Comagine Health

2021 Spring Provider Training

Assessments, Prior Authorizations and Appeals

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Qualis Health & HealthInsight
have joined forces to do great things.



Together, we're reimagining health care.

Who We Are:
A national, nonprofit, health care consulting firm working collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system

Our Mission:
Together, with our partners, we work to improve health and to create a better health care system so that people and communities will flourish.

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About Us

- Our services:
  - Care Management
  - Systemwide Quality Improvement
  - Consulting and Research
  - Health IT and Analytics
- Providing care management to Medicaid and private contracts since 1984
- Office locations in Alabama, Alaska, California, District of Columbia, Idaho, Mississippi, Nevada, New Mexico, Oregon, Utah, and Washington state

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What We Do

- Contract with Alaska Medicaid to review for select services:
  - Imaging (IMG)
  - Pre-service surgical procedures
  - Initial and Concurrent inpatient reviews
  - Retrospective inpatient and outpatient reviews
- Utilize InterQual® (IQ), state guidelines, and organizational policies to conduct reviews
- Offer web-based and telephonic provider education

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What We Don’t Do

We do not receive financial incentives to deny or limit services

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Objectives

- Prior Authorization List
- Review Documentation Requirements
- Authorization Approval Time Frames
- Procedures
- Assessments
- Appeals
- Review Provider Resources

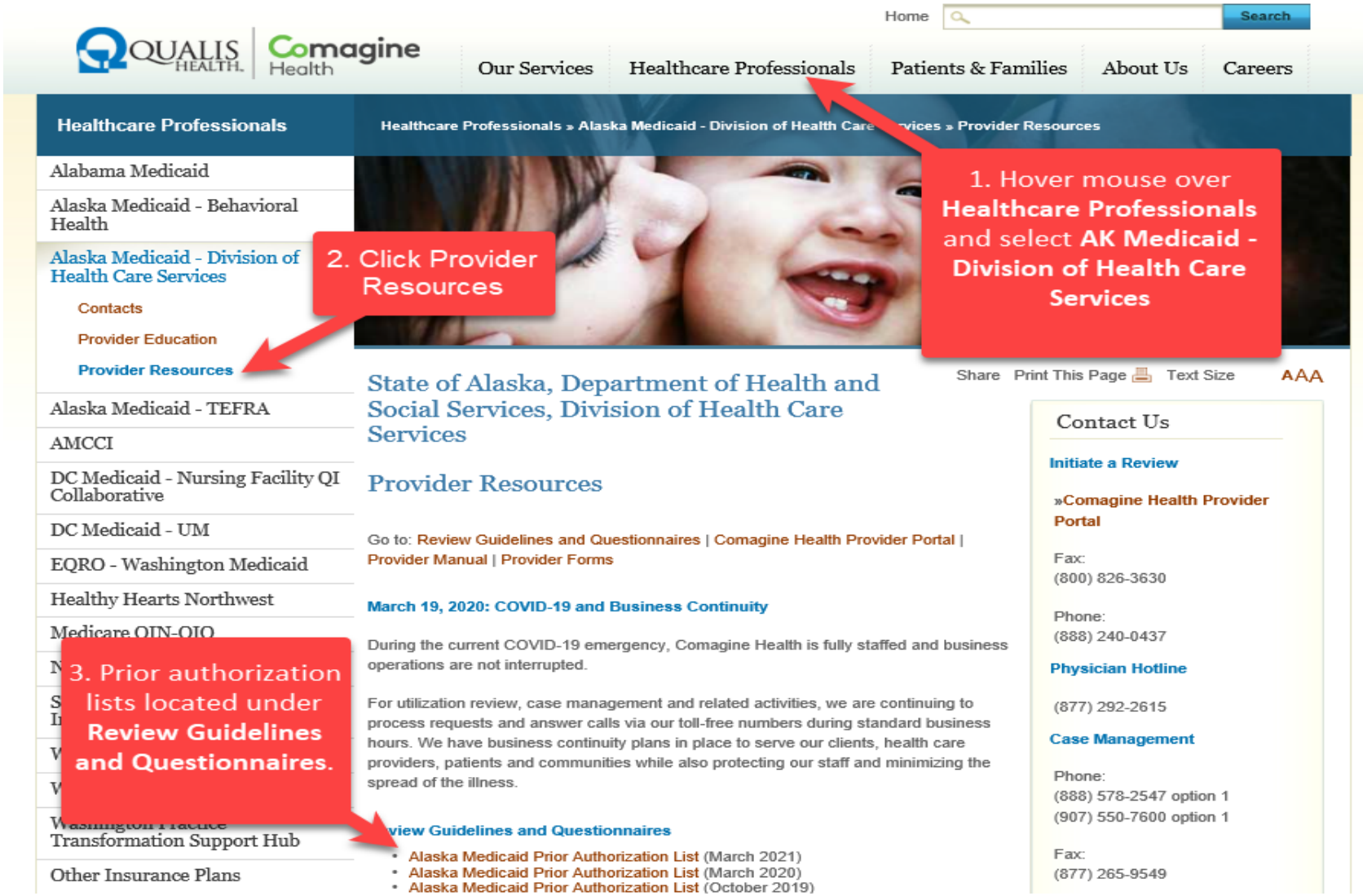
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Prior Authorization List

- Alaska Medicaid Prior authorization (PA) list
  - Contains procedures and services requiring PA
  - Updated on Qualis Health/Comagine Health website (www.qualishealth.org)
  - Revision date located on PA list
  - Save the link to the PA list and not the document

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Locating Prior Authorization List



Documentation Requirements

- Submit targeted clinical to support PA request
  - Per HIPAA, the minimum necessary is required
- Imaging assessments can stand alone if they contain sufficient clinical for the request
  - Additional documents can be uploaded but are not required
- AKM 3-day benchmark assessment for acute medical, neonatal and obstetric (OB) reviews require clinical to support the request
  - Clinical documents may be attached or submitted via Notes once assessment is completed

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Documentation Requirements, continued

- Dated progress notes for scheduled review
- Include any changes in the treatment plan
- Discharge plan and expected length of stay
- Entire chart is not required

- Word documents, PDFs and JPGs are acceptable attachment formats
- Image format files (.tif) are not accepted

Authorization Approval Time Frames

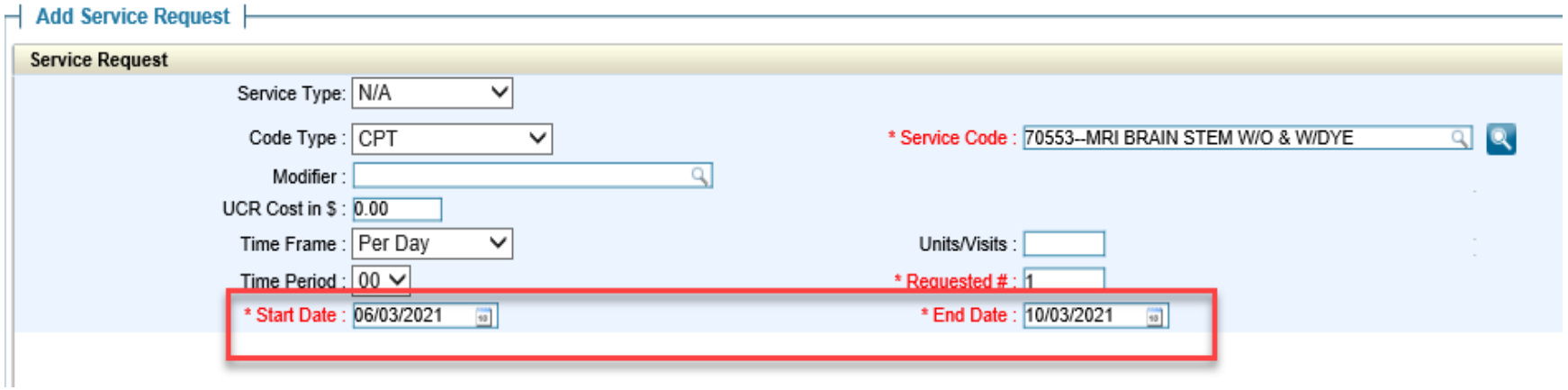
- IMG authorizations are valid for four months from the requested date of service
  - The date span must be entered when submitting the initial request
- Surgeries and procedures are valid for the requested date of service
- Transplants are valid for six months from the requested date of service
- Long term acute care hospital (LTACH) and rehabilitation (rehab) transfer approvals are valid for 7 days

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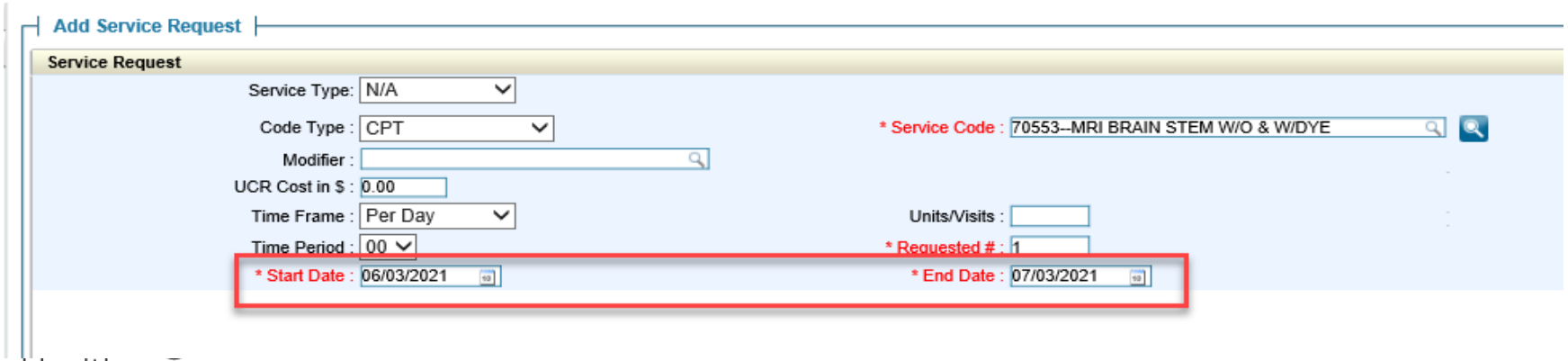
Imaging Authorization Submissions

Enter dates for imaging requests

- Providers to enter a four-month timespan when submitting the request through the portal



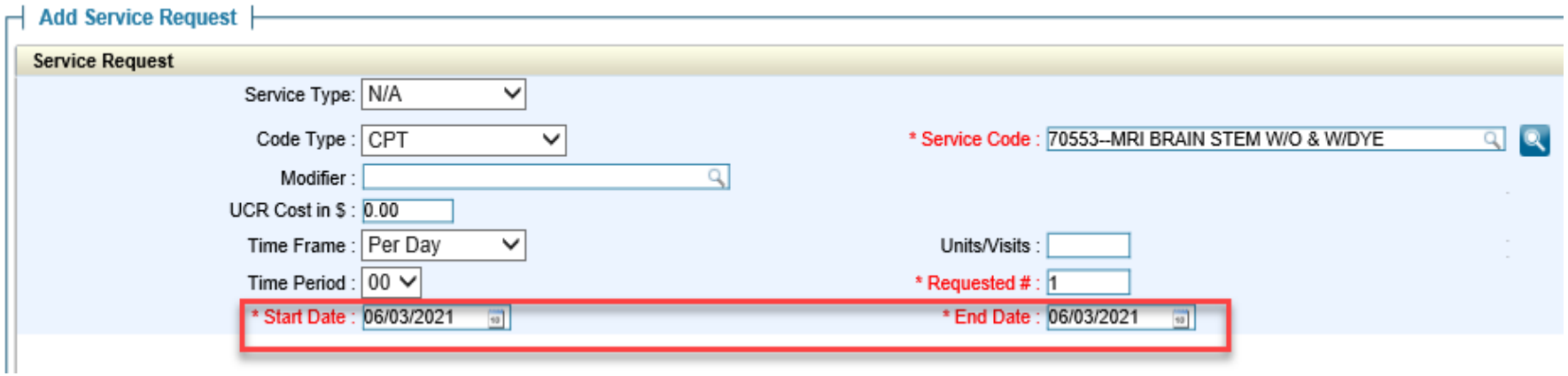
- If repeat imaging is to occur, you may enter a date span less than 4



Imaging Authorization Submissions, continued

Enter dates for imaging requests

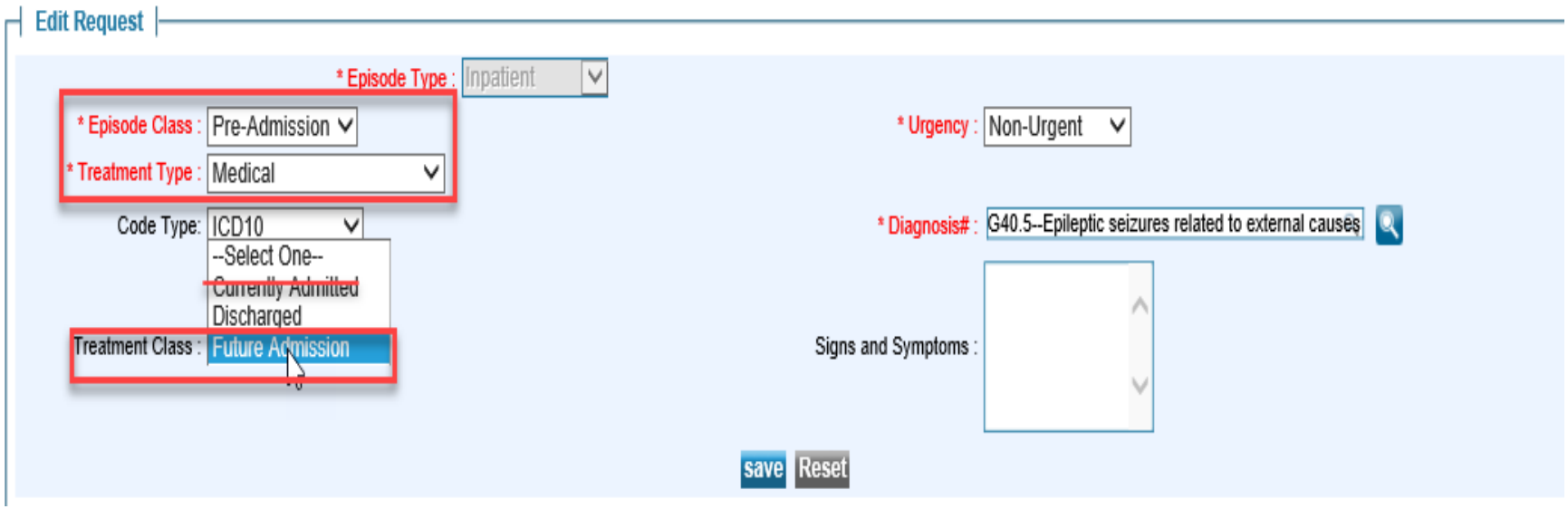
- Retrospective imaging requests will be for dates of completed service only



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Requests for Inpatient Video EEG

- Episode Class: **Pre-admission**
- Treatment type: **Medical**
- Treatment class: **Future Admission**
- Do NOT select **Currently Admitted**



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Imaging Assessment Questionnaires

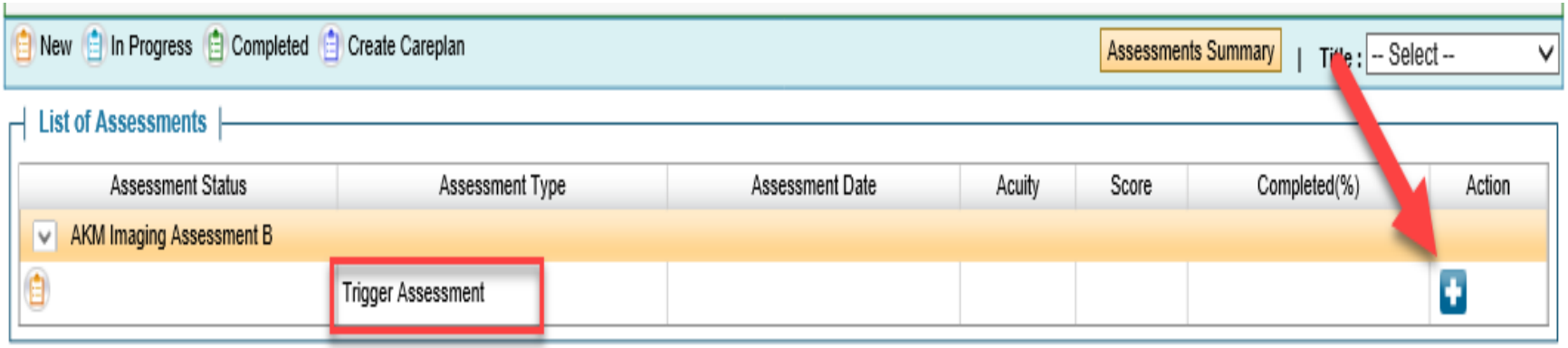
- Complete one assessment questionnaire per imaging request
- More than one assessment per request is allowed
- Required for PA and Retrospective reviews
- Correctly completed imaging assessment questionnaires do not require any additional information or documents
- Additional clinical documentation may be uploaded via the Comagine Health Provider Portal (CHPP) and are not required

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Imaging Assessment Example

Assessment Summary Report	
I affirm that the recipient's Medicaid eligibility has been confirmed. :	Yes
1. Is the imaging procedure being requested, for a work-related injury? :	No
2. Is the imaging procedure for an injury? :	No
3. What imaging procedure is being requested? (select ONE) :	MRI
4. Imaging procedure being requested to assess: (select ONE) :	70553
5. Part of body to be imaged: (select ONE) :	Brain
6. Reason for the requested imaging procedure: (include follow-up, pre/postop, accident, rule out dx, differential dx, etc.) :	New onset seizures after falling over a cliff while backpacking.
7. Previous Care completed: (select all that apply) :	Medications
Type of medication: :	Other: Tegretol started 05/30/2021
Other - date medication was completed: :	06/10/2021
Other - duration and results: :	Patient has been compliant with medications. He is still taking the medication.
8. Current treatment: (select all that apply) :	Not applicable
9. Brief description of the patients plan of care and any other information to be considered for this imaging review (Example: symptoms and duration, surgery/procedure planning, ruling out a diagnosis) :	Planning a Video EEG for next week.
10. Are you requesting additional imaging services in this episode? :	No

Imaging Trigger Assessment



Assessment Summary Report	
1. Has the patient presented with new or changing symptoms or findings? :	Yes
2. Is the requested imaging for diagnosis? :	Yes
3. Is the requested imaging procedure required for treatment planning? :	Yes
Affirm that the submitted clinical documentation supports the requested stay/service(s) and are medically necessary and consistent with the recipients 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

Assessment Questionnaires, continued

Acute Inpatient Initial Requests

- AKM 3-day benchmark for initial acute medical, neonatal and OB reviews require supportive clinical in either a WEB note or attached records.
- To prevent delays, submit targeted clinical progress notes, with dates included, for scheduled reviews
- Not required for LTACHs, Rehab, or surgical requests

Assessment Summary Report	
I affirm that the recipient's Medicaid eligibility has been confirmed. :	Yes
1. Which one of the following scenarios apply to the patient post 72 hours of admission? (Select all that apply) :	Is the patient admitted with a respiratory diagnosis and requiring chest tube placement or active chest tube management? Is the patient in an ICU, CCU, or IMCU? Is the patient requiring IV fluids to maintain volume status or blood pressure?
Affirm that the submitted clinical documentation supports the requested stay/service(s) and are medically necessary and consistent with the recipients 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

Appeals and Options Following a Non-Certification

All options	Details and information
Doctor-to-Doctor (DTD) consultations	• DTD is offered at the time of denial • Does not affect appeal rights • Also called a Peer-to-Peer consult • Request within 60 days of notice letter
Additional Information in lieu of a DTD	• Does not affect appeal rights or the right for a DTD • For denials based on lack of information • Request within 60 days of notice letter

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Appeals

Options	Details and Information
Expedited Appeal	• ONLY in a case involving urgent care • Person must be inpatient (IP) status • Providers to submit via the provider portal • Decision within 72 hours
Standard Appeal	• Submit via the CHPP (preferred) • Are completed internally and externally • Must decision within 30 days

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Appeals, continued

Options	Details and Information
Second-level appeal to the Division of Health Care Services (DHCS)	• Within 60 days to the State of Alaska
Fair Hearings	• Recipients' responsibility to request

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Appeal Documentation Details

- Submit clinical information specific to the denial decision and rationale
  - Clinical is not needed for dates or services already approved
- Upload clinical to the clinical documents tab (preferred)
  - Attach documents in categories and label records
  - For example, History and Physical (H&P), Clinical Note/Date, Plan of Care
- Suggested clinical:
  - MD orders/progress notes with exam, vital signs, ancillary results and plan of care
  - H&P if applicable and not submitted prior to appeal request
  - Discharge Summary (DC) if not submitted prior to appeal request
- The entire chart is not required and should not be submitted.

Utilization Management (UM) & Case Management (CM) Integration

- Most CM referrals are initiated from UM reviews
  - Medically complex patients
  - Support the DC plan
  - Long acute inpatient stays
- Potential non-certifications are referred to CM



Comagine Health Website Provider Resources

1. Go to http://www.qualishealth.org
2. Hover mouse over **Healthcare Professionals** (top of page)
3. Select **Alaska Medicaid - Division of Health Care Services**

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

Comagine Health Provider Portal Web-Based Utilization Management

- Registration and CHPP support
  - CHPP registration packet located on our website
    - Fax to (800) 826-3630
  - CHPP support contact
    - Teresa Kirn, Comagine Health, Clinical Manager and Yvette Stratton, Senior Director
    - Email: Tkirn@comagine.org and ystratton@comagine.org
    - Phone number: (888) 240-0437

Comagine Health Contact Information

Utilization Review

Toll-free phone
(888) 240-0437

Toll-free fax
(800) 826-3630

Utilization Review Hours

6:30 am to 5:00 pm Alaska Time
Monday through Friday



Utilization Management Questions

