SECTION IX: Medical Operations

OVERVIEW

The Care1st Medical Management (MM) program ensures that members get the right care from the appropriate service provider at the right place and at the right time. The framework of Care1st's MM Program drives the processes used to identify utilization patterns such as recidivism, adverse outcomes, and under/over utilization which may indicate quality of care issues. The program is further designed to identify and manage care for high risk members to ensure that appropriate care is delivered by accessing the most efficient resources. Finally, the MM program identifies opportunities to promote preventive health measures to decrease acute and chronic health care conditions. Care1st does not provide financial incentives for MM decision makers to encourage decisions that result in underutilization. Care1st does not reward practitioners, or other individuals involved in utilization review, for denying a service.

PRIOR AUTHORIZATION AND REFERRAL PROCESS

Prior authorization (PA) is a process by which Care1st determines in advance whether a service that requires prior approval will be covered, based on the initial information received. Services that require PA include though are not limited to all non-emergent services rendered by a non-participating care provider, vendor or facility and out-of-state services. Also any service considered experimental, investigational, or new technology procedures with by-report or new CPT codes require PA. PA may be pended until the receipt of required clinical documentation to substantiate compliance with criteria used by Care1st. For a complete list of services requiring authorization, refer to the online Care1st Arizona website: https://www.care1staz.com/az/providers/priorauthreferencegrid.asp.
Criteria used by Care1st to make decisions are available upon request.

The MM Department uses clinically sound, nationally developed and accepted criteria for making medical necessity decisions. Clinical criteria utilized in decision making include, but is not limited to:

- AHCCCS Guidelines
- InterQual Guidelines
- Official Disability Guidelines (ODG)
- American College of Obstetrics and Gynecology
- The American Academy of Pediatrics
- CMS Guidelines
- Centene/Care1st Guidelines
- Hayes, Inc.

PA is not a guarantee of payment. Reimbursement is dependent upon the accuracy of the information received with the original PA request, whether or not the service is substantiated through concurrent and/or medical review, eligibility, and whether the claim meets claims submission requirements.

AUTHORIZATION FORMS

PAs for medical services are requested on the *Medical/Behavioral Health Prior Authorization Form*. To obtain a Total OB authorization, submit a completed Pregnancy Risk Assessment Form and *ACOG Records*. Medications not listed on the Care1st Preferred Drug List (PDL) and Behavioral Health Preferred Drug List (BH PDL) are considered non-formulary drugs. Providers must submit prior authorization requests for all non-formulary medications and medications listed on the formulary with a PA requirement. Care1st will cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable. Prior Authorization forms are available on the Care1st website www.care1staz.com under the *Forms* section of the Provider menu. The Prior Authorization Guidelines and Formularies are also available on our website under the provider link. Providers without internet access may contact Network Management for a copy to be mailed or faxed to your office.

Requests for dental services that require authorization are submitted directly to Envolve Dental via mail, electronic clearinghouse, or Envolve Dental's provider web portal at www.envolvedental.com. Dental prior authorization requests sent by mail should be sent to:

Envolve Dental
PO Box 20132
Tampa, FL 33622-0132

The Envolve Dental Provider Manual identifies dental prior authorization and claim submission requirements and is available on the Envolve Dental website or by contacting Envolve Dental at (844-876-2028)

PRIOR AUTHORIZATION NUMBER SUBMISSION ON CLAIM

A PA number is issued by the PA Department for approved treatment authorization requests. The PA number must be included on the claim in order for claims adjudication and payment to occur.

1. UB-04 – place PA number in field 63
2. CMS 1500 – place PA number in field 23
3. ADA (J430D) – place PA number in field 2

A denial will occur if the PA number is not included for services requiring PA.

SECTION IX: Medical Operations

PRIOR AUTHORIZATION TIPS

- Please refer to the Prior Authorization Guidelines for procedures that require PA in addition to the visit. Prior authorization is required for some services when Care1st is the secondary payer.
- Please direct members to contracted providers including when Care1st is the secondary payer. All services requested for a non-contracted provider require prior authorization.
- For Specialties that require authorization for the initial consultation and/or follow-up visits, all visits and in-office procedures performed must fall within the authorization date range approved.
- Your PA request will be processed more expeditiously if you fax the completed Medical Health Prior Authorization Form with all supporting documentation and medical records. Allow sufficient time to process your request (especially on Friday afternoons following hospital discharges).
- Please contact Care1st for the status of your PA request before sending a duplicate request.
- Provide the past year's medical records and/or any supporting documents to justify request. Failure to submit supporting documents may delay processing.
- Provide laboratory results such as cultures and sensitivities, cholesterol panels, or any other pertinent lab results to expedite the medical necessity reviews for both medical and pharmacy requests.
- Prior authorization requests for medications are reviewed and completed within 24 hours of receipt. If needed, a 4- day supply of a non-excluded medication following a hospital or ED discharge can be obtained by calling the Care1st Pharmacy Department at 1-866-560-4042 (Options 5,5).

MEDICAL AND SERVICE AUTHORIZATION TIME FRAMES

Inpatient and outpatient referral requests for Care1st members that are received from primary care and specialty care physicians will be processed according to status within the following designated time frames:

Urgent - Processed and returned no later than 72 hours from date received by the PA Department as long as all necessary supporting medical documentation is included for review. Please remember not to use urgent for requests for member or provider convenience.

NOTE: Care1st reserves the right to review and downgrade urgent requests to routine status if determined not to be urgent. Urgent referrals are not for provider convenience and should only be used for urgently needed treatments. The requesting provider's office will be contacted by phone and fax if the team has determined a request should be downgraded to routine and allow the provider to submit additional documentation that would show the need for an urgent referral.

Routine- Processed and returned with authorization number within 14 calendar days from the date received by the PA Department. Providers will be notified of the determination via facsimile within one working day of making the decision.

Pended- Requests will be pended upon receipt for up to 28 calendar days if appropriate supporting documentation is not included with the request. Failure to submit supporting documentation will delay the processing of your request.

Note: If the information submitted is not adequate, it will be pended in order to afford the opportunity for the MM staff to obtain additional medical information.

For routine requests that are pended for more information, the PA Department will make two attempts to obtain any outstanding medical information that is required to make a determination based on medical necessity. This will increase the amount of time it takes to process the request and may take up to 28 days to complete the process. If two documented attempts to obtain additional information from the requesting provider have been unsuccessful, the applicable Medical Director will make a determination to approve, modify, or deny the authorization based on the medical information submitted by the provider.

Denial of authorization requests based on medical necessity occurs only after a Care1st Medical Director has reviewed the request and determines that the service does not meet criteria. You will receive notification that you can request a Peer to Peer discussion with a medical director if you have questions or concerns on the denial decision.

REFERRAL/PRIOR AUTHORIZATION PROCESS FROM PCP TO SPECIALIST

1. Select a contracted specialist.
2. Refer to the PA Guidelines to determine if an authorization is required.
3. If PA is NOT required, the PCP may contact the contracted specialist and schedule an appointment.
4. If PA is required, complete the Medical Health Prior Authorization Form, which must contain all supporting documentation including ICD-10 and/or CPT codes, and office fax number of the requesting provider. Supporting documentation should include physician progress notes, lab results, diagnostic test results and reports, consultant notes, or any other medical documentation from the medical record that is pertinent to the service being requested that will assist in making the decision.
5. Fax the completed Medical Health Prior Authorization Form and supporting documentation to the PA Department.
6. The PA Department will return the Medical Health Prior Authorization Form, with the authorization number, by fax.

7. After the approved Medical Health Prior Authorization Form has been received, contact the specialist and schedule the member's appointment. After the appointment has been made, send copy of approved Medical Health Prior Authorization Form to the authorized specialist.
8. Notify the member of the time, date, and location of the scheduled appointment.

SPECIALIST RESPONSIBILITIES

1. Schedule appointments for members in accordance with appointment availability standards when an appointment is requested by a contracted PCP.
2. If a member fails to appear for a scheduled visit the specialty care provider may reschedule the appointment within ninety (90) days without obtaining another PA number, as long as the member remains eligible with Care1st.
3. Use the PA number for billing purposes.
    - The PA number is valid for a consultation and two follow-up visits unless otherwise noted on the Medical Health Prior Authorization Form.
    - The PA number for a consultation is valid for ninety (90) days.
    - Authorizations for follow up visits are valid for ninety (90) days when given with a consultation, as long as the member retains eligibility with Care1st.
4. Verify member eligibility prior to all appointments (see note below).
5. Provide scheduled services.
6. Provide a copy of the consultation notes to the member's PCP.
7. If the Specialist plans to perform a surgery or a special procedure that requires PA, a Medical Health Prior Authorization Form must be completed and faxed to the PA Department.
    - The specialist must attach a legible consult note or clearly written documents to support the request along with appropriate ICD-10 and CPT codes.
    - Upon receipt of the Medical Health Prior Authorization Form, the PA Department will review and approve the procedure as necessary. An authorization number will be issued and noted on the Medical Health Prior Authorization Form then faxed back to the specialist. Authorization numbers for procedures remain valid for ninety (90) days. After that time, the request must be re-submitted to Care1st.
8. Ensure medical care is appropriate and consistent with each member's individualized health care needs.

NOTE: Claims will not be reimbursed if authorization is not obtained prior to date of service or if the member is not eligible with Care1st on the date of service. To verify member eligibility, providers should contact the Customer Service Department or use our secure Provider Portal on our website. It is the responsibility of the providers to verify eligibility prior to rendering services.

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REFERRAL PROCESS FROM SPECIALIST TO ANOTHER SPECIALIST

When a specialist needs to refer a member to another specialist, it is not necessary for the member to be referred back to the PCP. The referring specialist should follow the guidelines as outlined above.

REFERRALS TO DENTAL PROVIDERS

1. Prior authorizations, claim submissions and claim inquiries are submitted to Envolve Dental. For additional information see Section VI Covered Services.
2. Members may schedule their own appointment with any contracted general dentist.
3. The Envolve Dental Provider Manual provides detailed information regarding prior authorization and claim submission requirements. The Envolve Dental Provider Manual is available on the Envolve Dental website at envolvedental.com or by contacting Envolve Dental at 800.440.3408. All dental offices must verify member eligibility prior to rendering services.
4. After dental services are provided, the dentist is responsible for sending a printed report to the PCP to be included in the member's medical record.

ELECTIVE INPATIENT CARE

For Care1st members who require elective inpatient care (acute hospital), the admitting physician should:

- Complete the Medical Health Prior Authorization Form, which must contain all supporting documentation including ICD-10 codes, CPT codes, and office fax number of the requesting provider.
- Fax the Medical Health Prior Authorization Form to the PA Department.
- For urgent requests, the PCP may call the PA Department. NOTE: Medical information will be required over the phone to justify medical necessity for approval of the service being requested.
- The PA Department will return the Medical Health Prior Authorization Form with the authorization number via fax.
- After the approved Medical Health Prior Authorization Form has been received, contact the hospital and schedule the member's hospitalization and send approved Medical Health Prior Authorization Form to the authorized facility.

Providers who provide services on a fee-for-service basis for inpatients must use the applicable hospital's PA number on the claim.

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EMERGENCY DEPARTMENT CARE

Care1st does not require PA for a member to receive emergency services. Members may seek care at any emergency department in the event of an emergency.

REFERRALS TO ANCILLARY PROVIDERS

Providers should follow the instructions outlined above under "Referral Process from PCP to Specialist", considering the following:

DURABLE MEDICAL EQUIPMENT

Covered durable medical equipment (DME) must be medically necessary and prescribed by a PCP or specialist. DME can be obtained by directly contacting the Care1st contracted DME Provider.

Please include the following information when faxing your request:

1. Member information
    - Name
    - AHCCCS identification number
    - Phone number
    - Address
    - Diagnoses
    - Weight
2. Amount, type and size of equipment desired including HCPC code
3. Completed and signed Certificate of Medical Necessity (for oxygen and motorized wheelchair).
4. Recent room air oxygen content (RA O2) must be 88% or less, if the request is for oxygen

The following limitations apply:

- Reasonable repairs or adjustments of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of repair is less than the cost of rental or purchase of another unit. The equipment must be considered medically necessary by Care1st.

- The rental of such equipment shall terminate no later than the end of the month in which the member no longer needs the medical equipment as certified by the authorized provider or when the member is no longer eligible or enrolled with Care1st (except during transitions of care as specified by the Care1st Medical Director).

- If the duration of medically necessary rental equipment exceeds the cost of purchase, the Care1st Medical Director shall make the determination of rental or purchase of said equipment.

HOME HEALTH CARE AND HOME INFUSION

- Home Health Care and Home Infusion is obtained by directly contacting a Care1st contracted provider.
- If a Care1st member requires long term Home Health Care or Home Infusion a referral to the Care Management Division is made by the PA Department.

OUTPATIENT RADIOLOGY SERVICES

- Refer to the Care1st PA Guidelines for imaging services which require prior authorizations.
- Select a Care1st contracted provider from the Radiology Grid.
- Contact the contracted provider to schedule an appointment.
- It is the responsibility of the imaging service provider to verify member eligibility prior to rendering services.

OUTPATIENT LABORATORY SERVICES

- Complete laboratory requisition and direct member to a Care1st contracted laboratory site.
- If specimen is collected in office, contact the contracted laboratory for pick-up.
- PCPs and Specialists may perform in-office labs based on the Clinical Laboratory Improvement Amendments (CLIA) test complexity categorization provisions utilized by AHCCCS. In order for a lab to be payable, AHCCCS must allow the lab to be performed in POS 11. Practices with CLIA certifications must ensure that each CLIA certification is on file at AHCCCS for each provider and that each provider has an agency code of 200 noted on the AHCCCS PR020 Licenses/Certifications screen. All other laboratory services must be performed by Sonora Quest.

ORTHOTICS AND PROSTHETICS

When referring a Care1st member for orthotic/prosthetic services, the provider's office must submit a Medical Health Prior Authorization Form along with supporting documentation and appropriate HCPC code(s). Once approved, the orthotic/prosthetic provider will contact the member for fitting and delivery.

REHABILITATION SERVICES (OCCUPATIONAL/PHYSICAL/SPEECH THERAPY)

- For all AHCCCS members under 21, select a contracted provider for referral and fax a completed Medical Health Prior Authorization Form to the PA Department for review and approval.
- Speech Therapy for members 21 years and older is not an AHCCCS covered benefit.
- Outpatient physical therapy (PT) and occupational therapy (OT) visits for members 21 years and older are limited to 15 visits for the purpose of rehabilitation to restore a level of function and 15 visits for the purpose of keeping or getting to a level of function, for a total of 30 PT visits and 30 OT visits per contract year (10/1-9/30).

NUTRITIONAL SUPPLEMENTS FOR ELIGIBLE EPSDT MEMBERS

Members receiving oral nutritional supplements are tracked through the PA process or through ongoing reports received from the nutritional vendor. PCPs are required to complete the "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" Form. The "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" form may be found at http://www.azahcccs.gov/shared/downloads/MedicalPolicyManual/Chap400.pdf, pp. 90-91.

- Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or specialist. Providers requesting oral nutritional supplements should submit the completed medical necessity form to the nutritional vendor or to PA for review and approval.
- The PCP or specialist must document that nutritional counseling has been provided to the member. The documentation must include alternatives that have been tried.
- The completed medical necessity form must indicate the criteria that are met. At least two criteria must be met. The criteria includes:
    - The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more.
    - The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent).
    - The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment).
    - The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

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UTILIZATION REVIEW CRITERIA

Care1st has adopted utilization review criteria developed by InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the Participant's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Practitioners may obtain the full criteria used to make a specific adverse determination by contacting the Prior Authorization at 1-866-560-4042 (Option 5, 6). Examples of criteria that may be utilized are Care1st Clinical Policies and InterQual® criteria appropriate to clinical condition and member's unique needs (e.g. Adult, Geriatric, Child, Adolescent, and Behavioral Health/Psychiatry). Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling Care1st's main toll-free phone number at 1-866-560-4042 and asking for a Peer Review with the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals, with the Member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Care1st Health Plan Arizona
Attn: Grievance and Appeal Department
1850 W. Rio Salado Parkway, Suite 211
Tempe, AZ 85281
833-619-0415

CARE COORDINATION

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to Care1st members assigned to them, and

attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

1. Referring members to providers, vendors or hospitals within the Care1st network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
2. Coordinating with Care 1st's Prior Authorization Department with regard to prior authorization procedures for members;
3. Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals;
4. Coordinating the medical behavioral health care of the Care1st members assigned to them, including at a minimum:
    - Oversight of drug regimens to prevent negative interactive effects;
    - Follow-up for all emergency services and coordination of inpatient care;
    - Coordination of services provided on a referral basis; and
    - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

CARE MANAGEMENT

The Care1st Care Management (CM) program is a collaboration between Care Managers, members and providers, which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet the members' health care needs. The Care Management Program is developed to specifically address the needs of the members with complex medical or social conditions, high utilization, high costs, special needs, or high-risk conditions. The focus is on assisting members to use medical, social, or community resources effectively to maximize their quality of life.

Care Management will identify, support and engage our most vulnerable members at any point in the health care continuum and help them achieve improved health status. The goal is to decrease fragmentation of healthcare service delivery, to facilitate appropriate utilization of available resources, and to optimize member outcomes through education, care coordination and advocacy services for the medically compromised populations served. The program integrates medical, behavioral, and socioeconomic assistance to members by facilitating assessment of risk and health needs, coordination of care/benefits, service delivery, community resources, and education. Care Management will provide for continuity of care, transition of care, and coordination of care or services for all members' needs in an integrated and member-centric fashion.

Our objectives include:

- Increasing member engagement with the PCP and PCP-referred specialists
- Increasing member understanding and use of plan benefits

- Increasing member awareness of community resources available to help improve their quality of life
- Increasing members understanding of diseases/conditions
- Decreasing unnecessary emergency room utilization
- Decreasing unnecessary hospital visits and admissions
- Encouraging members to self-manage their conditions effectively and develop and sustain behaviors that may improve the member's quality of life; and
- Optimizing member's health outcomes.

Care Management is available to all members. Potential candidates for CM include, but are not limited to the following:

- Members with complex, chronic or co-morbid conditions such COPD,CHF, CAD, Diabetes, Asthma, HIV/AIDS, depression
- Members discharged home from acute inpatient or SNF with multiple services and coordination need
- Members requiring care coordination
- High utilizes of services such as pharmacy or emergency departments (either by cost or volume)
- Special populations (e.g., aged, blind, disabled, HIV-positive, substance abusers, pregnant women, special needs children, members with behavioral health needs, serious mental illness (SMI)

Identification of members in need of care management can come from a variety of different referral sources. Member identification occurs through, but not limited to:

- Data mining through claims, utilization management, hospital census/discharge reports, lab, and pharmacy data
- Predictive modeling information allowing care management to identify members at high risk for increased utilization of the healthcare system due to poorly controlled medical conditions.
- Health Assessment Survey (HAS) outcomes
- Direct Referrals to the Program include but not limited to:
    - Internal staff/department referrals such as Member Services, Medical Directors, Prior Authorization, Concurrent Review, CRS Coordinator, Quality, Pharmacy, and Behavioral Health
    - Practitioner referrals
    - 24/7 Nurse Line
    - Crisis Line
    - Member or caregiver self-referral.
    - External agency working with the member including AHCCCS, or CMS

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The Care Management Department will determine whether a member is appropriate for care management services by gathering and critically assessing relevant, comprehensive data, and potential positive healthcare effectiveness.

Care management process

- Screening and identification of members with high risk health problems or situations that could respond to care management
- Assessing members needs and determining barriers to care
- Developing an individualized care plan with inputs from the member and the PCP/Specialist(s)
- Identifying and implementing effective interventions, including exploration of alternative resources
- Working collaboratively with members' practitioners and providers as well as with other disciplines inside and outside the plan
- Coordinating care for defined conditions/diseases to attain optimal clinical and quality of life outcomes
- Providing education, support, and monitoring for the member, member's family, and others involved in care
- Working to ease barriers for members with special needs or cultural or language requirements
- Assisting members through Transitions of Care including but not limited to hospital to home.

Evaluating continuously the care plan to update and/or revise to accurately reflect the current member's needs.

To refer a patient to the care management program, please contact our Team at 1-866-560-4042

DISEASE MANAGEMENT

Care1st provides Disease Management programs to assist practitioners in managing members diagnosed with targeted chronic illnesses. Conditions included in disease management initiatives are those that frequently result in exacerbations and hospitalizations (high-risk) that require high usage of certain resources, and that have been shown to respond to coordinated management strategies.

Disease management activities include interventions such as:

- Assessment of member's risk and needs
- Education about disease, medications and self management
- Adherence monitoring
- Assistance with finding or coordinating resources and/or exploring alternative resources

- Working to ease barriers for members with special needs or cultural or language requirements

Potential candidates for Disease Management are identified thought:

- Administrative data such as medical and pharmacy claims
- Laboratory data
- HEDIS data
- Self reported data through health risk assessments
- Provider referrals
- Member and family self referrals
- Internal referrals from Care1st staff members

Disease management programs are structured around nationally recognized evidence-based guidelines. The guidelines are posted on the Care1st website: https://www.care1staz.com/providers/resources/disease-managment1.html.

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

To refer a patient to the disease management program, please contact our Team at 1-866-560-4042

PHARMACY MANAGEMENT

FORMULARY

The Care1st formularies, including updates, are made available as PDF documents on our website www.care1staz.com. Updated Drug Lists can be viewed on our website www.care1staz.com based on P&T implementation dates. Currently, AHCCCS P&T updates are effective April 1, July 1, and October 1. The Pharmacy department will send out formulary updates to all contracted providers 30 days prior to implementation via Blast Fax. Providers may also contact Network Management for a copy. Please ensure that your office is prescribing medications listed on the current formularies. Before submitting a Prior Authorization Request for a non-formulary drug or medication that requires PA, consider all formulary alternatives. The Care1st Preferred Drug List and Behavioral Health Preferred Drug List can be found on the Care1st website at www.care1staz.com. Submit Drug Prior authorization requests and supporting documentation to Care1st for review:

- Electronically via Cover My Meds
  - http://www.covermymeds.com/main/prior-authorization-forms/
- Via fax using the appropriate Prior Authorization form
- By calling our pharmacy department at 866-560-4042 (option 5, 5)

Care1st utilizes the AHCCCS Drug List as mandated by Policy 310-V. Our website contains a link to the AHCCCS Drug List on the AHCCCS website.

1. AHCCCS developed the AHCCCS Drug List of the medications that are available to all members when medically necessary.
2. AHCCCS' goal is to use the AHCCCS Drug List to assist providers when selecting clinically appropriate medications for AHCCCS members.
3. The AHCCCS Drug List is not an all-inclusive list of medications.
4. The AHCCCS Drug List specifies medications available without prior authorization as well as medications that have specific quantity limits, or require step therapy and/or prior authorization prior to dispensing to AHCCCS members.
5. Health plans are required to cover all medically necessary, clinically appropriate, cost effective medications that are federally and state reimbursable.

Care1st's formulary is more extensive than the AHCCCS PDL – it includes the medications listed on the AHCCCS Drug List and additional drugs necessary to meet the needs of our specific patient population. Our Prescription Benefit Manager manages all prescription drug transactions and pharmacy networks for all lines of business.

DRUG UTILIZATION MANAGEMENT TOOLS

For certain drugs, there are additional requirements for coverage. These requirements ensure appropriate drug therapy is utilized by the most cost effective means. A team of physicians and pharmacists develop the specific requirements. Examples of these utilization management tools include:

Prior Authorization (PA) is the process by which certain drugs are reviewed against specific prior authorization criteria that is developed by either AHCCCS P&T or Care1st P&T prior to allowing the prescription to be filled. PA'd drugs on the pharmacy benefit will not adjudicate prior to obtaining PA approval. For drugs on the medical benefit, if prior approval is not received, then the drug may not be approved for payment.

Quantity Limits (QL) are designed to identify the excessive use of drugs which may be dangerous in large quantities and to highlight the potential need for a different type of treatment. Quantity limits define the amount of the drug that is covered per prescription or for a defined period of time (for example, per month).

Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary. The aims are to control costs and minimize risks. Also called step protocol.

Step-therapy allows coverage only after specific preferred medications are tried first. When applied to a pharmacy plan, step-therapy requires one or more prerequisite,

clinically equivalent drugs (in many cases less expensive) to be tried before certain "step-therapy" drugs will be covered.

Antipsychotics and Lithium: All antipsychotics and lithium medications must be prescribed by an in-network behavior health specialist per AHCCCS AMPM Policy 310-V. Please contact the Care1st Network Management Department at 866-560-4042 (Options 5, 7) to be added to the antipsychotic-lithium prescriber network.

All requests for non-formulary drugs will be reviewed for medical necessity and for prior use of formulary alternatives.

PRESCRIPTION DRUG COVERAGE LIMITATIONS

1. A new prescription or refill prescription in excess of a 30-day supply or a 90-unit dose is not covered unless:

    a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 90 days or 90-unit dose, whichever is greater; or

    b. The medication is prescribed for contraception and the prescription is limited to no more than a 90-day supply.

    c. Care1st does not currently provide prescriptions for more than 30-day supply except in the instances outlined above.

2. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies.

3. AHCCCS covers the following for AHCCCS members who are eligible to receive Medicare:

    a. Over-the-counter medications that are not covered as part of the Medicare Part D prescription drug program and meet the requirements in section D of this policy.
    b. Medications for persons determined to have a SMI, regardless of Title XIX/XXI eligibility, when their third-party insurer (Medicare or private insurance) denies coverage for a medication that is a covered behavioral health medication on the Preferred Drug List.
    c. Medicare Part D copays for persons determined to have a SMI, when the medication is used to treat a behavioral health diagnosis.
    d. Short-term medication coverage for non-Title XIX/XXI SMI and dual eligible SMI members who have opted out of Medicare part D when:
        a. The member is unable to obtain required documentation to support an eligibility determination, or

b. Due to their mental status, the member is unable or refuses to participate in a Medicare Plan D, AND they do not have a legal guardian.

e. For dual eligible SMI members, Care1st provides secondary coverage of their Medicare-covered prescription medications for the remainder of a calendar year after they have been in a medical institution funded by Medicaid for a full calendar month.

PHARMACY BENEFIT EXCLUSIONS

1. Medication prescribed for the treatment of a sexual or erectile dysfunction, unless prescribed to treat a condition other than a sexual or erectile dysfunction and the Food and Drug Administration has approved the medication for the specific condition.

2. Medications that are personally dispensed by a physician, dentist or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.

3. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the Food and Drug Administration

4. Outpatient medications for members under the Federal Emergency Services Program, except for dialysis related medications for Extended Services individuals

5. Medical Marijuana. Refer to Policy 320-M, *Medical Marijuana*

6. Drugs eligible for coverage under Medicare Part D for Care1st members eligible for Medicare whether or not the member obtains Medicare Part D coverage.

7. Experimental medications are excluded from coverage.

8. Medications furnished solely for cosmetic purposes.

VACCINES AND EMERGENCY MEDICATIONS ADMINISTERED BY PHARMACISTS TO PERSONS AGE 19 YEARS AND OLDER

Care1st covers vaccines and emergency medication without a prescription order when administered by a pharmacist who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and state law ARS §32-1974.

1. For purposes of this section "Emergency Medication" means emergency epinephrine and diphenhydramine. "Vaccines" are limited to AHCCCS covered vaccines as noted in the AMPM Policy 310-M

2. The pharmacy providing the vaccine must be an AHCCCS registered provider (see note below regarding Indian Health Services (IHS)/638 outpatient facilities).

3. Vaccine administration by pharmacists is limited to the Care1st network pharmacies.

4. Influenza Vaccinations are available in pharmacies for all AHCCCS members ages 3 years of age and older during the flu season.

5. COVID-19 vaccinations are covered through the member's medical and pharmacy benefit depending on the setting vaccine is being administered.

PHARMACY PRIOR AUTHORIZATION

If a drug requires prior authorization, the request should be completed by the prescribing physician/physician's representative. The required information must be provided in order for the request to be considered. Only pertinent clinical documentation should accompany the request.

Pharmacy Benefit requests for pharmacy-dispensed drugs may be:

- Faxed to Care1st at 602-778-8387 or
- Phoned in at 866-560-4042 (Options 5, 5) or
- Submitted via Electronic Prior Authorization (ePA) through Cover My Meds http://www.covermymeds.com/main/prior-authorization-forms/

The turn-around time (TAT) for review of Drug Prior Authorization requests is as follow:

24 hours – All Drug Prior authorization requests are processed and returned no later than 24 hours from date received by the Pharmacy PA Department as long as all necessary supporting medical documentation is included for review.

7 business days- Missing information requests will be pended upon receipt for up to 7 business days if appropriate supporting documentation is not included with the request. Failure to submit supporting documentation will delay the processing of your request.

Determinations for coverage will be faxed to the requesting provider, and denials are mailed to the patient (member)/guardian. Step therapy requests are handled the same as prior authorization requests. All pertinent information regarding previous drug therapy should be included.

Requests for uses outside the accepted indications (off-label use) will require documented clinical support (e.g., published clinical trials, nationally accepted practice guidelines) concluding that the treatment is safe and effective for the requested diagnosis, patient age, and dosage regiment requested.

LIMITED SPECIALTY NETWORK:

Care1st Medicaid has a Limited Specialty Network primarily for chronic conditions that require Specialty Medications dispensed through the pharmacy benefit. The Limited Specialty Network was developed with 3 key areas of focus:

- Specialty Pharmacy Certification
- Documented and proactive adherence management to minimize gaps and identify barriers to care AND
- Drug therapy management programs to promote cost effective drug management

The current pharmacies included in our Limited Specialty Network include:

AcariaHealth	Multiple Locations Nationwide	1-800-511-5144
CVS Caremark Specialty Pharmacy	Multiple Locations Nationwide	1800-237-2767 OR 1-866-387-2573

Contact Pharmacy Prior Authorization at 866-560-4042 (Options 5, 5) if you have any questions.

CONCURRENT REVIEW

Care1st provides for continual reassessment of all acute inpatient care. Concurrent review includes both admission certification and continued stay review. Concurrent review is performed by nurses who work closely with the medical director in reviewing documentation for each case. Other levels of care such as partial day hospitalization or skilled nursing care may also require concurrent review at Care1st's discretion. Review may be performed on-site or may be done via telephone or fax. The authorization is given for the admission day and from then on, contingent upon the inpatient care satisfying criteria for that level of care. This would include the professional services delivered to the inpatient on that day. Any exceptions to this (i.e. procedures, diagnostic studies, or professional services

provided on an otherwise medically necessary inpatient day which do not appear to satisfy criteria) will require documented evidence to substantiate payment. Care1st uses the Milliman Care Guidelines® to ensure consistency in hospital-based utilization practices. A copy of individual guidelines pertaining to a specific case is available for review upon request. Providers are notified when there are denials given for a specific day.

RETROSPECTIVE REVIEW

Care1st reserves the right to perform retrospective review of care provided to its member for any reason. Additionally, care is subject to retrospective review when claims are received for services not authorized. There may also be times, during the process of concurrent review (especially telephonic) that the Concurrent Review Nurse is not satisfied with the concurrent information received based on the Milliman Care Guidelines®. When this occurs the case will be pended for a full medical record review by the Chief Medical Officer.

PRACTICE GUIDELINES

Care1st utilizes practice guidelines, criteria, quality screens and other standards for certain areas of medical management, disease management, and preventive health. Our guidelines follow nationally accepted standards and are reviewed and approved by our Medical Management Committee, which is comprised of both clinical staff and network physicians. Updates occur annually or more frequently if needed. If you have questions on our guidelines or would like a hard copy of our guidelines mailed to your office you may contact Network Management.