingency for Payment

Comagine Health certification indicates only that the admission is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

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SECTION 6: MEDICAID ELIGIBILITY AND THIRD PARTY LIABILITY

Providers are responsible for evaluating eligibility and third-party liability prior to submitting review requests to Comagine Health.
For questions regarding eligibility or other insurance coverage, log on to the Conduent State Healthcare provider portal at www.medicaidalaska.com or call Conduent Provider Inquiry at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

Eligibility Categories

There are more than 25 eligibility categories under which an individual may be approved for Medicaid. Each eligibility category is assigned a distinct eligibility code, which is printed on the recipient's Medicaid card or coupon.
Covered services may vary based on eligibility category. Each category provides coverage for mandatory services, and may provide coverage for additional, optional services. For more information about covered services, refer to the Alaska Medicaid provider billing manuals at http://medicaidalaska.com/providers/Billing.shtml or contact Conduent Provider Inquiry.

Eligibility Verification

Providers are responsible for verifying eligibility before submitting review requests. Medical assistance cards and coupons and/or the Eligibility Verification System can help you verify patient eligibility.

ID Cards and Coupons

The Department of Health and Social Services (DHSS), Division of Public Assistance (DPA), produces and distributes medical assistance cards that verify a recipient's eligibility. Cards and coupons contain the eligible recipient's name, identification number, date of birth, eligibility month and year, and eligibility code. Cards and coupons also contain a Resource Code that indicates if the recipient has a payment source in addition to medical assistance. Refer to your billing manual from the fiscal agent for further clarification.

Eligibility Verification System

The fiscal agent provides and maintains the Eligibility Verification System (EVS) to help providers determine recipient eligibility. Each enrolled provider receives a unique EVS PIN and instructions for using EVS. You can use EVS to verify recipient eligibility with a touch-tone phone 24 hours a day, seven days a week at (800) 884-3223.

To verify eligibility, log on to the Conduent State Healthcare provider portal at www.medicaidalaska.com or call Provider Inquiry at (907) 644-6800, option 1, 2 or (800) 770-5650, option 1, 1, 2 (toll-free in Alaska).

Third Party Liability and Dual Eligibility

There are instances in which Alaska Medicaid recipients could be covered under another insurance or program, and the requirements for review may vary. Medicaid recipients may also be eligible for Medicare or other health insurance, which can impact review requirements. Reviews are not required in the following instances:

If the requested service is	And the individual has
Inpatient	Medicare Part A (unless the requested service is not covered or if benefits have been exhausted)
Outpatient	Medicare Part B (unless the requested service is not covered or if benefits have been exhausted)
Inpatient or Outpatient	Other third-party health insurance coverage (e.g., Blue Cross, Aetna) For Medicaid purposes, eligibility to access healthcare through the Indian Health Service (IHS) is not considered a third-party liability.

SECTION 7: UTILIZATION REVIEW PROCESS OVERVIEW

Submission Modes

Providers must submit review requests via the web using the Comagine Health Provider Portal (CHPP). The CHPP allows you to directly enter the information required for pre-service, concurrent and retrospective review requests.

Eligibility Verification

Providers are responsible for verifying eligibility before submitting review requests. To verify eligibility, log on to the Conduent State Healthcare provider portal at www.medicaidalaska.com or call (907) 644-6800 or (800) 770-5650 (toll-free in Alaska). Refer to Section 6, Medical Eligibility and Third Party Liability, for more information about eligibility verification.

First-level Non-physician Review

Comagine Health provides all utilization review services in accordance with URAC health UM standards. URAC recognizes two levels of review: clinical review (first-level review) and peer clinical review (second-level review).

The first-level review process begins when a facility, provider or patient requests a review from Comagine Health. We collect basic demographic information and enter the case into our care management system. A clinical reviewer then performs the review using InterQual medical necessity criteria and, as applicable, contract-specific criteria. InterQual criteria are based on well-researched medical evidence that is reviewed and updated annually by Change Healthcare.

Comagine Health currently uses the following InterQual criteria sets for non-physician utilization review:

- Acute (Adult and Pediatric)
- Behavioral Health
- Rehabilitation (Inpatient, Outpatient and Chiropractic)
- Surgical Procedures (Adult and Pediatric)
- Home Care
- Sub-acute Care
- Skilled Nursing Care
- Long-term Acute Care
- Durable Medical Equipment
- Imaging

If medical necessity and appropriateness of the level of care can be established through the application of these criteria, the clinical reviewer approves the procedure or the admission for an appropriate number of days and notifies the requestor of the certification.

When the requested services involve inpatient treatment, the clinical reviewer uses InterQual criteria to identify an appropriate LOS and set a “next review” point for concurrent review, and then notifies the requester of the certification. If appropriate level of care and/or medical necessity criteria are not met, secondary medical review is required, and the case is referred to a Comagine Health medical director or physician/practitioner consultant (P/PC).

Second-level Peer Review

The Comagine Health physician reviewer evaluates the information they have received and uses their specialty expertise and clinical judgment to make the second-level review determination. The physician reviewer has up-to-date reference materials and guidelines available to help ensure their review determination is founded on current evidence-based best practices and accepted standards of practice.

When a non-certification decision is made, Comagine Health notifies the provider via the CHPP and telephone. Comagine Health also sends an Alaska Division of Health Care Services Denial Notice with information about fair hearing and appeals rights. The notification letter contains instructions for the provider in case they disagree with our determination.

Requesting a doctor-to-doctor conversation does not affect the time requirement for requesting an appeal. To request a doctor-to-doctor conversation, call (877) 292-2615. The request must be made within 60 days of the date of the letter.

Providers may request both a doctor-to-doctor conversation and an appeal. If the doctor-to-doctor conversation does not occur within this time frame, Comagine Health issues a non-certification determination. If the doctor-to-doctor conversation does occur, Comagine Health issues a determination following the discussion.

SECTION 8: WEB-BASED UTILIZATION REVIEW SUBMISSIONS

Purpose

The Comagine Health Provider Portal (CHPP) allows physicians, facilities and other healthcare providers to submit utilization review requests to Comagine Health using a secure Internet connection.

Responsibility

Providers must submit all utilization management reviews via the CHPP web-based review system.

Requirements

The Comagine Health Provider Portal requires:

- Internet access
- Provider account setup
- Individual user registration
- Completion of training

More information about the CHPP is on Comagine Health's website at:
http://qualishealth.org/healthcare-professionals/alaska-medicaid-health-care-services/provider-resources

Process and Procedures

Submission

If you have already received CHPP training from Comagine Health, submit your review requests via the Internet at:

https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin

Required Review Documentation

The following basic information is needed for each review/request:

- Recipient Name
- Recipient birth date
- Complete recipient address
- Recipient telephone number
- Sex of recipient
- Recipient Medicaid ID number
- Physician name
- Facility Address
- Facility phone number
- Facility Medicaid provider number
- Current principal diagnosis and ICD-10-CM code(s)
- Procedure(s) to be performed, including the ICD-10-CM code(s) and/or CPT code(s)
- Justification for the hospitalization and/or recipient symptoms
- Treatment proposed/provided

- Physician phone number
- Physician Medicaid provider number
- Facility name
- Admit date and/or surgery date

Medical Necessity Screening

Once we receive all information needed for the review, a Comagine Health clinical reviewer assesses that information using established criteria to determine whether the condition of the recipient meets the Severity of Illness (SI) and Intensity of Service (IS) requirements for the level of care and the type and number of services requested. If the criteria are met, the clinical reviewer issues a reference ID number and the review is certified. They also determine a length of stay and establish the date for a concurrent review if the recipient has not been discharged. Refer to Exhibit 1, Pre-service Review Flow Chart.

Comagine Health certification indicates only that the admission or procedure is medically necessary. This certification does not guarantee payment for services rendered.

Payment is contingent upon eligibility and compliance with the rules and regulations that govern Alaska Medicaid/Denali KidCare.

Second-level Peer Review

When episodes do not meet the criteria, the clinical reviewer refers those episodes to a Comagine Health physician reviewer (medical director or P/PC) for clinical peer review. The physician reviewer evaluates the clinical information and either certifies the admission or issues a potential non-certification. In the event of a potential non-certification, the attending physician can request a discussion with the Comagine Health physician reviewer (doctor-to-doctor conversation). If a doctor-to-doctor conversation is requested, our physician reviewer and the recipient's attending physician discuss the treatment plan, as well as appropriate alternatives. Following this discussion, Comagine Health either certifies or non-certifies the admission. See Section 3, Questions #2 and 3, for more information about doctor-to-doctor conversations, including the time constraints for holding those conversations.

Non-certifications

If the physician reviewer non-certifies the admission, Comagine Health notifies the appropriate provider (e.g., attending physician, facility) via the CHPP and telephone. We also send non-certification letters to the recipient, attending physician, facility and the Department within one (1) working day.

The non-certification letters contain justification for the non-certification and an explanation of the right to request an appeal of Comagine Health's initial non-certification determination. Refer to Section 16 of this manual for a detailed description of the appeal procedure.

The provider may request both a doctor-to-doctor conversation and an appeal. Requesting a doctor-to doctor conversation does not affect the time requirement for requesting an appeal.

The Department does not reimburse providers for services that are non-certified by Comagine Health, with the exception of non-certifications that are reversed as the result of an appeal review by Comagine Health or a provider appeal or recipient fair hearing by the state.

Questionnaires

In order to help you provide appropriate clinical information, the CHPP contains questionnaires and checklists associated with specific procedures and diagnoses.

CHPP questionnaires and checklists are available at http://qualishealth.org/healthcare-professionals/alaska-medicaid-health-care-services/provider-resources

Submitting Retrospective (Retro) Reviews

To submit a retrospective medical/surgical review via the CHPP, start by selecting "retrospective" from the "treatment type" dropdown box. Include targeted clinical information to support medical necessity. Include weekly clinical progress notes and/or team meeting progress notes if applicable.

Document the following information in the Communication field:

- Verification of Medicaid eligibility
- Admit and discharge dates (if applicable)
- Previous case ID# (if applicable)
- Reason for retro request (e.g., eligibility established while inpatient, review submission late)
- Contact name and phone number

Reviews with a length of stay start date more than 365 days in the past cannot be submitted via the CHPP. Contact Comagine Health for instructions.

Time Frames

The most common time frames for completion of reviews submitted via the CHPP are listed below. These time frames adhere to URAC guidelines and are measured beginning with the date of notification to Comagine Health.

Review Type	Time Frame for Completion
Pre-service review—Urgent	Three (3) calendar days
Pre-service review—Non-urgent	Fifteen (15) calendar days
Concurrent review—Urgent	Three (3) calendar days
Concurrent review—Non-urgent	Three (3) calendar days
Retrospective review	Thirty (30) calendar days

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SECTION 9: PRE-SERVICE UTILIZATION REVIEWS

Purpose

Care management best practices indicate that the most effective form of review takes place before the recipient enters the facility. The chief advantage is that medically unnecessary admissions can be avoided. DHCS has determined that certain select diagnoses and frequently performed procedures require pre- service review. These medical conditions and procedures are listed in Appendix A.
The Department has varying requirements for pre-service reviews. Surgical necessity review is required for select inpatient and outpatient non-urgent surgical procedures. Medical necessity review is required for select medical conditions to assure that inpatient hospitalization is warranted.

Responsibility

The recipient's attending physician is ultimately responsible for obtaining the pre-service review from Comagine Health. The attending physician is most knowledgeable about the recipient's medical history and condition. However, Comagine Health accepts requests for pre-service review from surgeons, physician office personnel and facility personnel (e.g., utilization review coordinator, admitting office, patient accounts office). Providers must submit all utilization management reviews via the CHPP web-based review system. Comagine Health must receive all of the appropriate clinical information to satisfy criteria before we certify a pre-service review.

Requirements

Pre-service review is required for all inpatient admissions and outpatient procedures on the Select Diagnoses and Procedures List (Appendix A). However, review is required only if the admitting/principal diagnosis or procedure (inpatient and outpatient) is on the select list and the facility is approved for Medicaid coverage by the Department.
We ask that you provide at least one (1) week's notice for all non-urgent inpatient hospitalizations or outpatient services for those diagnoses or procedures on the Select Diagnoses and Procedures List. You can request pre-service review up to four (4) weeks prior to the scheduled admission or procedure.

Late Notification

Timely review submission is important. Non-urgent pre-service review requests received less than one (1) week before treatment are considered late unless there are extenuating circumstances that preclude timely notification (e.g., acute injury). Late notification does not apply in those instances whereby the eligibility of the patient was established either during the admission or following discharge.

Comagine Health monitors and reports to the state those reviews that are not received timely. Accommodations are made for holidays and weekends.

Non-urgent pre-service review approvals are valid for four (4) months except for all transplant approvals, which are valid for six (6) months from the date of initial authorization.

Comagine Health may request updated clinical information from a provider prior to a procedure. If an admission or procedure date changes, the provider must notify Comagine Health prior to the scheduled admission.

Processes for the Select Diagnoses and Procedure Review Guidelines

Operational hours for Alaska Medicaid reviews are Monday through Friday, 6:30 am to 5:00 pm Alaska Time, excluding scheduled holidays.
Physicians or designated personnel must submit pre-service review requests to Comagine Health via the CHPP.

How to Reach Comagine Health	
CHPP2	https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Phone	(888) 240-0437
Fax	(800) 826-3630
Mail	Comagine Health PO Box 33400 Seattle, WA 98133-0400

Comagine Health's voice mail system is available 24 hours a day. If you call after business hours, or if no one is available to answer your call during regular business hours, you may leave a confidential voice mail. We check voice mail frequently throughout the day. We retrieve messages left outside regular business hours first thing on the next business day and return those calls by 12:00 noon Alaska Time.

Refer to Exhibit 8 for the Pre-service Review Request Fax Form if you have been notified by Comagine Health personnel to submit a review via fax.

Providers are responsible for verifying eligibility prior to submitting review requests. Comagine Health confirms Alaska Medicaid eligibility prior to issuing review approvals. Refer questions regarding eligibility or coverage and benefits to the fiscal agent provider services unit.

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2 If your Internet connection is temporarily unavailable, or if you do not have a CHPP user ID and password, call Comagine Health at (888) 240-0437 for information on alternate submission methods.

Information Needed for Reviews

Comagine Health representatives collect the following basic information for pre-service reviews:

- Recipient name
- Recipient birth date
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis and ICD-10-CM code
- Physician name
- Physician address
- Physician phone number
- Physician Medicaid provider number
- Facility name
- Facility address
- Facility phone number
- Facility Medicaid provider number
- Current principal diagnosis and ICD-10-CM code
- Procedure to be performed, including the ICD-10-CM code and/or CPT code
- Justification for the hospitalization and/or recipient symptoms
- Treatment proposed/provided
- Admit date and/or surgery date

Medical Necessity Screening

Once we have received all information needed for the review, a Comagine Health clinical reviewer assesses the medical information using InterQual criteria to determine whether the condition of the recipient meets the Severity of Illness (SI) and Intensity of Service (IS) requirements for the level of care and the type and number of services requested. If the screening criteria are met, the clinical reviewer issues a reference ID number and the review is certified. They also determine a length of stay and establish the date for a concurrent review if the recipient has not been discharged. Refer to Exhibit 1, Pre-service Review Flow Chart.

Comagine Health certification indicates only that the admission or procedure is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

Second-level Peer Review

Episodes that do not meet criteria are referred for clinical peer review by a Comagine Health physician reviewer (medical director or P/PC). The physician reviewer evaluates the clinical information and either certifies the admission or issues a potential non-certification. In the event of a potential non-certification, the attending physician can discuss the review with the Comagine Health physician reviewer.

If a doctor-to-doctor conversation is requested, our physician reviewer and the recipient's attending physician discuss the treatment plan, as well as appropriate alternatives. Following this discussion, Comagine Health either certifies or non-certifies the admission. See Section 3, Questions #2 and 3, for more information about doctor-to-doctor conversations, including the time constraints involved in holding those conversations.

Non-certifications

If the Comagine Health physician reviewer non-certifies the admission, we notify the appropriate provider (e.g., attending physician, facility) via the CHPP and telephone. We also send non-certification letters to the recipient, attending physician, facility and the Department within one (1) working day.

The non-certification letters contain justification for the non-certification and an explanation of the right to request an appeal of Comagine Health's initial non-certification determination. Refer to Section 16 of this manual for a detailed description of the appeal procedure.

The provider may request both a doctor-to-doctor conversation and an appeal. Requesting a doctor-to-doctor conversation does not affect the time requirement for requesting an appeal.

The Department does not reimburse providers for services that have been non-certified by Comagine Health, with the exception of non-certifications that are reversed as the result of an appeal review by Comagine Health or a provider appeal or recipient fair hearing by the state.

Process and Procedures for Urgent Inpatient Admissions and Outpatient Procedures

When an urgent admission or procedure that is listed in the Select Diagnoses and Procedure Review Guidelines occurs either during normal business hours or on a weekend or legal holiday, providers or designated facility personnel must notify Comagine Health within one (1) working day. This can be done in the CHPP.

If you call after business hours, or if no one is available to answer your call during regular business hours, you may leave a confidential voice mail. We check voice mail frequently throughout the day. Leave the following information in your voice mail message:

- Your name
- Your telephone number, including area code, beeper number or extension
- Physician full name
- Recipient name (with the correct spelling)
- Recipient ID number (Medicaid)
- Recipient date of birth
- Facility name
- Date and time of admission or surgery
- Diagnosis or surgical procedure
- ICD-10 diagnosis codes and ICD-10 or CPT procedure codes
- Case ID number for continued stay review

Leaving a voice mail message with this information does not complete the review or automatically certify the review. Comagine Health must return your call and initiate the review process. The same review guidelines and notification process for certifications and non-certifications as were previously described are followed.

Care and treatment of a recipient never should be delayed, particularly in urgent situations, in order to obtain Comagine Health certification.

Medical Transfer Reviews

Medical transfer reviews are required for inter-facility transfers. An inter-facility transfer is a transfer from one inpatient facility to another inpatient facility. The receiving ("transferred to") facility must initiate a new review for the medical transfer. Thus, each facility has a unique case identification or authorization number. The following special considerations apply:

- All transfers from one acute inpatient setting to another require a review. They are evaluated to ensure that the patient continues to meet criteria for either pre-service or concurrent review.
- An admission from a non-acute bed (i.e., swing bed or skilled nursing facility, or outpatient setting), or the emergency room is not considered a transfer for review purposes and is treated as a new admission.
- Also see Section 12, Physical Rehabilitation Reviews, for information about physical rehabilitation transfer reviews.

Time Frames

The most common time frames for completion of reviews are as follows:

Review Type	Time Frame for Completion
Pre-service review—Urgent	Three (3) calendar days
Pre-service review—Non-urgent	Fifteen (15) calendar days

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SECTION 10: CONCURRENT UTILIZATION REVIEWS

Purpose

A concurrent review takes place during the time in which a recipient is confined to a facility. The purpose is to determine if the facility confinement and associated physician services are medically necessary and appropriate. Comagine Health performs concurrent reviews for recipients when one of the following situations occurs:

- The recipient's facility confinement reaches the review date assigned by Comagine Health at the time of the pre-service review ("scheduled discharge date") and when discharge on that day is unlikely.
- For those diagnoses and procedures not included on the select pre-certification list, there is a three-day benchmark that applies. These episodes are reviewed concurrently when the recipient's confinement reaches day four, and the patient does not discharge from the facility. On day four, the episode is reviewed back to the date of admission and must meet criteria for all days. Concurrent reviews are done thereafter at intervals determined by Comagine Health.

Responsibility

The facility is responsible for securing concurrent review back to the day of admission when a recipient's facility confinement reaches day four or the assigned review date. Providers must submit all utilization management reviews via the CHPP web-based review system. Comagine Health must receive all of the appropriate clinical information to satisfy criteria before we certify a concurrent stay review.

Requirements

If the recipient is admitted with a diagnosis or procedure that does not require pre-service review and the diagnosis or procedure subsequently changes to one of the select diagnoses or procedures listed in Appendix A, their provider must contact Comagine Health within one (1) working day to obtain certification if a review has not been initiated. The principal diagnosis or procedure code may be updated and added to the existing concurrent review.

Late Notification

Timely review submission is important. Non-urgent concurrent review requests received more than one (1) business day after the next review date are considered late. Late notification does not apply in those instances whereby the eligibility of the patient was established either during the admission or following discharge.

Comagine Health monitors and reports to the state those reviews that are not received timely. Accommodations are made for holidays and weekends.

For concurrent hospital days where the facility failed to obtain continued stay review authorization in a timely manner and the patient has not been discharged, Comagine Health processes the review as a concurrent review and considers the review late.

Once a review has been initiated with Comagine Health, the review process continues until one of the following occurs:

- The recipient is discharged
- The recipient is transferred to another facility
- Concurrent review is non-certified by Comagine Health
- The recipient loses Medicaid eligibility
- The recipient becomes eligible for Medicare Part A after admission

Process and Procedures

Operational hours for Alaska Medicaid reviews are Monday through Friday, 6:30 am to 5:00 pm Alaska Time, excluding scheduled holidays.

Designated personnel must submit concurrent review requests to Comagine Health via the CHPP and must complete the AKM 3-day benchmark assessment questionnaire.
Refer to Exhibit 14 b, AKM 3-Day Benchmark Questionnaire.

How to Reach Comagine	
CHPP[3]	https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Phone	(888) 240-0437
Fax	(800) 826-3630
Mail	Comagine Health PO Box 33400 Seattle, WA 98133-0400

If you call after business hours, or if no one is available to answer your call during regular business hours, you may leave a confidential voice mail. We check voice mail frequently throughout the day. We retrieve messages left outside regular business hours first thing on the next business day and return those calls by 12:00 noon Alaska Time.

See Exhibit 11, Concurrent Review Request Form, if you are submitting a review via fax.

Providers are responsible for verifying eligibility prior to submitting review requests. Comagine Health confirms Alaska Medicaid eligibility prior to issuing review approvals. Refer questions regarding eligibility or coverage and benefits to the fiscal agent provider services unit.

Providers may contact the fiscal agent at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

[3] If your Internet connection is temporarily unavailable, or if you do not have a CHPP user ID and password, call Comagine Health at (888) 240-0437 for information on alternate submission methods.

Information Needed for Reviews

- Recipient name
- Recipient birth date
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis and ICD-10-CM code
- Physician name
- Physician address
- Physician phone number
- Physician Medicaid provider number
- Facility name
- Facility address
- Facility phone number
- Facility Medicaid provider number
- Current principal diagnosis and ICD-10-CM code
- Procedure to be performed, including the ICD-10-CM code and/or CPT code
- Justification for the hospitalization and/or recipient symptoms
- Treatment proposed/provided
- Admit date and/or surgery date
- Baby's weight in grams (required for review of newborns)

Medical Necessity Screening

Once we have received all information needed for the review, a Comagine Health clinical reviewer examines the medical information to assess the recipient's progress for the days being evaluated. InterQual criteria are applied to determine whether the condition of the recipient meets the Severity of Illness (SI) and Intensity of Service (IS) requirements. If criteria are met, the clinical reviewer issues a reference ID number (if not previously obtained in a pre-service review) and the concurrent review is certified. They also determine an approved length of stay and establish the next assigned review date if the recipient has not been discharged. Refer to Exhibit 2, Concurrent Review Flow Chart.

Comagine Health certification indicates only that the admission, procedure or continued hospitalization is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

Second-level Peer Review

Cases that do not meet criteria are referred for clinical peer review by a Comagine Health physician reviewer (medical director) or physician/practitioner consultant (P/PC). The physician reviewer evaluates the clinical information and either certifies the admission or issues a potential non-certification. In the event of a potential non- certification, the attending physician can ask to discuss the review with the Comagine Health physician reviewer. If a doctor-to-doctor conversation is requested, our physician reviewer and the recipient's attending physician discuss the treatment plan, as well as appropriate alternatives.
Following this discussion, Comagine Health either certifies or non-certifies the admission. See Section 3, Questions #2 and 3, for more information about doctor-to-doctor conversations, including the time constraints involved in holding those conversations.

Non-certifications

If the Comagine Health physician reviewer non-certifies all or part of the stay, a Comagine Health representative notifies the appropriate provider (e.g., attending physician, facility) of the adverse determination via the CHPP and telephone. We also send non-certification letters to the recipient, attending physician, facility and the Department within one (1) working day.

The non-certification letters contain justification for the non-certification and an explanation of the right to request an appeal of Comagine Health's non-certification determination. Refer to Section 16 of this manual for a detailed description of the appeal procedure.

The provider may request both a doctor-to-doctor conversation and an appeal. Requesting a doctor-to-doctor conversation does not affect the time requirement for requesting an appeal.

The Department does not reimburse providers for services that are non-certified by Comagine Health, with the exception of non-certifications that are reversed as the result of an appeal review by Comagine Health or a provider appeal or recipient fair hearing by the state.

Procedures for Concurrent Reviews Due on Weekends and Holidays

In those instances where the concurrent review date falls on a weekend or holiday, the following procedure is followed:

> If the concurrent review is due on a Saturday, Sunday or holiday, the concurrent review takes place on the following Comagine Health business day. Non-certification can be retrospective to the first day the recipient was not meeting acute level of care.

Alternatives to Discharge

Administrative Wait Days, Swing Bed Review

When a patient's hospital stay is non-certified, there are alternatives available other than discharging the patient from the hospital. Alaska Medicaid has provided two different programs for hospitals, the Swing Bed and the Administrative Wait Day(s) program, depending on whether the facility has been designated as a rural or urban hospital.

Rural hospitals may apply to the Division of Health Care Services to be an Alaska Medicaid Swing Bed provider. Once a hospital is enrolled by Alaska Medicaid as a Swing Bed provider, they can request reimbursement for the days the patient remains in the hospital beyond Comagine Health's non-certification.

Urban hospitals may apply to the Division of Health Care Services to be an Alaska Medicaid provider that may request Administrative Wait Day(s). When a hospital is enrolled in Alaska Medicaid they may request Administrative Wait Day(s) reimbursement for a hospital stay where the patient remains in the hospital beyond Comagine Health's non-certification.

Requests for Administrative Wait Day(s) (AWD) or Swing Bed authorization must be submitted on a Long-Term Care (LTC) Authorization form to the Division of Senior and Disabilities Services (DSDS). Comagine Health does not process review requests for AWD or Swing Bed authorizations.

Time Frames

The most common time frames for completion of reviews are as follows:

Review Type	Time Frame for Completion
Concurrent Review—Urgent	Three (3) calendar days
Concurrent Review—Non-Urgent	Three (3) calendar days

When additional information is required to complete the review, the timeline is adjusted accordingly. Comagine Health may choose to exercise a single extension of up to 15 calendar days on non-urgent reviews when there are reasons beyond the control of the organization that requires an extension. When this occurs, Comagine Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision. This single extension is allowed only for non-urgent reviews; it is not allowed for urgent care reviews.

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SECTION 11: RETROSPECTIVE UTILIZATION REVIEWS

Definition and Purpose

A retrospective review is typically a review for medical necessity submitted after services have been rendered and the patient has been discharged. A retrospective review may also be necessary if Medicaid eligibility is established while the patient is inpatient. Although pre-service or concurrent review is the preferred—and most advantageous—type of review, retrospective reviews are necessary to determine medical necessity of services already provided. A review of a facility confinement that is conducted retrospectively can result in non-certified hospital days or procedures/treatments.

Responsibility

The facility utilization reviewer is responsible for reviewing each chart for the appropriate information regarding Medicaid eligibility at the time of hospitalization. Providers must submit all utilization management reviews via the CHPP. Comagine Health must receive all of the appropriate clinical information to satisfy criteria before we certify a retrospective review.

Requirements

Retrospective review is required only for those outpatient or inpatient hospitalizations where the primary diagnosis or procedure would have required pre-service review, or the hospitalization exceeded the three-day benchmark

Retrospective Review Submission When Eligibility is Established during the Inpatient Admission

On occasion, recipients may complete an application for Medicaid during an inpatient stay and subsequently become Medicaid eligible prior to discharge. Providers must notify Comagine Health as soon they know the recipient is Medicaid eligible. If this hospitalization has exceeded 30 days, submit a retrospective review from date of admission to date of notification to Comagine Health, with targeted clinical documentation supporting medical necessity. Additionally, a continued stay review may be necessary from notification date to discharge and is reviewed using the concurrent review process outlined in Section 10. This results in a split bill authorization with two separate authorizations for the episode of care.

All retrospective reviews may be submitted via the CHPP with the exception noted below. Reviews that exceed 365 days in length may not be submitted via the CHPP. Contact Comagine Health for submission instructions.

Late Notification

Timely review submission is important. Retrospective review requests are considered late if the patient's Medicaid eligibility existed at the time the authorization was due (eligibility established prior to admission). Late notification does not apply in those instances whereby the eligibility of the patient was established either during the admission or following discharge. Comagine Health monitors and reports to the state those reviews that are not received timely. Accommodations are made for holidays and weekends.

Process and Procedures

Operational hours for Alaska Medicaid reviews are Monday through Friday, 6:30 am to 5:00 pm Alaska Time, excluding scheduled holidays.
Designated personnel must submit retrospective review requests to Comagine Health via the CHPP.

How to Reach Comagine	
CHPP[3]	https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Phone	(888) 240-0437
Fax	(800) 826-3630
Mail	Comagine Health PO Box 33400 Seattle, WA 98133-0400

If you call after business hours, or if no one is available to answer your call during regular business hours, you may leave a confidential voice mail. We check voice mail frequently throughout the day. We retrieve messages left outside regular business hours first thing on the next business day and return those calls by 12:00 noon Alaska Time.

Providers are responsible for verifying eligibility prior to submitting review requests. Comagine Health confirms Alaska Medicaid eligibility prior to issuing review approvals. Refer questions about eligibility or coverage and benefits to the fiscal agent provider services unit at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

[4] If your Internet connection is temporarily unavailable, or if you do not have a CHPP user ID and password, call Comagine Health at (888) 240-0437 for information on alternate submission methods.

Information Needed for Reviews

- Recipient name
- Recipient birth date
- Complete recipient address
- Date of Medicaid eligibility
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis and ICD-10-CM code
- Physician name
- Physician address
- Physician phone number
- Physician Medicaid provider number
- Facility name
- Facility address
- Facility phone number
- Facility Medicaid provider number
- Current principal diagnosis and ICD-10-CM code
- Procedure to be performed, including the ICD-10-CM code and/or CPT code
- Justification for the hospitalization and/or recipient symptoms
- Treatment proposed/provided
- Admit date and/or surgery date
- Baby's weight in grams (required for review of newborns)

Medical Necessity Screening

Once we have received all information needed for a review, a Comagine Health clinical reviewer examines the medical information to assess the recipient's progress for the days being evaluated. The clinical reviewer applies criteria to determine whether the condition of the recipient met the Severity of Illness (SI) and Intensity of Service (IS) requirements and determines an approved length of stay. Refer to Exhibit 15, Retrospective Review Request Form.

Comagine Health certification indicates only that the admission, procedure or continued hospitalization is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Alaska Medicaid/Denali KidCare programs.

Second-level Peer Review

Episodes that do not meet criteria are referred for clinical peer review by a Comagine Health physician reviewer (medical director or P/PC). The physician reviewer evaluates the clinical information and either certifies the admission or issues a potential non-certification. In the event of a potential non-certification, the attending physician can discuss the review with the Comagine Health physician reviewer. If a doctor-to-doctor conversation is requested, our physician reviewer and the recipient's attending physician discuss the treatment plan, as well as appropriate alternatives. Following the discussion, Comagine Health either certifies or non-certifies the admission. See Section 3, Questions #2 and 3, for more information about doctor-to-doctor conversations, including the time constraints involved in holding those conversations.

Non-certifications

If the Comagine Health physician reviewer non-certifies the admission, we notify the appropriate provider (e.g., attending physician, facility) via the CHPP and telephone. We also send non-certification letters to the recipient, attending physician, facility and the Department within one (1) working day.

The non-certification letters contain justification for the non-certification and an explanation of the right to request an appeal of Comagine Health's initial non-certification determination. Refer to Section 16 of this manual for a detailed description of the appeal procedure.

The provider may request both a doctor-to-doctor conversation and an appeal. Requesting a doctor-to-doctor conversation does not affect the time requirement for requesting an appeal.

The Department does not reimburse providers for services that have been non-certified by Comagine Health, with the exception of non-certifications that are reversed as the result of an appeal review by Comagine Health or a provider appeal or recipient fair hearing by the state.

Time Frames

Review Type	Time Frame for Completion
Retrospective review	Thirty (30) calendar days

When additional information is required to complete the review, the timeline is adjusted accordingly.

SECTION 12: PHYSICAL REHABILITATION UTILIZATION REVIEWS

Purpose

Care management best practices indicate that the most effective form of review takes place before the recipient enters the rehabilitation facility. The chief advantage is that medically unnecessary rehabilitation stays can be avoided.

Responsibility

The facility utilization review department is responsible for the identification of Medicaid cases that require physical rehabilitation review. The attending physician is ultimately responsible for obtaining certification of inpatient physical rehabilitation admissions. Providers must submit all utilization management reviews via the CHPP web-based review system. Comagine Health must receive all of the appropriate clinical information to satisfy criteria before we certify a pre-service review.

Requirements

All physical rehabilitation services must be provided in state-certified or Medicare-approved rehabilitation units. We recommend that you submit requests at least one (1) week prior to a planned rehabilitation admission, or preferably as soon as admission to a rehabilitation unit is anticipated.

Late Notification

Timely review submission is important. Non-urgent pre-service review requests received less than one (1) week before treatment are considered late unless there are extenuating circumstances that preclude timely notification, such as anticipated acceptance to physical rehabilitation earlier than one (1) week. Late notification does not apply in those instances whereby the eligibility of the patient was established either during the admission or following discharge. Comagine Health monitors and reports to the state those reviews that are not received timely. Accommodations are made for holidays and weekends.

Process and Procedures

Operational hours for Alaska Medicaid reviews are Monday through Friday, 6:30 am to 5:00 pm Alaska Time, excluding scheduled holidays.

Designated personnel must submit physical rehabilitation review requests to Comagine Health via the CHPP.

How to Reach Comagine	
CHPP	https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Phone	(888) 240-0437
Fax	(800) 826-3630
Mail	Comagine Health PO Box 33400 Seattle, WA 98133-0400

If you call after business hours, or if no one is available to answer your call during regular business hours, you may leave a confidential voice mail. We check voice mail frequently throughout the day. We retrieve messages left outside regular business hours first thing on the next business day and return those calls by 12:00 noon Alaska Time.

Providers are responsible for verifying eligibility prior to submitting review requests. Comagine Health verifies Alaska Medicaid eligibility for those reviews requiring retrospective review. Refer questions about eligibility or coverage and benefits to the fiscal agent provider services unit.

Pre-service review for rehabilitation has two components: assessment and evaluation.

1. Assessment of a recipient's rehabilitation potential

Before a recipient is admitted to the rehabilitation facility or unit specifically for rehabilitative care, Comagine Health must assess the following elements:

- Medical condition and history
- Functional limitations
- Prognosis
- Possible need for corrective surgery
- Attitude toward rehabilitation
- Ability to learn, meet rehabilitation goals, and participate in three (3) hours of therapy five (5) days per week
- The existence of any social problems affecting rehabilitation
- Expected outcome(s) from rehabilitation treatment

Reasonable rehabilitation goals should be identified for the Comagine Health evaluation. The plan of care should include both short- and long-term goals.

[5] If your Internet connection is temporarily unavailable, or if you do not have a CHPP user ID and password, call Comagine Health at (888) 240-0437 for information on alternate submission methods.

2. Evaluation of the rehabilitation program

Evaluation of the weekly multi-disciplinary rehabilitation team documentation occurs during the next scheduled concurrent review. This includes:

- Physical, occupational and/or speech therapy that total three (3) hours per day, five (5) days per week. (Medical reasons or complications precluding this criterion must be documented.)
- Any of the following services as indicated:
  - o Medical/social services
  - o Psychology
  - o Recreational therapy
  - o Vocational counseling
- Skilled rehabilitative nursing care or supervision required and available on a 24-hour basis.
- Documentation of measurable weekly improvement in functional in at least one (1) therapy, and revision of goals if necessary.

The Physical Rehabilitation Review Worksheet for Pre-service Review (Exhibit 12) can assist you with collecting the necessary information to submit a review by fax.

Information Needed for Reviews

- Recipient name
- Recipient birth date
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis and ICD-10-CM code
- Physician name
- Physician address
- Physician phone number
- Physician Medicaid provider number
- Facility name
- Facility address
- Facility phone number
- Facility Medicaid provider number
- Current principal diagnosis and ICD-10-CM code
- Relevant surgeries including the ICD-10-CM and/or CPT code(s)
- Justification for the hospitalization and/or recipient symptoms
- Treatment proposed/provided
- Admission date

Medical Necessity Screening

Once we receive all information needed for a review, a Comagine Health clinical reviewer assesses the medical information using InterQual criteria to determine whether the condition of the recipient meets the Severity of illness (SI) and Intensity of Service (IS) requirements for the level of care and the type and number of services requested. If the screening criteria are met, the clinical reviewer issues a reference ID number and the review is certified. They also determine a length of stay and establish the date for a concurrent review if the recipient has not been discharged.

Comagine Health certification indicates only that the admission or procedure is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

Second-level Peer Review

Episodes that do not meet criteria are referred for clinical peer review by a Comagine Health physician reviewer (medical director) or physician/practitioner consultant (P/PC). The physician reviewer evaluates the clinical information and either certifies the admission or issue a potential non-certification. In the event of a potential non-certification, the attending physician can discuss the review with the Comagine Health physician reviewer. If a doctor- to-doctor conversation is requested, our physician reviewer and the recipient's attending physician discuss the treatment plan, as well as appropriate alternatives. Following the discussion, Comagine Health either certifies or non-certifies the admission. See Section 3, Questions #2 and 3, for more information about doctor-to-doctor conversations, including the time constraints involved in holding those conversations.

Non-certifications

If the Comagine Health physician reviewer non-certifies the admission, we notify the appropriate provider (e.g., attending physician, facility) via the CHPP and telephone. We also send non-certification letters to the recipient, attending physician, facility and the Department within one (1) working day. Non-certification letters contain justification for the non-certification and an explanation of the right to request an appeal of Comagine Health's initial non-certification determination. Refer to Section 16 of this manual for a detailed description of the appeal procedure.

The provider may request both a peer-to-peer conversation and an appeal. Requesting a doctor-to-doctor conversation does not affect the time requirement for requesting an appeal.

The Department does not reimburse providers for services that have been non-certified by Comagine Health, with the exception of non-certifications that are reversed as the result of an appeal review by Comagine Health or a provider appeal or recipient fair hearing by the state.

Physical Rehabilitation Transfer Reviews

Definitions

There are two types of transfers: intra-facility and inter-facility. Both require a new physical rehabilitation pre-service review.

- **Intra-facility Transfer** is a transfer from a medical/surgical unit in a facility to a physical rehabilitation unit within the same facility. Effective July 1, 2021, a new review will still be required for the rehab admission, however, a new authorization number will not be required. Once approved, the internal transfer will remain on the original acute inpatient episode of care until discharge. Both the acute care and the rehab admission will have the same authorization number. A review is not required for transfers to other types of medical/surgical units (e.g., ICU, CCU) within the same facility.
- **Inter-facility Transfer** is a transfer from one inpatient facility to another inpatient facility. The receiving facility initiates a new review for each inter-facility transfer. Thus, each facility has a unique certification number to use on the claim form.

Purpose

The purpose of a transfer review is to ensure that Alaska Medicaid recipients receive the most appropriate level of care within an acute care facility.

Special Requirements

Scheduled or non-urgent/emergent transfers to a physical rehabilitation unit should be pre-certified before the recipient is transferred to the unit

Urgent or emergent transfers should be pre-certified by submitting review requests in the CHPP within 24 hours or one (1) business day of the transfer.

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SECTION 13: OUTPATIENT IMAGING UTILIZATION REVIEWS

Purpose

Care management best practices indicate that the most effective form of review takes place before the recipient receives the services. The chief advantage is that medically unnecessary procedures can be avoided.

DHCS has determined that certain select outpatient imaging procedures require pre-service review. This list of medical conditions and procedures is contained in Appendix A. Only outpatient imaging procedures are subject to this requirement; emergency room and inpatient hospital imaging procedures are excluded.

Responsibility

The recipient's ordering physician is ultimately responsible for obtaining the pre-service review from Comagine Health. The ordering physician is most knowledgeable about the recipient's medical history and condition related to the outpatient imaging review request. Providers must submit outpatient imaging utilization management reviews via the CHPP web-based review system and must complete the imaging review questionnaire. Comagine Health must receive all the appropriate clinical information to satisfy criteria before we certify a pre-service review.

Requirements

Pre-service review is required for all outpatient imaging procedures included in Appendix A, Select Diagnoses and Procedure Review Guidelines. A review is required only if the outpatient imaging procedure is on the select list and the provider/facility is approved for Medicaid coverage by the Department. Emergency room and hospital procedures are excluded from the outpatient imaging pre-service review process.

Prior to scheduling any of the non-urgent imaging procedures listed in Appendix A, Select Diagnoses and Procedure Review Guidelines, initiate a pre-authorization request. Once Comagine Health receives the review request, we contact the requestor through the CHPP with the results of the pre-authorization.

Late Notification

Timely review submission is important. Non-urgent pre-service review requests must be received prior to the outpatient imaging procedure services being provided or the request for review is considered late. Late notification does not apply in those instances whereby the eligibility of the patient was established retroactively. Extenuating circumstances that preclude timely notification may also be taken into consideration.

Comagine Health monitors and reports to the state those reviews that are not received timely. Accommodations are made for holidays and weekends.

Outpatient imaging pre-service review approvals are valid for four (4) months from the date of initial authorization.

Comagine Health may request updated clinical information from a provider prior to a procedure. If an admission or procedure date changes, the provider must notify Comagine Health prior to the scheduled admission.

Process and Procedures for Select Outpatient Imaging

Operational hours for Alaska Medicaid reviews are Monday through Friday, 6:30 am to 5:00 pm Alaska Time, excluding scheduled holidays.

Physicians or designated personnel must submit pre-service review requests to Comagine Health via the CHPP and must complete the imaging questionnaire. Refer to Exhibit 14 a, AK Medicaid Imaging Assessment Questionnaire.

How to Reach Comagine	
CHPP[3]	https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Phone	(888) 240-0437
Fax	(800) 826-3630
Mail	Comagine Health PO Box 33400 Seattle, WA 98133-0400

If you call after business hours, or if no one is available to answer your call during regular business hours, you may leave a confidential voice mail. We check voice mail frequently throughout the day. We retrieve messages left outside regular business hours first thing on the next business day and return those calls by 12:00 noon Alaska Time.

Refer to Exhibit 8 for the Pre-service Review Request Fax Form if you have been notified by Comagine Health personnel to submit a review via fax.

Providers are responsible for verifying eligibility prior to submitting review requests. Comagine Health confirms Alaska Medicaid eligibility prior to issuing review approvals. Refer questions regarding eligibility or coverage and benefits to the fiscal agent provider services unit.

[6] If your Internet connection is temporarily unavailable, or if you do not have a CHPP user ID and password, call Comagine Health at (888) 240-0437 for information on alternate submission methods.

Information Needed for Reviews

Comagine Health representatives collect the following basic information for pre-service reviews:

- Recipient name
- Recipient birth date
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis and ICD-10-CM code
- Physician name
- Physician address
- Physician phone number
- Physician Medicaid provider number
- Facility name
- Facility address
- Facility phone number
- Facility Medicaid provider number
- Current principal diagnosis and ICD-10-CM code
- Procedure to be performed, including the ICD-10-CM code and/or CPT code
- Justification for the hospitalization and/or recipient symptoms
- Procedure proposed/provided
- Procedure date

Medical Necessity Screening

Once we receive all information needed for a review, a Comagine Health clinical reviewer assesses the medical information using InterQual criteria to determine whether the condition of the recipient meets the Severity of Illness (SI) and Intensity of Service (IS) requirements for the type and number of services requested. If the screening criteria are met, the clinical reviewer issues a reference ID number and the review is certified. Refer to Exhibit 1, Pre-service Review Flow Chart.

Comagine Health certification indicates only that the procedure is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

Second-level Peer Review

Episodes that do not meet criteria are referred for clinical peer review by a Comagine Health physician reviewer (medical director or physician consultant). The physician reviewer evaluates the clinical information and either certifies the procedure or issues a potential non-certification. In the event of a potential non-certification, the attending physician can discuss the review with the Comagine Health physician reviewer. If a doctor-to-doctor conversation is requested, our physician reviewer and the recipient's attending physician discuss the treatment plan, as well as appropriate alternatives. Following the discussion, Comagine Health either certifies or non-certifies the procedure request. See Section 3, Questions #2 and 3, for more information about doctor-to-doctor conversations, including the time requirements involved in holding those conversations.

Non-certifications

If the Comagine Health physician reviewer non-certifies the admission, we notify the appropriate provider (e.g., ordering physician) via the CHPP and telephone. We also send non-certification letters to the recipient, ordering physician, facility and the Department within one (1) working day.

The non-certification letters contain justification for the non-certification and an explanation of the right to request an appeal of Comagine Health's initial non-certification determination. Refer to Section 16 of this manual for a detailed description of the appeal procedure.

The provider may request both a peer-to-peer conversation and an appeal. Requesting a doctor-to-doctor conversation does not affect the time requirement for requesting an appeal.

The Department does not reimburse providers for services that have been non-certified by Comagine Health, with the exception of non-certifications that are reversed as the result of an appeal review by Comagine Health or a provider appeal or recipient fair hearing by the state.

Process and Procedures for Outpatient Imaging Services

When a procedure that is on the pre-certification list occurs either during normal business hours or on a weekend or legal holiday, providers must notify Comagine Health within one (1) working day. This can be accomplished by using the CHPP and completing the imaging questionnaire.

If you call after business hours, or if no one is available to answer your call during regular business hours, you may leave a confidential voice mail. We check voice mail frequently throughout the day. Leave the following information in your voice mail message:

- Your name
- Your telephone number, including area code, beeper number or extension
- Physician full name
- Recipient name (with the correct spelling)
- Recipient ID number (Medicaid)
- Recipient date of birth
- Facility name
- Date and time of procedure
- Diagnosis and procedure
- ICD-10 diagnosis codes and ICD-10 or CPT procedure codes

Leaving a voice mail message with this information does not complete the review or automatically certify the review. Comagine Health must return your call and initiate the review process. The same review guidelines and notification process for certifications and non-certifications as were previously described are followed.

Care and treatment of a recipient never should be delayed, particularly in urgent situations, in order to obtain Comagine Health certification.

Time Frames

The most common time frames for completion of reviews are as follows:

Review Type	Time Frame for Completion
Pre-service Review—Urgent	Three (3) calendar days
Pre-service Review—Non-Urgent	Fifteen (15) calendar days

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SECTION 14: POTENTIAL QUALITY OF CARE CONCERNS

Comagine Health is committed to promoting optimum quality of care for all recipients. Therefore, we assess quality of care in various settings while performing reviews. The facility and attending physician are responsible for delivering the utmost quality of care for their patients. The Comagine Health clinical reviewer is responsible for identifying potential quality of care concerns regarding Alaska Medicaid recipients. Potential quality of care concerns may be identified during all types of reviews, including retrospective chart reviews.

If the Comagine Health clinical reviewer identifies a potential quality of care concern when performing a review, the situation is handled in one of two ways:

- If the clinical reviewer determines that the recipient's quality of care is currently being compromised, they consult a Comagine Health physician (medical director) or physician/practitioner consultant (P/PC). If the Comagine Health physician concurs that there is a potential quality of care concern, Comagine Health refers the case to DHCS for further action.
- If the clinical reviewer determines that there is a potential quality of care concern, but the recipient's care is not currently being compromised, they consult a Comagine Health physician (medical director or P/PC). If the Comagine Health physician concurs that there is a potential quality of care concern, Comagine Health refers the case to DHCS for further action and obtains the records if requested to do so.

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SECTION 15: SPECIAL CASE UTILIZATION REVIEWS

Purpose

Special case reviews for Medicaid recipients may be reviewed at any time at the direction of the Department. Special case reviews may include a variety of treatment and or procedure reviews particularly those that are potentially non-covered or experimental/investigational in nature. Care management best practices indicate that the most effective form of review takes place before the recipient enters the facility. The chief advantage is that medically unnecessary admissions can be avoided.

DHCS has determined that certain select diagnosis and procedures require pre-service special case review. This list of medical conditions and procedures is in Appendix A.

Responsibility

Providers are responsible for submitting clinical records to support the medical necessity for the review at the time of the request.

At the direction of the Department, Comagine Health performs special case reviews and makes recommendations. We forward these recommendations to the Department for final review and determination. When Comagine Health receives the Department's determination, we provide written notification of the determination to the attending physician, facility and recipient if it is approved, denied or a partial denial. If the clinical information received does not support the review request, we may request additional clinical information. Mail this information to:

Comagine Health
Attn: Provider Services Department/Special Case Review
PO Box 33400
Seattle, WA 98133-0400

Requirements

The facility must submit requested information to Comagine Health within 30 days of receipt of notification of the case requested for review.

Process and Procedures

Comagine Health reports the result of the review to the Department only. Comagine Health notifies the attending physician, facility and recipient of the state determination in writing.

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SECTION 16: UTILIZATION REVIEW APPEALS

Comagine Health offers an appeal process to providers and recipients in all episodes involving an adverse determination. When a review determination is to deny, reduce or terminate covered services, Comagine Health generates written notification of the adverse decision within one (1) business day of the date the decision is made. The non-certification notification includes rights for an appeal review. Comagine Health's appeal process features a second opinion by a physician who specializes in the services under review. URAC requires that appeal reviews be conducted by individuals who:

- Are clinical peers
- Hold an active, unrestricted license to practice medicine or a health profession
- Are board-certified by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists
- Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment under appeal
- Are neither the individual who made the original non-certification nor the subordinate of such an individual
- Have no conflicts of interest with the patient, attending physician or facility being reviewed

There are two types of appeals potentially available: expedited and standard. Instructions on how to initiate each type of appeal are included in the non-certification letter Comagine Health sends when the adverse determination is made.

Expedited Appeals

Definition

An expedited appeal is an appeal of a non-certification in a case involving urgent care.

Process and Procedures

Requests for expedited appeal may be submitted via the CHPP, telephone, fax or mail within two (2) business days of the receipt of the non-certification notification if the recipient has not yet been discharged. If an expedited appeal request is filed after two (2) business days, Comagine Health responds to that request through the standard appeal process.

Requests for expedited appeals should be directed as follows:

CHPP	https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Phone	(888) 240-0437
Fax	(888) 664-0168
Mail	Comagine Health Attn: Care Management Department/Appeal Coordinator PO Box 33400 Seattle, WA 98133-0400

Upon receipt of a request for an expedited appeal:

1. Comagine Health notifies all appropriate parties of the request.
2. If needed, Comagine Health requests that any additional medical information (e.g., medical records, physician office notes) necessary for the appeal review be submitted to us within two (2) hours.
3. The case is referred to a Comagine Health physician/practitioner consultant (P/PC) licensed and/or accredited in the appropriate specialty or subspecialty who is not the same individual who initially reviewed and non-certified the review.
4. The P/PC reviews the medical information.
5. If the P/PC reverses the non-certification decision, Comagine Health issues a reference ID number and length of stay (if applicable) and notifies all appropriate parties telephonically and in writing.
6. If the P/PC modifies the decision or upholds the non-certification, Comagine Health notifies the requesting physician or facility telephonically and in writing.
7. Notification with the review outcome, including clinical rationale, is sent to the recipient, attending physician and facility.

If the recipient, attending physician or facility disagrees with the expedited outcome, the standard appeal process may be followed.

Standard Appeals

Definition

A standard appeal is an appeal of a non-certification that is not an expedited appeal. Typically, standard appeals do not relate to cases involving urgent care. However, standard appeals may include secondary appeals of expedited appeals.

[7] If your Internet connection is temporarily unavailable, or if you do not have a CHPP user ID and password, call Comagine Health at (888) 240-0437 for information on alternate submission methods.

Process and Procedures

Recipients or providers may request a standard appeal via the CHPP, fax, telephone or mail within 180 days of the date shown on the non-certification notice. Direct requests for standard appeals as follow:

CHPP	https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Phone	(888) 240-0437
Fax	(888) 664-0168
Mail	Comagine Health Attn: Care Management Department/Appeal Coordinator PO Box 33400 Seattle, WA 98133-0400

Any requests for appeal of non-certifications are reviewed by a Comagine Health physician/practitioner consultant who is licensed and/or accredited in the appropriate specialty or subspecialty as the attending physician, but is not the same individual(s) who initially non-certified the review or the expedited appeal, if applicable.

Comagine Health must receive all appropriate clinical information before reviewing appeals. Upon receipt of complete records, Comagine Health issues the appeal decision within 30 days of receipt of the request for a standard appeal. All appropriate parties are notified in writing of Comagine Health's determination to uphold, reverse or modify the initial non-certification decision.

Documents Required for Appeal Processing

The following documents are required for review. Additional information may be submitted or requested to justify medical necessity.

- Admitting history and physical
- Interim or discharge summary, as applicable
- Operative report, as applicable
- Results/reports of diagnostic testing (e.g., MRI, CT, lab)
- Physician orders
- Physician progress notes

Submitting the required documentation with the appeal request reduces the amount of time required to process the appeal. Conversely, any required documents not submitted with the appeal must be requested from the provider, delaying the decision.

Comagine Health's appeal decision takes precedence over the initial non-certification decision or the expedited appeal decision, if applicable. For example, if an appeal review certifies more facility days than the original review, then more facility days are recommended for certification. Conversely, if an appeal review certifies fewer days than the original review, then fewer facility days are recommended for certification. Refer to Exhibit 4, Standard Appeal Process Flow Chart.

[8] If your Internet connection is temporarily unavailable, or if you do not have a CHPP user ID and password, call Comagine Health at (888) 240-0437 for information on alternate submission methods.

Recipient Fair Hearing and Division of Health Care Services Appeal Procedures

Fair Hearing Rights for Recipients

DHCS Fair Hearing procedure is the process by which recipients can contest Comagine Health non-certification decisions. Recipients may request fair hearings by phone or letter to the Fair Hearing representative at DHCS, within 30 days of the date on Comagine Health's standard appeal determination letter non-certifying the service. The request must state the rationale for requesting a fair hearing. The address and phone number to request a fair hearing are:

Fair Hearing Representative
Conduent State Healthcare
PO Box 240808
Anchorage, AK 99524
(800) 780-9972 or (907) 644-6800

If the recipient has been getting a service paid by DHCS that is stopped, suspended or reduced by an action we take, the recipient may ask that the service be continued. If the recipient wants to have the service continued while awaiting a hearing decision, they should ask for a continuation of the service within 10 days of the date of the action to stop, suspend or reduce the service. If the recipient asks for the service to be continued and the hearing decision determines that DHCS was correct to stop, suspend or reduce the service, the state may require the recipient to repay the cost of the services provided. (Regulatory References: 42 CFR 431.230(b) and 7 AAC 49.200)

Second-level Appeal Rights for Providers

An additional appeal process is available to providers through DHCS. Providers may request second-level appeals when they are not satisfied with the results of first-level appeal decisions by Comagine Health. Second-level appeals must be requested in writing and postmarked within 60 days of the date of the first-level appeal decision by Comagine Health. Second-level appeal requests cannot be made by telephone. Submit second-level appeals to:

Claims Appeal Representative
Alaska Division of Health Care Services
4501 Business Park Blvd., Bldg. L
Anchorage, AK 99503-7167

Include a copy of the Comagine Health first-level decision and supporting documentation considered relevant with the written appeal request.

Providers are notified in writing of the final decision by DHCS. If the recipient has been getting a service paid by DHCS that is stopped, suspended or reduced by an action we take, the recipient may ask that the service be continued. If the recipient wants to have the service continued during the time awaiting an appeal decision, they should ask for a continuation of the service within 10 days of the date of the action to stop, suspend, to reduce the service. If the recipient asks for the service to be continued and the appeal decision determines that DHCS was correct to stop, suspend or reduce the service, the state may require the recipient to repay the cost of the services provided. (Regulatory References: 42 CFR 431.230(b), 42 CFR 431.231(a), 7 AAC 49.190 and 7 AAC 49.200)

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SECTION 17: CASE MANAGEMENT

Definition and Compliance with URAC

URAC defines case management as "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality and cost-effective outcomes. Comagine Health complies with URAC case management standards when performing case management services. Comagine Health's URAC accredited case management program provides a combination of assessment, coordination, recommendation, education, and support for Alaska Medicaid recipients with medically complex conditions and costly healthcare needs.

Purpose

Case management is focused on helping medically complex patients receive appropriate medical services in an efficient and cost-effective manner. A comprehensive care plan is developed in collaboration with the patient (recipient) and the patient's family, attending physician, and other health and social service providers. This care plan outlines the patient's needs in the most appropriate and timely manner.

In addition to working with the recipient/family, physician and other medical providers to develop a coordinated care plan, Comagine Health's case management program for Alaska Medicaid includes the following types of activities:

- Assessing the recipient's personal situation and challenges
- Providing information and resources to support treatment needs
- Coordinating services provided by healthcare professionals involved in the recipient's medical treatment
- Discharge planning and assessment to support transitions of care from acute care facilities to the home environment

Special Considerations

Comagine Health provides case management services for Alaska Medicaid from our Alaska and Washington offices. We use Anchorage- and Fairbanks-based case managers to serve the unique needs of the Alaska population, and have a Seattle-based case manager to assist with cases needing specialized services in the Seattle area.

The following special considerations apply to the case management program Comagine Health provides for Alaska Medicaid:

- Case management is a voluntary program for recipients. All recipients who agree to participate in case management are asked to sign a release of information indicating their willingness to participate in the case management process.
- Alaska Medicaid recipients are eligible for case management services regardless of location.
- Recipients who are on the Alaska Medicaid Waiver, TEFRA, and Breast and Cervical Cancer Programs are eligible to participate in case management.
- Case management services are provided telephonically, but also include appropriate on-site visits.

Targeted Cases

Comagine Health care management software can automatically route utilization management cases that have a condition or diagnosis on a Case Management Referral Triggers list. These cases are referred to case managers for case management screening. The types of cases often found in case management are:

- Patients with complex coordination and planning needs that include services such as durable medical equipment, home health care, wound care and pharmacy
- High-cost cases targeted by utilization review (e.g., long lengths of stay, frequent emergency and inpatient admissions)
- Burns/wounds/non-healing ulcers
- Cancer
- Cardiovascular disease
- Chronic respiratory disease
- Complicated pregnancy
- Congenital defects
- Congenital heart disease
- High-risk pregnancy
- HIV/AIDS
- Neonate less than 38 weeks or with complications
- Neurodegenerative disorders (e.g., ALS, MS, MD)
- Neurological conditions (e.g., aneurysm, meningitis, encephalitis)
- Organ and bone marrow/stem cell transplants
- Possibility of severe permanent impairments
- Rehabilitation
- Pattern of re-hospitalization
- Spinal cord injuries
- Traumatic brain injury
- Multiple trauma injuries

Process and Procedures

Case Identification

While many referrals to case management occur through the utilization management process, cases can be referred from multiple sources, including patient self-referral, physician or other provider, discharge planner, care coordinator, Alaska Medicaid, and other state agencies. Comagine Health screens referrals utilizing criteria established in conjunction with the Department. Cases are screened by case managers and then referred to the Department for referral determination. If approved, involved parties and facilities are then notified of case management services. See Exhibit 16 for the Case Management Referral Form.

Opening a Case

Once a case has been approved by the Department, the recipient and/or family is offered the opportunity to participate in case management, and with their consent, a case is opened with further assessment performed. A case manager begins the initial case management process, which includes:

- Gathering information to help identify the healthcare needs of the recipient
- Making recommendations regarding the recipient's healthcare needs
- Informing the recipient and healthcare team members about benefits and available resources
- Coordinating complex care needs and assisting in obtaining appropriate healthcare services

Reports are submitted to the Department illustrating case management interventions, goals and recommendations.

Provider Interface

The case manager notifies the attending physician and involved healthcare providers of the recipient's participation in case management to assist with coordination of care needs. The case manager works collaboratively with all healthcare providers to assure all services are appropriate and medically necessary.

Case Closure

Once it is determined that case management services are no longer indicated (e.g., patient's medical condition stable and all appropriate services in place, no ongoing needs), the case is reviewed for closure. The recipient is notified by phone and correspondence that the case is being closed.

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APPENDICES

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Appendix A: Select Diagnoses and Procedure Review Guidelines

The Select Diagnoses and Procedure Review Guidelines are located at

http://qualishealth.org/healthcare-professionals/alaska-medicaid-health-care-services/provider-resources

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Appendix B: Glossary of Terms & Acronyms

Terms

Administrative Wait Days: Acute care bed in an urban facility where a patient can continue to receive care at a lower rate.

Alaska Medical Assistance Program: Aggregate title used to identify or when referring to all three medical programs, Medicaid, Denali KidCare (DKC), and Chronic and Acute Medical Assistance (CAMA), administered by the Alaska Department of Health and Social Services.

Call Date or Call-back Date: Notification date or date the review is conducted (same as "Review Date" or "Scheduled Discharge Date").

Care Management Department: Includes the telephonic, medical record review areas and case management services at Comagine Health.

Case ID Number: Comagine Health certification number assigned to each case certified; eight-digit number beginning with "88." The last six digits are assigned by the Comagine Health case management software system. This number is used on all billing or claim forms for the fiscal agent to verify the pre-certification.

Concurrent Review: The process of reviewing for continued medical necessity.

Conduent State Healthcare, LLC: Fiscal agent for DHCS.

Disabled or Disability: The inability to engage in substantial gainful activity by reason of a medically-determined physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. (Alaska Administrative Code AAC 48.598)

Health Insurance Portability and Accountability Act: Relating to the uses and disclosures of Protected Health Information.

InterQual Criteria: Evidence-based clinical review criteria that support first-level clinical review by Comagine Health clinical reviewers.

Intensity of Services: InterQual criteria component that means diagnostic and therapeutic services that can be provided only in a hospital.

Non-certification: Comagine Health decision not to authorize a service.

Non-urgent/Emergent Procedure: Procedure that is subject to the choice or decision of the recipient or physician regarding medical services that are advantageous to the recipient but not necessary to prevent the death or disability of the recipient.

Pre-service Review: The process whereby Comagine Health reviews clinical information from the provider to determine medical necessity for specific services found on the DHCS pre-certification list for recipients.

Prior Authorization: Authorization granted for services or medical procedures requiring prior review and approval by the state medical professionals (or designee), before such service can be performed and paid.

Provider: An individual, firm, corporation, association or institution providing or approved to provide medical services to an Alaska Medicaid recipient.

Provider Contract ID: Number assigned to each provider by Conduent State Healthcare, fiscal agent for DHCS, also known as "Medicaid Contract ID."

Recipient: An individual eligible for benefits under Alaska Medicaid9.

Retrospective Review: All types of post-payment and/or post-admission review; recipient may or may not be eligible at the time of admission.

Review Date: Notification date or date review required (same as "Call Back Date" and "Scheduled Discharge Date").

Scheduled Discharge Date: Notification date or date review required (same as "Review Date" or "Call Back Date").

Severity of Illness: InterQual criteria component that means objective clinical findings that define severity of illness.

Swing Bed: Acute care bed in a rural facility where a patient can continue to receive care at a lower rate.

Urgent Care Services: A case is considered to involve urgent care whenever the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function, or (b) in the opinion of a physician with knowledge of the recipient's medical condition, would subject the recipient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

[9] Unless otherwise indicated, the term Medicaid refers to both Medicaid and Denali KidCare.

Acronyms

AWDs: Administrative Wait Days

CAMA: Chronic and Acute Medical Assistance

CHPP: Comagine Health Provider Portal

CM: Case Manager at Comagine Health

CMS: Centers for Medicare & Medicaid Services

CPT: Physicians' Current Procedural Terminology

DBH: Division of Behavioral Health

DHCS: Division of Health Care Services

DHSS: Department of Health and Social Services, also known as the Department

DKC: Denali KidCare

DME: Durable Medical Equipment

DOB: Date of birth

DPA: Division of Public Assistance

DS: Discharge screening criteria indicative of patient stability and readiness for discharge

DSDS: Division of Senior and Disabilities Services

HIPAA: Health Insurance Portability and Accountability Act

ICD-10-CM: International Classification of Diseases (10th Edition, Clinical Modification)

IS: Intensity of Services

LOC: Level of Care

LOS: Length of Stay

P/PC: Physician/Practitioner Consultant at Comagine Health

QIO: Quality Improvement Organization

SI: Severity of illness

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982

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Appendix C: Key Contacts for Comagine Health and Alaska DHCS

Comagine Health Contact Information

Care Management Department
PO Box 33400 Seattle, WA 98133
Phone: (800) 949-7536 or (206) 364-9700
Fax: (206) 368-2419

Utilization & Case Management
PO Box 243609 Anchorage, AK 99524
UM Phone: (888) 240-0437
UM Fax: (800) 826-3630
CM Phone: (888) 578-2547 or (907) 550-7600
CM Fax: (877) 265-9549

Case Managers
Becky Foster, RN, BSN, CPHQ, CCM (800) 949-
7536 ext. 7611 (877) 776-2805 ext. 7611
beckyf@qualishealth.org

Medical Affairs
John Sparks, MD Senior Medical Director
(800) 949-7536 ext. 2333
johns@qualishealth.org

Administration
Deon Westmorland, RN, BSN, CCM Sr Director, Care Management (800) 949-7536 ext. 2347 deonw@comagine.org

Yvette Stratton, RN, BSN, CCM Sr Director, Care Management (800) 949-7536 ext. 2443
ystratton@comagine.org

Bud Beall Vice President, Care Management
(800) 949-7536 ext. 2041
bbeall@comagine.org

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State of Alaska Contact Information

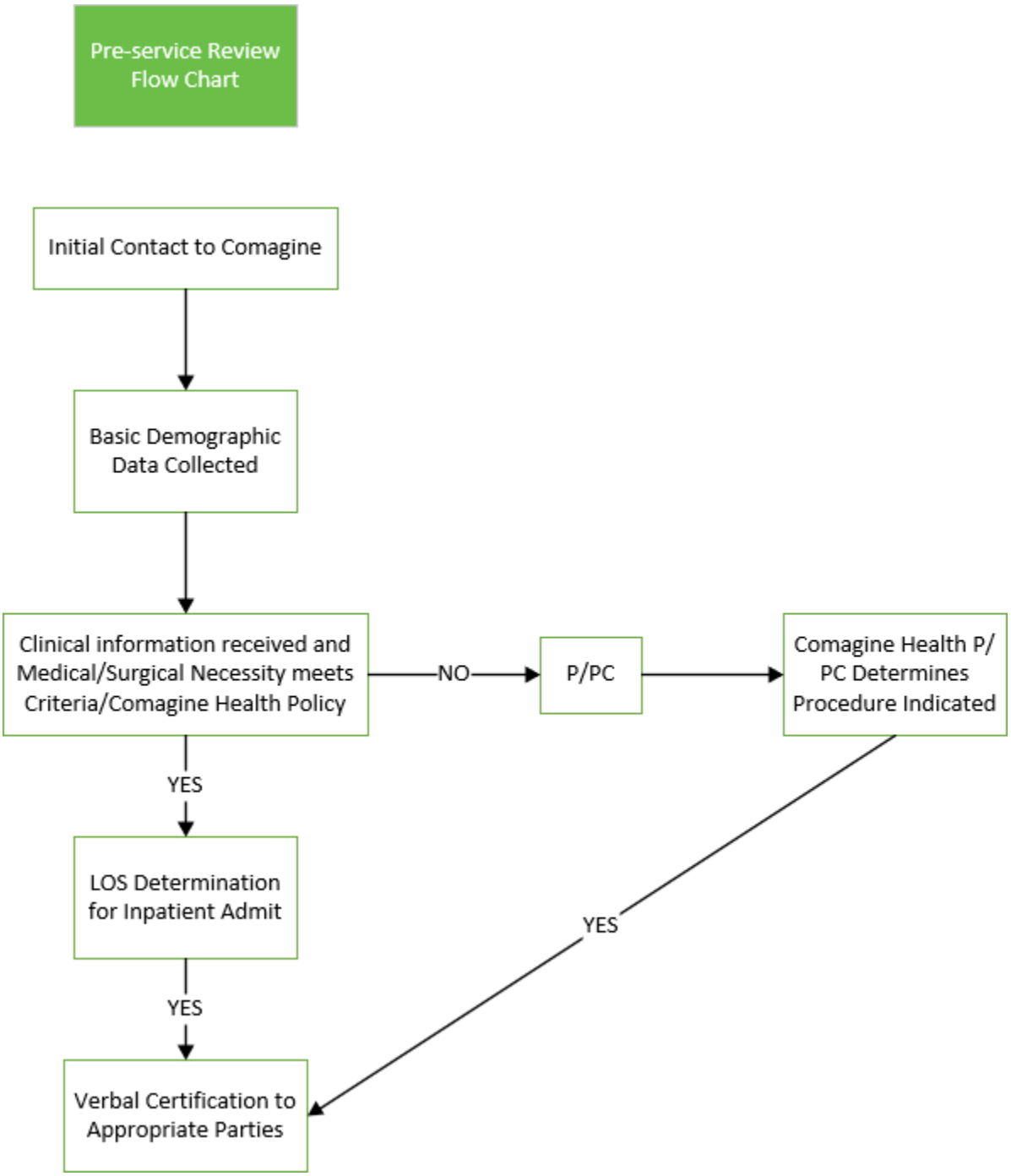
State of Alaska
Department of Health & Social Services
Division of Health Care Services
4501 Business Park Blvd., Building L
Anchorage, AK 99503-7167
Phone: (907) 334-2400
Fax: (907) 561-1684

Appendix D: List of Exhibits

Exhibit 1	Pre-service Review Flow Chart
Exhibit 2	Concurrent Review Flow Chart
Exhibit 3	Expedited Appeal Process Flow Chart
Exhibit 4	Standard Appeal Process Flow Chart
Exhibit 5	Case Management Referral Process Flow Chart
Exhibit 6	Case Management Assessment Process Flow Chart
Exhibit 7	Case Management Workflow: Initial Assessment to Closure Flow Chart
Exhibit 8	Pre-service Review Request Fax Form
Exhibit 9	Inpatient Review Concept Template
Exhibit 10	Inpatient Review Worksheet
Exhibit 11	Concurrent Review Request Form
Exhibit 12	Physical Rehabilitation Review Worksheet for Pre- service Review
Exhibit 13	Physical Rehabilitation Review Worksheet for Concurrent Review
Exhibit 14 a	AK Medicaid Imaging Questionnaire
Exhibit 14 b	AKM 3 Day Benchmark Questionnaire
Exhibit 15	Retrospective Review Request Form
Exhibit 16	Case Management Referral Form
Exhibit 17	Maternal Newborn Length of Stay

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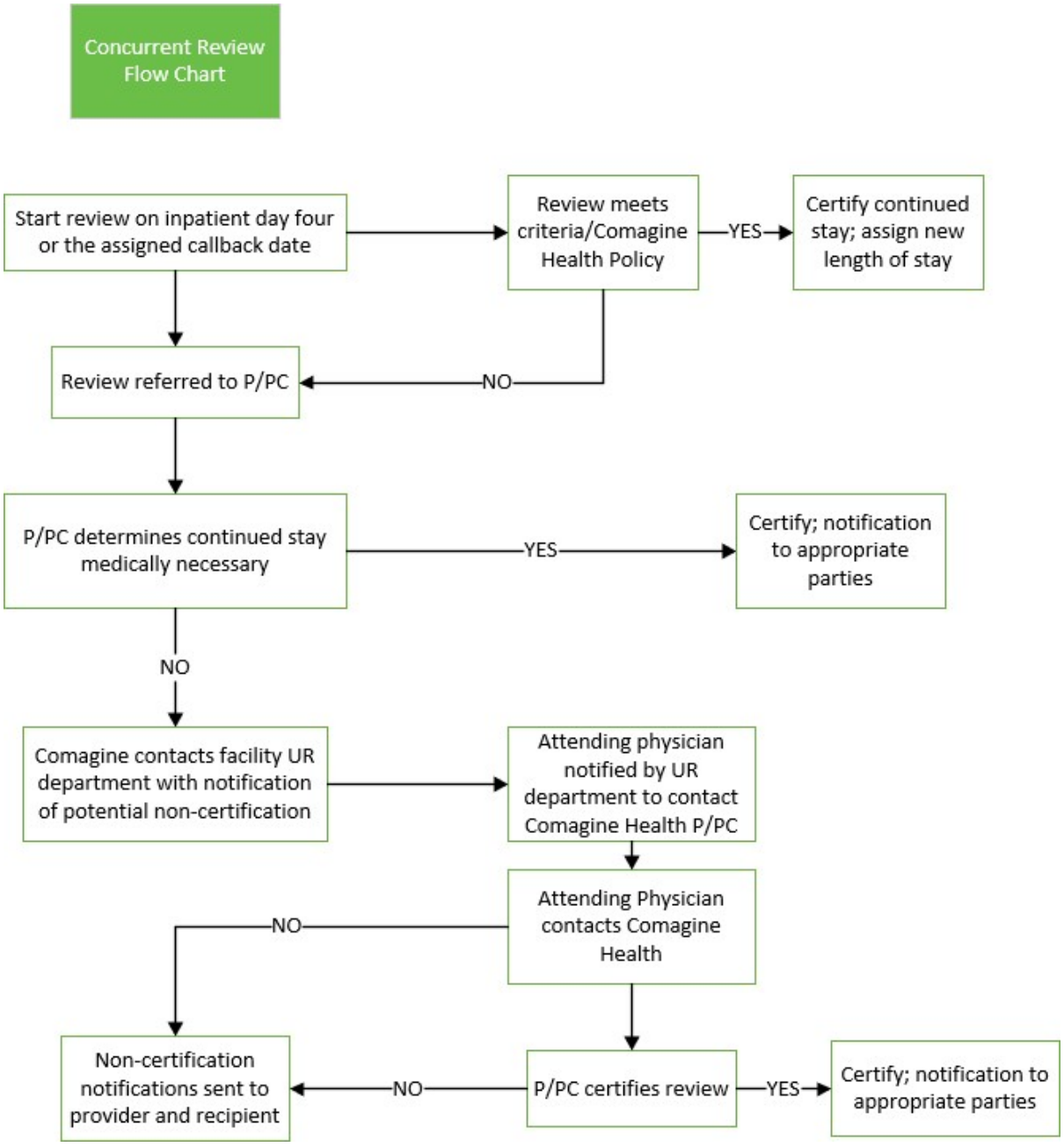
Exhibit 1



P/PC = Physician/Practitioner Consultant
LOS = Length of Stay

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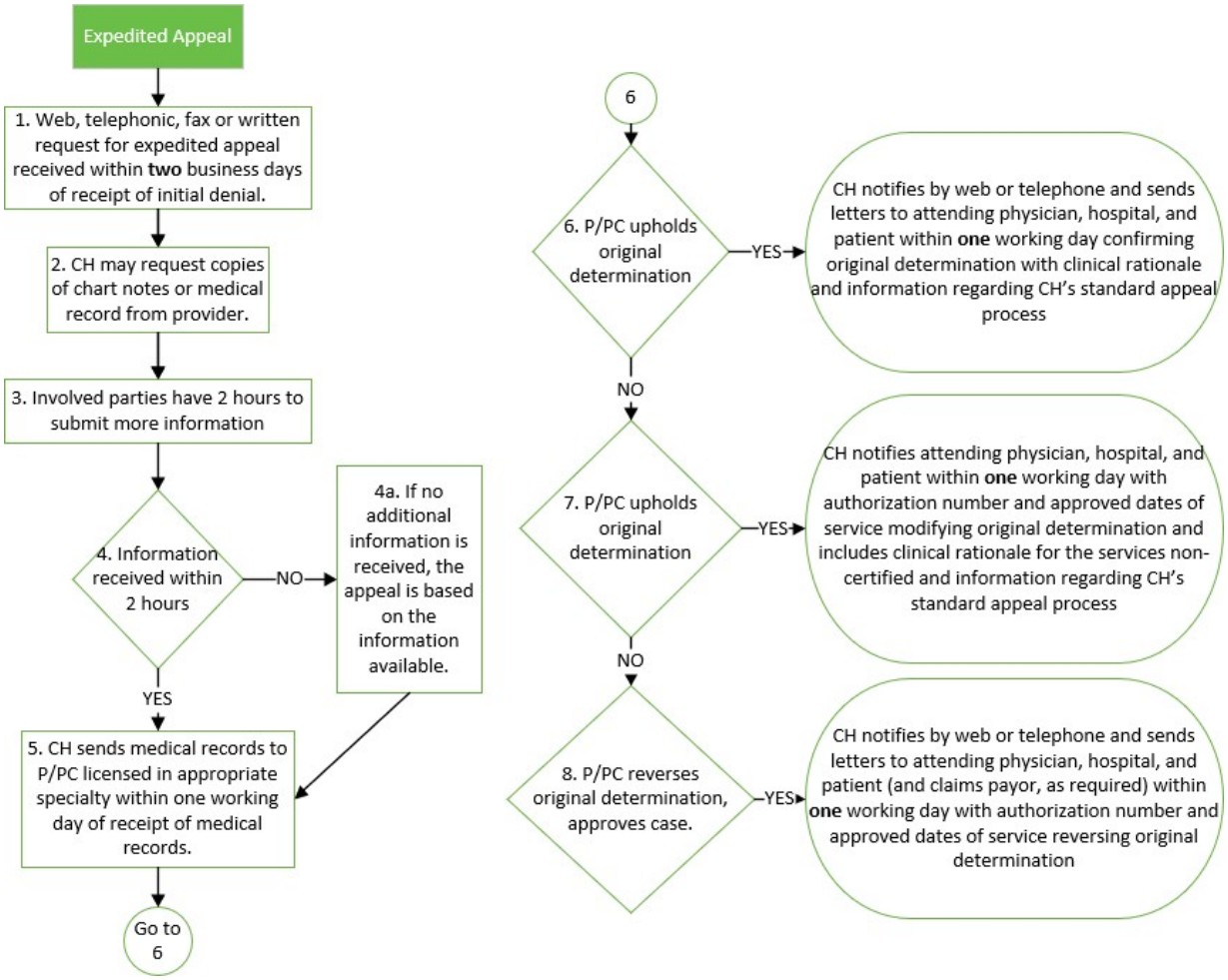
Exhibit 2



P/PC = Physician/Practitioner Consultant
NR = Nurse Reviewer

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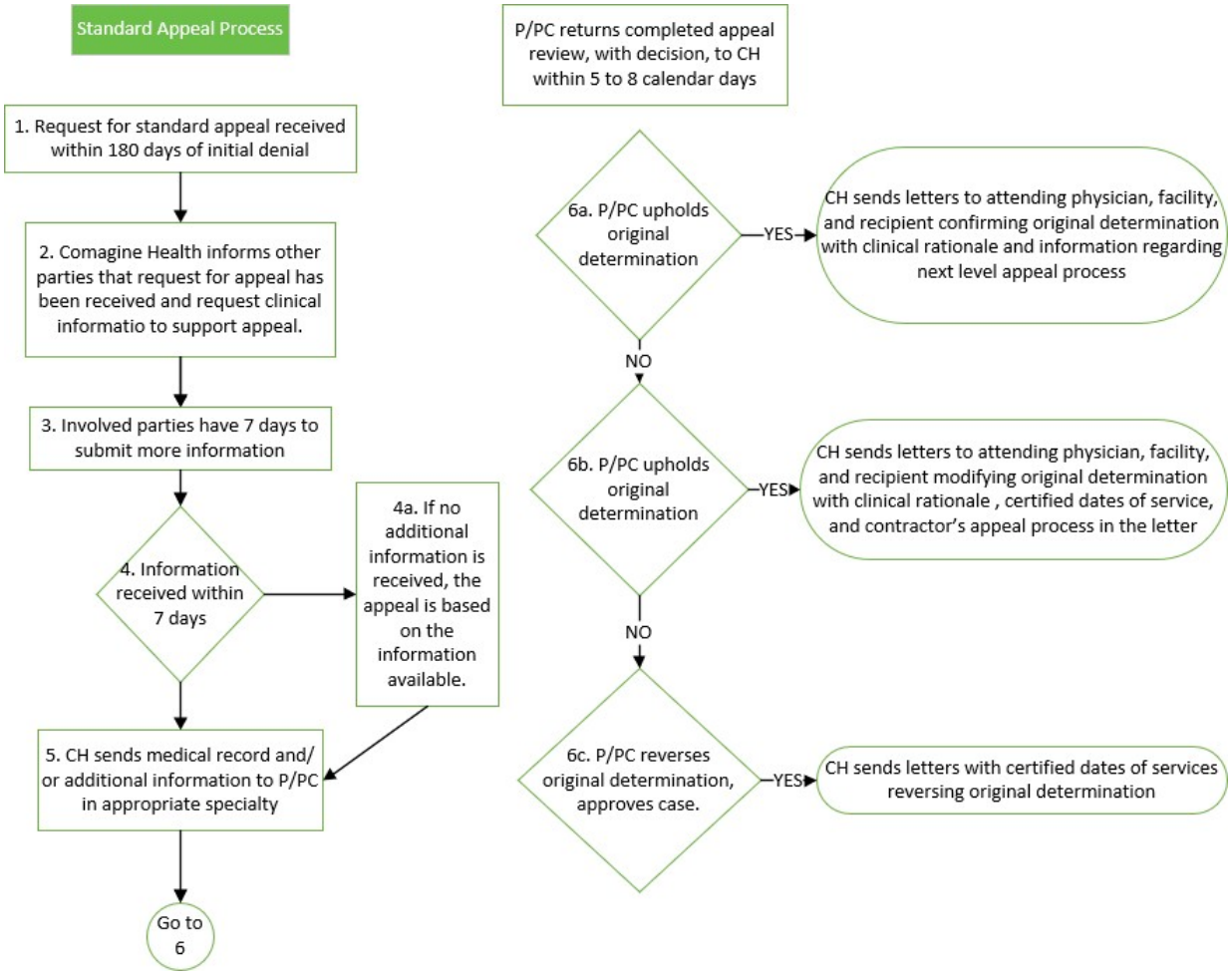
Exhibit 3



P/PC = Physician/Practitioner Consultant
Expedited Appeal = An appeal of non-certification in a case involving urgent care.

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Exhibit 4

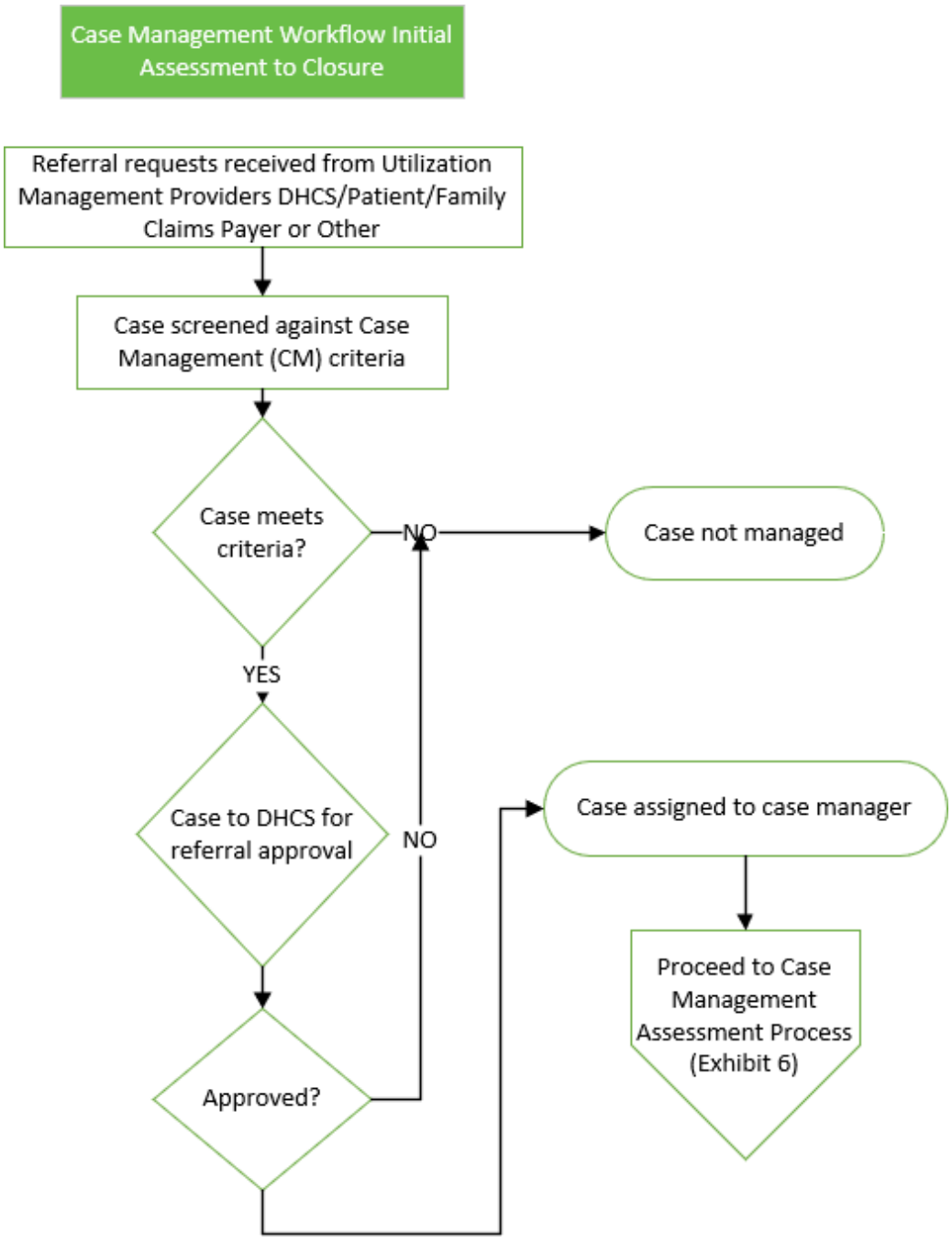


P/PC = Physician/Practitioner Consultant

*Review completed and letters mailed within 30 days of receipt of request to perform standard appeal.
** For Alaska Medicaid if an appeal is received after the 180-day deadline, a technical denial will be issued.

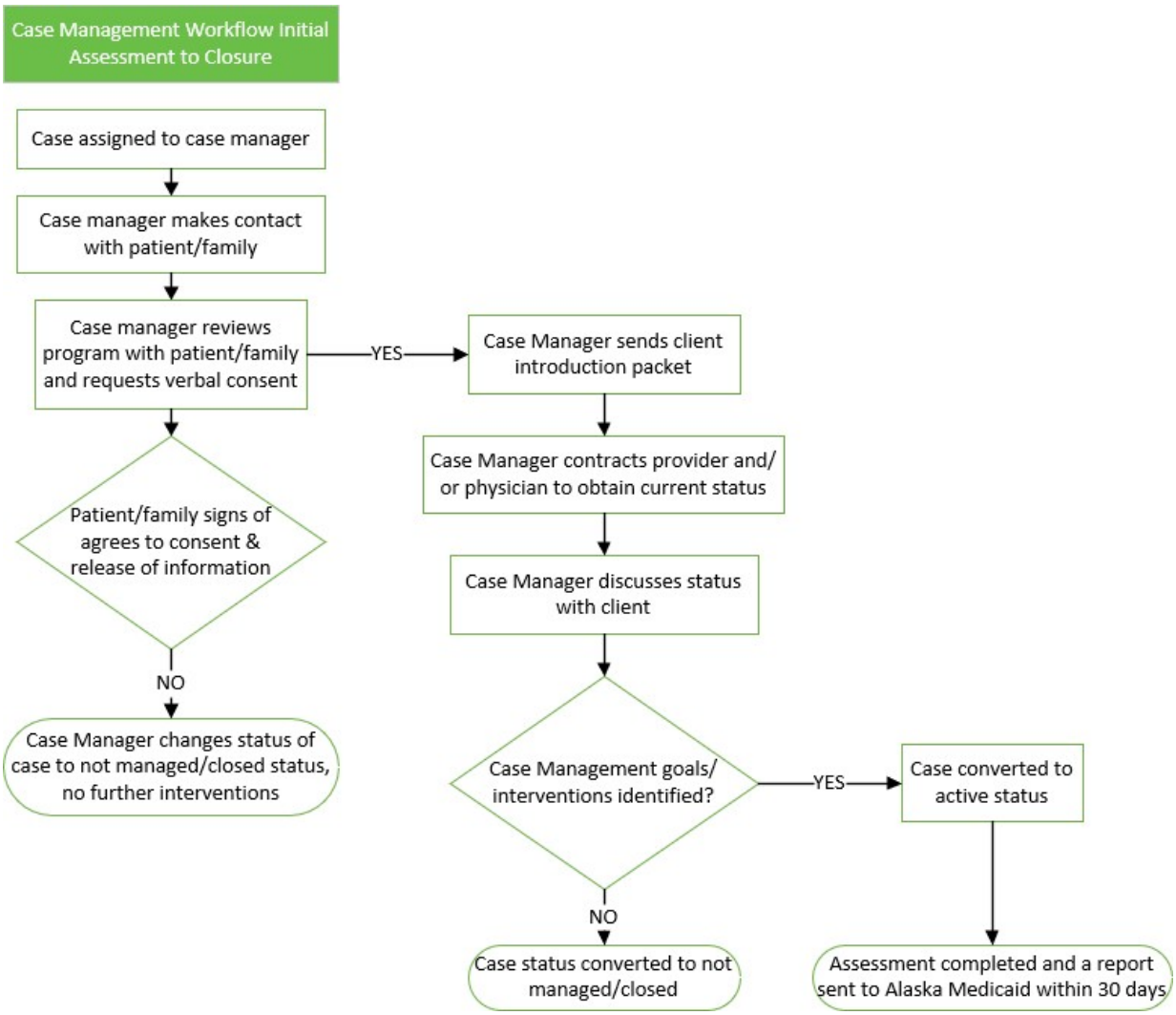
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Exhibit 5


Case Management Workflow Initial Assessment to Closure
Referral requests received from Utilization Management Providers DHCS/Patient/Family Claims Payer or Other
Case screened against Case Management (CM) criteria
Case meets criteria?
NO
Case not managed
YES
Case to DHCS for referral approval
NO
Case assigned to case manager
Proceed to Case Management Assessment Process (Exhibit 6)
Approved?

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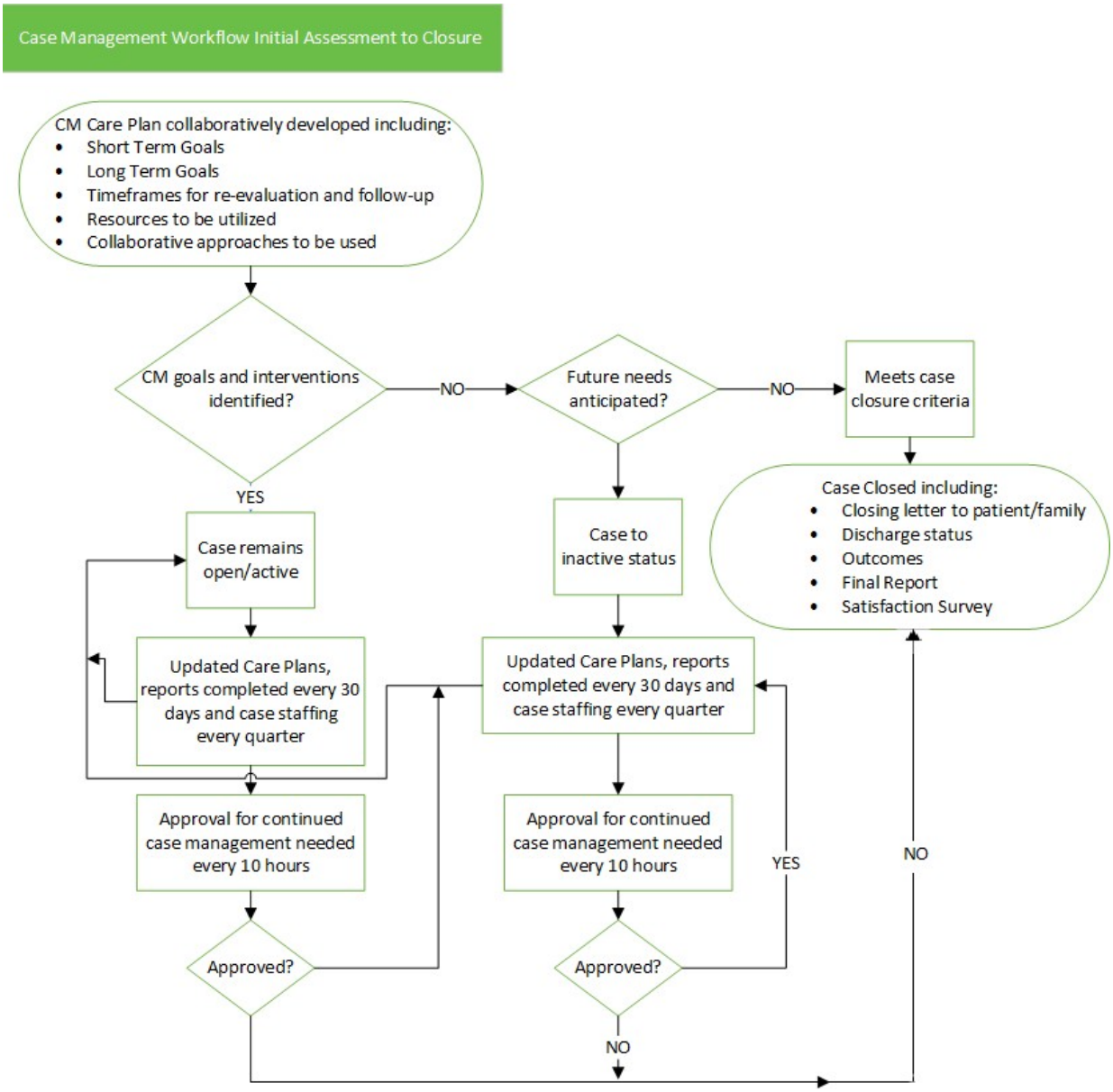
Exhibit 6



*Introduction packet includes Release of Information, Patient Introduction, Overview of Services and Patient Bill of Rights.

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Exhibit 7


Case Management Workflow Initial Assessment to Closure
CM Care Plan collaboratively developed including:
Short Term Goals
Long Term Goals
Timeframes for re-evaluation and follow-up
Resources to be utilized
Collaborative approaches to be used
CM goals and interventions identified?
NO
Future needs anticipated?
NO
Meets case closure criteria
YES
Case remains open/active
Case to inactive status
Case Closed including:
Closing letter to patient/family
Discharge status
Outcomes
Final Report
Satisfaction Survey
Updated Care Plans, reports completed every 30 days and case staffing every quarter
Updated Care Plans, reports completed every 30 days and case staffing every quarter
Approval for continued case management needed every 10 hours
Approval for continued case management needed every 10 hours
YES
NO
Approved?
Approved?
NO

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Comagine Health

Exhibit 8

Review Request Fax Form

Providers with no access to the Qualis Health Provider Portal may use this form.
See Section 8 of this manual for additional information.

DATE:_____

ATTN.:_____

FAX #: _____ PHONE #:_____

FROM:_____

FAX #: _____

NUMBER OF PAGES (INCLUDING COVER SHEET): _____
If there is problem with the receipt of this fax, call _____

RECIPIENT/PATIENT NAME: _____

RECIPIENT/PATIENT DATE OF BIRTH: _____

COMPLETE RECIPIENT ADDRESS: _____

MEDICAID NUMBER:_____

REQUESTED ADMIT DATE:_____DIAGNOSIS CODE(S)_____

PROCEDURE DATE(S):_____

DAYS REQUESTED:_____PROCEDURE CODE(S)_____

CONTINUED STAY REVIEW? Y ( ) IF SO, REFERENCE #_____

NEW ADMIT? ( ) TRANSFER ( )

SETTING: ☐ INPATIENT ☐ OUTPATIENT ☐ PHYSICIAN OFFICE ☐ OUT OF STATE
☐ NON-URGENT ☐ URGENT

PHYSICIAN NAME:_____PHONE #_____
FAX #_____

FACILITY: _____PHONE #_____
FAX #_____

CLINICAL INFORMATION:_____

_____

_____

_____

This message is intended for the use of the individual entity to which it is transmitted and may contain information that is privileged, confidential and exempt from disclosure under applicable laws. If the reader of this communication is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original communication to us at the address below via U.S. Postal Service. We will reimburse you for the mailing costs.

Thank you.

10700 Meridian Ave N. Seattle WA 98133
Phone: (888) 240-0437 **Alaska Review Fax (800) 826-3630**

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Comagine Health

Exhibit 9

Qualis Health

Inpatient Review Concept Template

This is provided as a tool to help organize information that will help patients get medically necessary services at the right level of care and at the right time while meeting Qualis Health's need for appropriate InterQual® documentation. Please consider the following as a guide, not a requirement or guarantee of payment for admission or for continued stay review.

Demographics:

- Patient name, ID number
- Attending name, pager number and best time for a Qualis Health Medical Director to call if needed
- The day or dates under review

SI (Symptom Intensity) How sick is the patient? This places the patient's services in context with their clinical condition and is needed both for initial review and for concurrent review.

- What is the main clinical issue?
- Abnormal vital signs?
- Pain present? Where? What is cause?
- Neurological status (alert to obtunded)
- Brief description of diagnostic tests (especially if lab or x-rays are abnormal)
- Any consultations and evaluations or procedures?

IS (Intensity of Services) What care is the patient receiving?

- IV medications and frequency
- Any IV PRN meds given for nausea, pain? How often each day?
- IV fluids/ TPN
- Blood or blood products (should have a HCT as a reason)
- Oxygen needed? FiO2 and route? ABGs done or O2 sats?
- Diet/tube feeds/gavage (What is infant's weight?)
- If patient is on a sliding scale, what were high/low glucose values? How many coverage units were given on each day (not the routine doses)?
- Wound management: describe wound and dressing/debridement/special issues
- Any other treatments or therapies?

DS (Discharge Screens) What is the long-term plan?

- What is the expected destination after the hospitalization?
- What discharge planning activities are being done
- What care needs are there post-discharge? Educational needs?
- Are there significant psycho-social issues?

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Comagine Health

Exhibit 10

Inpatient Review Worksheet

DATE:

Patient Name:_____ ID #_____
Attending name/contact info*/best time:_____
Admit Diagnosis/Code _____ Procedure Code_____

[SYMPTOM INTENSITY: CLINICAL ISSUES] SI

Review covers dates from _____ to _____
What is the main reason the patient is in the hospital for this day/days?

_____
_____
_____
_____

Briefly describe progress, diagnostic tests & results, consultations, evaluations.

_____
_____
_____
_____

[INTENSITY OF SERVICES: TREATMENT] IS

IV medications & frequency. Include IV PRN meds—esp. pain—and # of times given per 24h.

_____
_____
_____
_____

IV fluids/TPN/lipids/rates/bolus/blood_____
_____
Respiratory status/treatment_____
Nutritional status/treatment_____
Insulin coverage/ values_____
Wound mgmt issues/frequency_____
_____
Other treatments_____
_____

[DC SCREENS] DS

Briefly describe discharge planning: expected destination, care needs, educational needs.

_____
_____
_____
_____
_____

**In case a Qualis Health Medical Director needs to speak with the attending, include a pager # or office # and best time to call.

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Exhibit 11

Comagine Health

Concurrent Review Request Form

PLEASE VERIFY ELIGIBILITY BEFORE SUBMITTING

Providers with no access to the Qualis Health Provider Portal may use this form.

See Section 8 of this manual for additional information

Patient Information

Patient Name		Admit Date
Gender Male ☐ Female ☐	Patient ID # or L&I #	Patient DOB
Subscriber Name *(If different from patient)*		ID #
FOR L&I ADMISSIONS ONLY:		
Description of Injury		Date of Injury

Facility and Attending Physician Information

Facility Name	
Facility Reviewer Name	Phone #
Attending Physician Name	Phone #

Clinical Information *(Please print or type)*

Primary Diagnosis w/ ICD-10 Code	CPT Code(s)
Number of Days Requested	Date Range of Request
Chart Notes Attached? ☐ Yes ☐ No	Number of Pages
Current Treatment Plan	

Diagnostic Results	Lab Results
Discharge Plan or Other Issues	

Alaska Medicaid Phone Number: 888-240-0437

Alaska Medicaid Fax Number: 800-826-3630

Comagine Health

Exhibit 12

Physical Rehabilitation Review Worksheet

for

Pre-service Review

Providers with no access to the Qualis Health Provider Portal may use this form.

See Section 8 of this manual for additional information.

Initial call date_____ Caller name_____

Caller phone #_____ Planned rehabilitation admission date_____

Patient name_____

Patient address_____

_____

Birth date_____ Sex_____Medicaid ID number_____

Rehabilitation facility_____ Location_____

Current physician name_____

Physician ID #_____ Phone #_____

Proposed rehabilitation physician_____

Physician ID #_____ Phone #_____

Address_____

ICD-10-CM code(s)_____

and written description _____

_____

_____

_____

Relevant surgery codes_____

_____

Severity of Illness

What is the illness/injury/surgery or exacerbation that has occurred within the last 30 days?

_____

What is the mobility, ADL or respiratory impairment requiring at least minimum assistance?

_____

Comagine Health

Exhibit 12 (continued)

Patient Name:_____

Severity of Illness (continued)

Is the patient clinically stable within the last 24 hours? Provide the temperature, heart rate, respiratory rate and BP from the last 24 hours. _____

_____

Is the patient able to tolerate the comprehensive rehabilitation program of 3 hours/day or longer of skilled therapy for 5 days or greater a week? _____

_____

Is the patient able to follow visual/verbal commands?_____

_____

Does the patient desire to and are they able to actively participate? _____

_____

Is the patient active in the community and home prior to admission with rehabilitation potential? _____

_____

Is the patient fully participating in the therapeutic evaluation and interventions prior to transfer? _____

_____

Is the admission a trial admission for 1 week or less? _____

_____

Is the prospective assessment completed by a rehabilitation professional? _____

_____

Is full participation/tolerance projected? _____

_____

What therapies are indicated? _____

_____

Is the treatment precluded in a lower level of care due to the clinical complexity? _____

Comagine Health

Exhibit 12 (continued)

Patient Name:_____

Severity of Illness (continued)

Will the physician do an assessment/intervention 3 times/week or greater? _____

_____

Is there specialized therapeutic skills/equipment required? If so, please identify? _____

_____

Will the rehabilitation nursing services be available 24 hours/day? _____

_____

Intensity of Service

Will the progressive therapy program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:_____

_____

_____ ADLs
_____ Bed mobility/transfers
_____ Home lifestyle modifications
_____ Positioning/splinting
_____ Pulmonary rehabilitation
_____ ROM/strengthening
_____ Speech language retraining
_____ Swallowing retraining
_____ Wheelchair mobility/ambulation/balance

If this is an admission trial of 1 week or less, the program will provide:

_____At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy

_____Full participation in evaluation/therapy

_____Rehabilitation evaluations completed within 2 days

Identify the new medical condition that decreases the patient's participation in therapy for less than 3 hours/day for up to 3 days._____

What medical/psychosocial management is required for this patient?_____

_____

Comagine Health

Exhibit 12 (continued)

Patient Name: _____

Program Coordination

What is the ongoing needs assessment/procurement? _____

_____

What instruction does the patient require? _____

_____

What is identified as discharge needs, barriers, patient support systems? _____

_____

_____

_____

_____

_____

_____

Disposition Planned:

1. If Goals Achieved: _____
2. If Goals Not Achieved: _____

Physiatrist's Plan of Care and Recommendation (if applicable):

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Thank you.

10700 Meridian Ave N, Seattle WA 98133

Phone: (888) 240-0437 **Alaska Review Fax (800) 826-3630**

Comagine Health

Exhibit 13

Physical Rehabilitation Review Worksheet

for

Concurrent Review

Providers with no access to the Qualis Health Provider Portal may use this form.

See Section 8 of this manual for additional information

Call Date: _____ Caller: _____ Reference # _____

Admit Date: _____

Patient's Name: _____

Medicaid #: _____

Rehabilitation Facility: _____

Phone #: _____

New Procedures: _____ Date: _____

In general, has measurable improvement been documented weekly? Yes ☐ No ☐

Indicate:

1. Specific improvement—or lack of improvement—in the following areas, and

_____

_____

2. Revision of goals, if necessary

_____

_____

Improvements		**Comments**
Cognitive function	Y ☐ N ☐	_____
Communication	Y ☐ N ☐	_____
Continence, bowels	Y ☐ N ☐	_____
Continence, bladder	Y ☐ N ☐	_____
Mobility	Y ☐ N ☐	_____
Pain management	Y ☐ N ☐	_____
Perceptual motor function	Y ☐ N ☐	_____
Self-care activities	Y ☐ N ☐	_____

Comagine Health

Exhibit 13 (continued)

Patient Name:_____

Intensity of Service

Will the progressive therapy program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:

_____ADLs

_____Bed mobility/transfers

_____Home lifestyle modifications

_____Positioning/splinting

_____Pulmonary rehabilitation

_____ROM/strengthening

_____Speech language retraining

_____Swallowing retraining

_____Wheelchair mobility/ambulation/balance

If this is an admission trial of 1 week or less, the program will provide:

_____At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy

_____Full participation in evaluation/therapy

_____Rehab evaluations completed within 2 days

Identify the new medical condition that decreases the patient's participation in therapy for less than 3 hours/day for up to 3 days. _____

What medical/psychosocial management is required for this patient? _____

_____

Program Coordination

What is the ongoing needs assessment/procurement? _____

_____

What instruction does the patient require? _____

_____

What is identified as discharge needs, barriers, patient support systems, and patient capabilities? _____s

Comagine Health

Exhibit 13 (continued)

Patient Name: _____

Disposition Planned

1. If goals achieved:_____
2. If goals not achieved:_____

Physiatrist's Plan of Care and Recommendation (if applicable)

_____

_____

_____

_____

_____

_____

_____

Number of days requested_____

Number of days approved_____

Approved until_____

Authorization #_____

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Thank you.

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Phone: (888) 240-0437 **Alaska Review Fax (800) 826-3630**

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Exhibit 14 a

AK Imaging Assessment *updated December 2020*

I affirm that the recipient's Medicaid eligibility has been confirmed.

☐ Yes

☐ No (Per the Alaska Medicaid Provider Manual, page 17 & 19, providers are responsible for evaluating Medicaid eligibility and third party liability prior to submitting review requests to Comagine Health. For questions regarding eligibility or other insurance coverage, log on to the Conduent State Healthcare provider portal at www.medicaidalaska.com or call Conduent Provider Inquiry at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

1. Is the imaging procedure being requested, for a work-related injury?
   ☐ Yes (STOP: We are unable to process this work related review. Please contact the patient's employer for assistance.)
   ☐ No

2. Is the imaging procedure for an injury?
   ☐ Yes (Enter Date)
   ☐ No

3. What imaging procedure is being requested? (select ONE)
   ☐ Angiogram
   ☐ MRI
   ☐ PET (select one)
      ☐ Staging
      ☐ Restaging
   ☐ Other (Enter Text)

4. Imaging procedure being requested to assess: (select ONE)
   ☐ 70551
   ☐ 70553
   ☐ 72141
   ☐ 72146
   ☐ 72148
   ☐ 72156
   ☐ 72158
   ☐ 73221
   ☐ 73222
   ☐ 73721
   ☐ 74183
   ☐ 78452
   ☐ 78815
   ☐ Other **(answer AKM Imaging Assessment B)**

5. Part of body to be imaged: (select ONE)
   - ☐ Abdominal
   - ☐ Abdominal and Pelvis
   - ☒ Brain
   - ☐ Breast
     - ☐ Breast – Bilateral
     - ☐ Breast – Left
     - ☐ Breast – Right
   - ☐ Cervical Spine
   - ☐ Chest
   - ☐ Elbow
     - ☐ Elbow – Left
     - ☐ Elbow – Right
   - ☐ Face/Orbit/Ear/Throat
   - ☐ Foot
     - ☐ Foot – Left
     - ☐ Foot – Right
   - ☐ Hand
     - ☐ Hand – Left
     - ☐ Hand – Right
   - ☐ Heart
   - ☐ Hip
     - ☐ Hip – Left
     - ☐ Hip – Right
   - ☐ Knee
     - ☐ Knee – Left
     - ☐ Knee – Right
   - ☐ Lower Extremity
     - ☐ Lower Extremity – Left (non-joint)
     - ☐ Lower Extremity – Right (non-joint)
   - ☐ Lumbar Spine
   - ☐ Shoulder
     - ☐ Shoulder – Left
     - ☐ Shoulder – Right
   - ☐ Thoracic Spine
   - ☐ Upper Extremity
     - ☐ Upper Extremity – Left (non-joint)
     - ☐ Upper Extremity – Right (non-joint)
   - ☐ Whole Body PET (base of skull to thigh)
   - ☐ Wrist
     - ☐ Wrist – Left
     - ☐ Wrist – Right
   - ☐ Other (Enter Text)

6. Reason for the requested imaging procedure: (include restaging, follow-up, pre/postop, accident, rule out dx, differential dx, etc.)
   Enter Text:_____

7. Previous Care completed: (select all that apply)

☐ HEP (Home Exercise Program) (answer all)
Date HEP was complete: Enter Date
What body part? Enter Text
Was HEP effective in reducing your symptoms? Yes/No

☐ Imaging (answer all)
Date imaging was completed: Enter Date
What type of imaging test? (select ONE)
☐ MRI
☐ CT
☐ US
☐ PET
☐ X-Ray
☐ Other: Enter Text

☐ Labs (answer all)
Date labs were complete: Enter Date
Type of lab tests and results: Enter Text

☐ Medications (answer all)
Type of medication: (select all that apply)
☐ Narcotics (answer all if selected)
Narcotics – date medication was completed: Enter Date
Narcotics – duration and results: Enter Text
☐ NSAIDS (nonsteroidal anti-inflammatory drugs) or Acetaminophen (answer all if selected)
NSAIDS or Acetaminophen – date medication was completed: Enter Date
NSAIDS or Acetaminophen – duration and results: Enter Text
☐ Other: Enter Text (answer all if selected)
Other – date medication was completed: Enter Date
Other – duration and results: Enter Text

☐ Surgery/Biopsy (answer all)
Date surgery/biopsy was completed: Enter Date
Surgery/biopsy results: Enter Text

☐ Physical/Occupational Therapy (answer all)
Date therapy was completed: Enter Date
What body part? Enter Text
Was therapy effective in reducing your symptoms? Yes/No

☐ Activity Modification or Other: (Enter Text) (answer all)
Activity modification or Other – date completed: Enter Date
Activity modification or Other – duration and results: Enter Text

☐ Not Applicable

AKM Imaging Assessment B
This trigger assessment is tied to AK Imaging question 4 answer 'Other'.

1. Has the patient presented with new or changing symptoms or findings?
   ☐ Yes
   ☐ No

2. Is the requested imaging for diagnosis?
   ☐ Yes
   ☐ No

3. Is the requested imaging procedure required for treatment planning?
   ☐ Yes
   ☐ No

AFFIRMATION
Affirm that the submitted clinical documentation supports the requested stay/service(s) and are medically necessary and consistent with the recipient's current level of impairment.
☐ I affirm

Acknowledge the services are subject to post payment review of medical necessity and completeness of documentation according to Medicaid program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules.
☐ I acknowledge

Acknowledge that approval of this authorization request does not guarantee payment.
☐ I acknowledge

Exhibit 14 b

AKM 3 Day Benchmark Assessment *updated December 2020*

I affirm that the recipient's Medicaid eligibility has been confirmed.

☐ Yes

☐ No (Per the Alaska Medicaid Provider Manual, page 17 & 19, providers are responsible for evaluating Medicaid eligibility and third- party liability prior to submitting review requests to Comagine Health. For questions regarding eligibility or other insurance coverage, log on to the Conduent State Healthcare provider portal at www.medicaidalaska.com or call Conduent Provider Inquiry at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

1. Which one of the following scenarios apply to the patient post 72 hours of admission? (Select all that apply)
   - ☐ Is the patient in an ICU, CCU, or IMCU?
   - ☐ Is the patient admitted for a stroke that is confirmed by imaging (CT or MRI)?
   - ☐ Does the patient have intercranial hemorrhage?
   - ☐ Is the patient requiring a mechanical ventilator or requiring active titration of BiPAP?
   - ☐ Is the patient requiring IV fluids to maintain volume status or blood pressure?
   - ☐ Is the patient requiring high flow oxygen of 10 or more liters? (Via high flow nasal cannula)
   - ☐ Is the patient requiring active management of an arrhythmia with titration of IV meds?
   - ☐ Is the patient admitted with a respiratory diagnosis and requiring chest tube placement or active chest tube management?
   - ☐ Does the patient have ongoing transfusion requirements?
   - ☐ Was the patient involved in a major trauma (example: fall from greater than 20 feet, motor vehicle accident, ejection from a vehicle, motorcycle accident, or pedestrian/bicyclist vs motor vehicle collision) with an injury or severe polytrauma? For example: head, organ, or major fracture(s)
   - ☐ Did the patient sustain at least a 2nd degree burn with a minimum of 5% body surface area (BSA) with active treatment (wound care, surgery planned or on a ventilator)?
   - ☐ Did the patient sustain frostbite with active treatment orders (wound care or surgery)?
   - ☐ Does the patient require an hour per day of complex wound care and dressing changes?
   - ☐ Does the patient have a post-surgical ileus?
   - ☐ Does the patient have SBO with NGT and ongoing wall suction?
   - ☐ Did the patient have a total shoulder, hip, or knee replacement?
   - ☐ Does the patient require IV steroids?
   - ☐ Is the patient requiring PRN antipsychotics?
   - ☐ Is the patient requiring IV medications for pain control?
   - ☐ Does the patient require titration of IV diuretics?
   - ☐ Is the patient requiring IV antibiotics with pending cultures?
   - ☐ Does the patient have neutropenic fever?
   - ☐ Does the patient have a post-operative infection requiring IV antibiotics?
   - ☐ Does the patient have an acute infection with failed outpatient antibiotics?
   - ☐ Is the patient admitted with alcohol withdrawal syndrome and a CIWA score greater than 8?
   - ☐ Does the patient require a 1:1 sitter?
   - ☐ Does the patient have ongoing delirium?

☐ Is the patient less than 38 weeks gestation with +fern/loss of fluids or active bleeding?
☐ Is the patient admitted for preterm labor, active labor, or induction of labor?
☐ Does the patient have pre-eclampsia, HELP syndrome, or intrauterine growth retardation?
☐ Does the patient have post-partum fever or hemorrhage?
☐ Did the patient have a vaginal delivery after induction in the last two days?
☐ Did the patient have a cesarean section in the last 4 days?
☐ Is the patient a neonate born at less than 38 weeks gestation at birth?
☐ None of the above are applicable

AFFIRMATION

Affirm that the submitted clinical documentation supports the requested stay/service(s) and are medically necessary and consistent with the recipient's current level of impairment.

☐ I affirm

Acknowledge the services are subject to post payment review of medical necessity and completeness of documentation according to Medicaid program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules.

☐ I acknowledge

Acknowledge that approval of this authorization request does not guarantee payment.

☐ I acknowledge

Comagine Health

Exhibit 15

Retrospective Review Request Form

Providers with no access to the Qualis Health Provider Portal may use this form.
See Section 8 of this manual for additional information

PATIENT INFORMATION		Request date:
Patient Name	Patient Date of Birth	Insurance ID #

Insurance Information: ☐ AK Medicaid ☐ ID Medicaid ☐ WA Labor & Industries ☐ Private

FACILITY INFORMATION			
Facility	Admit Date	Discharge Date	Physician
UR Contact Person		UR Phone #	Fax #

Request Reason (check all that apply)

☐ Exceeds LOS ☐ Pre-service review late ☐ Other _____

☐ Medicaid patient (eligible post admit date) Eligible date _____

☐ Medicaid eligible (eligible before admit date) Eligible date _____

☐ Concurrent review late Previous authorization # _____

For lengths of stay **less than 15 days**, submit:

☐ UB 04 ☐ DC summary ☐ H & P ☐ Operative report (if applicable)

For lengths of stay **15 days or greater** & ID Medicaid psych diagnosis for patients under age 21:

SEND ENTIRE MEDICAL RECORD

Additional information needed for:

☐ Rehabilitation: weekly team meeting notes, functional status, goals

☐ Adult psychiatric/chemical dependency: MD and multi-disciplinary progress notes, medication administration record

ADDITIONAL INFORMATION MAY BE REQUESTED

Mail medical record to:
Qualis Health
PO Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-0400

For Internal Use Only - Calls Made for Additional Information

☐ _____ date ☐ _____ date ☐ _____ date

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Exhibit 16

Comagine Health

urac urac

CASE MANAGEMENT REFERRAL FORM

From: _____

RE: _____

Patient name _____

Patient SSN _____

Address _____

City _____ State _____

Zip _____ DOB _____

Phone (W) _____ (H) _____

Subscriber name _____

Subscriber number ____-____-____

Plan _____

Date of referral _____

Contact _____

Phone _____

Primary diagnosis _____

Secondary diagnosis _____

Current issues _____

Primary care physician _____

Phone _____

Physician specialist, if applicable _____

Specialty _____ Phone _____

Reason for referral _____

Expectations _____

Other _____

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Phone: (888) 578-2547 **Alaska Review Fax (877) 265-9549**

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Comagine Health

Exhibit 17

Maternal Newborn Length of Stay

Type of Delivery	# of Days Between Admit Date & Discharge Date	Delivery Date	Type of Prior Authorization
Vaginal	2 days or less	Any	None required
Vaginal	3 days	Day after admit date	Administrative PA from Conduent
Vaginal	3 days or more	More than one (1) day after admit date	PA (medical necessity review from Qualis Health)
Vaginal	Discharge more than 2 days after delivery	Any	PA (medical necessity review from Qualis Health)
Cesarean	4 days or less	Any	None required
Cesarean	5 days	Day after admit date	Administrative PA from Conduent
Cesarean	5 days or more	More than one (1) day after admit date	PA (medical necessity review from Qualis Health)
Cesarean	Discharge more than 4 days after delivery	Any	PA (medical necessity review from Qualis Health)

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