Establish Case

CM Case Management	
Establish Case	
Item	**Details**
Description	The Care Management, ***Establish Case*** business process uses criteria and rules to: • Identify target members for specific programs. • Assign a care manager. • Assess the member's needs. • Select a program. • Establish a treatment plan. • Identify and confirm provider. • Prepare information for communication. This business process may establish a case for one individual, a family or a target population such as: • Medicaid Waiver program case management o Home and Community-Based Services (HCBS) o Other • Disease management • Catastrophic cases • Early Periodic Screening, Diagnosis, and Treatment (EPSDT) • Vaccines for children and adults • Population management This business process may initiate a case from claim processing indicators such as: • Several claims for an individual member over a time interval. • New claims close to discharge date. • Claims containing one of the with the following: o Place of Service – Certain Places of Service o Discharge Date o Admit Date o PWK - Attachments containing lab results, treatment plans, etc. o NTE - Notes containing discharge plans, goals, treatment plan o EPSDT Referral Claim o Claims containing certain types of the following information: ✓ Principle Diagnosis ✓ Admitting Diagnosis ✓ Patient Reason for Visit ✓ Other Diagnosis Information ✓ Principle Procedure ✓ Other Procedure

CM Case Management	
Establish Case	
Item	**Details**
	✓ Condition Info ✓ Treatment Code o Prescription drug claim o CLIA certification o Home Health claim o Test Result Different criteria and rules, relationships, and information define each type of health care case and require different types of external investigation. The Health Information Exchange (HIE) provides health information and clinical records for member and care coordination with provider and other agencies.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic review to scan for new cases is due. • Request to look into a specific case. Interaction-based Trigger Events to include but not limited to: • An alert triggered by other events, such as a targeted diagnosis or referral generated from information submitted on a claim. • Receive enrollment of member from ***Enroll Member*** business process. • Receive information to establish a case (e.g., Electronic Data Interchange (EDI)).
Result	• List of members associated with cases and programs. • Assessment of the needs of the member for care management. • Treatment Plan for member. • Associated Providers List. • Case file information. • Communications information for providers and members. • Alert to notify member of care management case. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Identify candidates for new cases with specific criteria (e.g., patient characteristics, medical conditions, location, or age). 2. Identify information requirements and parameters to include such items as periods of time, data elements, and data relationships. 3. Identify new case(s) for care management based on requirements and parameters. 4. Create case record for each new case.

CM Case Management	
Establish Case	
Item	**Details**
	5. Assign care manager. 6. Care manager reviews health and clinical information from Health Information Exchange (HIE). 7. Assess the needs of the member for care management. 8. Based on needs, determine which program(s) is appropriate for the member. 9. Based on needs, establish treatment (care) plan that identifies the services the member needs to receive, the types of providers, the care setting, frequency, and expected results. 10. Based on the treatment plan, select providers to deliver the services, contact and confirm availability, record decisions. 11. Record care management determination and related information. 12. **END:** Send alert to notify member of care management case.
Shared Data	Member data store including demographics Health Information Exchange (HIE) data store including health information, clinical record and clinical information Enterprise Master Patient Index (EMPI) for single and complete view of patient information Provider data store including provider network information Health Benefits data store including programs and services Information
Predecessor	**Receive Inbound Transaction** ***Enroll Member*** ***Manage Applicant and Member Communication*** ***Manage Member Grievance and Appeal*** ***Identify Utilization Anomalies***
Successor	**Send Outbound Transaction** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Authorize Treatment Plan*** ***Manage Treatment Plan and Outcomes***
Constraints	States and programs within States use different criteria to establish cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. States will conform to required Affordable Care Act requirements for EPSDT and immunizations case management.
Failures	• Details of the case are inconsistent with criteria; discontinued case.

CM Case Management	
Establish Case	
Item	**Details**
Performance Measures	• Time required to establish a case. • Effectiveness of selection criteria in determining real cases.

Manage Case Information

CM Case Management	
Manage Case Information	
Item	**Details**
Description	The ***Manage Case Information*** business process uses state-specific criteria and rules to ensure appropriate and cost-effective medical, medically-related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as: • Medicaid Waiver program case management • Home and Community-Based Services (HCBS) • Other agency programs • Disease management • Catastrophic cases • Early Periodic Screening, Diagnosis, and Treatment (EPSDT) • Immunizations for children and adults The ***Establish Case*** business process creates each individual case and treatment plan. The ***Manage Case Information*** business process includes activities to confirm delivery of services and compliance with the plan. It also includes activities such as: • Service planning and coordination. • Facilitation of services (e.g., finding providers, or establishing limits or maximums). • Advocating for the member. • Monitoring and reassessment of services for need and cost effectiveness. o This includes assessing the member's placement and the services received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs. The Health Information Exchange (HIE) provides health information and clinical records for member and care coordination with provider, pharmacist, and other agencies.
Trigger Event	Environment-based Trigger Events to include but not limited to:

	• Periodic timetable (e.g. monthly, quarterly) review of a case is due. • Monitor member's case activity. • Receive case modifications (e.g., create, update, or delete). Interaction-based Trigger Events to include but not limited to: • Receive information regarding services delivered/not delivered (including claims information). • Receive health plan or health benefit modification that may affect a treatment plan. • Receive information regarding an enrollment modification, including disenrollment. • Receive information regarding modification in member's conditions or situation.
Result	• Updated case history with possible revision to the following: o Case history o Needs assessment o Treatment Plan o Associated Providers List o Case file information (e.g., contact dates and times) • Content of communications sent to providers and members. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request to review case (review of the member's status and needs). 2. Based on review, take follow-up action, as needed, to: o Identify services delivered, issues impeding delivery of service and/or member's progress. o Establish appointment with member to review case status. o Contact provider(s) to review member's progress. o Review services provided (claims payment information). o Close case for non-chronic conditions or change in member's status. 3. Revise treatment plan to: o Add or remove services. o Change nature of plan (e.g. shifting drug regimen, shifting from drug to behavioral). o Reassess needs. o Revise expected results. 4. **END:** Send alert to notify of care management modifications or care coordination updates.

Shared Data	Member data store including demographics Health Information Exchange (HIE) data store including health information, clinical record and clinical data Enterprise Master Patient Index (EMPI) for single and complete view of patient information Provider data store including provider network information Health Benefits data store including programs and services Information Case History data store including action lists, journal notes, reviews and approvals
Predecessor	**Receive Inbound Transaction** ***Perform Screening and Assessment*** ***Establish Case*** ***Authorize Referral*** ***Authorize Service*** ***Authorize Treatment Plan*** ***Manage Treatment Plan and Outcomes***
Successor	**Send Outbound Transaction** ***Authorize Treatment Plan*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Population Health Outreach*** ***Manage Registry*** ***Submit Electronic Attachment*** ***Manage Data***
Constraints	States and programs within States use different criteria to manage cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. States will conform to required Affordable Care Act requirements for EPSDT and immunizations case management.
Failures	• Information required to manage case is not available or is inaccurate.
Performance Measures	• The State Medicaid Agency (SMA) updates cases within the timeframe specified by state policy. • Movements towards desired health care outcomes because of improvements in case management practices.

Manage Population Health Outreach

CM Case Management	
Manage Population Health Outreach	
Item	**Details**
Description	The ***Manage Population Health Outreach*** business process is responsible for the implementation of strategy to improve general population health. The State Medicaid Agency (SMA) identifies target populations or individuals for selection by cultural, diagnostic, or other demographic indicators. The inputs to this business process are census, vital statistics, immigration, and other information sources. This business process outputs materials for: • Campaigns to enroll new members in existing health plan or health benefit. • New health plan or health benefit offering. • Modification to existing health plan or health benefit offering. It includes production of information materials and communications to impacted members, providers, and contractors (e.g., program strategies and materials, etc.). The communication of information includes a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI).
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive information from census, vital statistics, public health departments, immigration, and other information sources. • Periodic timetable (e.g., monthly, quarterly) to distribute information is due. • Receive new population or problem-specific legislated health improvement initiatives. • Receive request for information from other originators (e.g., federal actions or constituency interests). Interaction-based Trigger Events to include but not limited to: • Receive alert from Establish Case to place member into care management monitoring.
Result	• The SMA produces outreach communications (e.g., mailing brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements) and distributes to targeted populations or individuals. The SMA may also conduct face-to-face meetings. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for outreach materials or communication. 2. Target population identified and defined by analyzing information, performance measures, feedback from community, and policy directives. 3. Approve, deny, or modify decisions to develop outreach communications. 4. Determine content and method of communication (e.g., email, mail, publication,

CM Case Management	
Manage Population Health Outreach	
Item	**Details**
	mobile device, facsimile, telephone, web or EDI). 5. Determine performance measures. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message sent to target population. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).
Shared Data	Member data store including demographic information Provider data store including provider network Information Contractor data store including provider network Information Plan data store including policy information Health Benefit data store including program and service information Data from external agencies including: census, vital statistics, immigration, and various health registries
Predecessor	There are several business processes that can result in the interest or need to reach out to the Medicaid population in an attempt to improve behavior or promote prevention: ***Identify Utilization Anomalies*** ***Manage Performance Measures*** ***Manage Member Grievance and Appeal*** ***Manage Provider Grievance and Appeal*** ***Manage Health Plan Information***
Successor	***Manage Applicant and Member Communication*** ***Perform Population and Member Outreach*** ***Manage Provider Communication*** ***Perform Provider Outreach*** ***Manage Contractor Communication*** ***Manage Performance Measures***
Constraints	Agencies do not coordinate amongst each other in order to share information. Potential political and inter-agency conflicts over appropriate use of health care information.

CM Case Management	
Manage Population Health Outreach	
Item	**Details**
Failures	• Inter-agency agency communication or lack of access to information impairs ability to gather information to support strategies.
Performance Measures	• Time to complete communication: By phone __ minutes; by email __hours; by mail __ days • Accuracy of communications = __% • Communications successfully delivered = __%

Manage Registry

CM Case Management	
Manage Registry	
Item	**Details**
Description	The ***Manage Registry*** business process receives a member's health outcome information, prepares updates for a specific registry (e.g., immunizations, cancer, disease) and responds to inquiries with response information. In the context of MITA, a medical registry consolidates related records from multiple sources (e.g., intrastate, interstate or federal agencies) into one comprehensive data store. This data store may or may not reside within the Medicaid information system.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive inquiry for health outcome information. Interaction-based Trigger Events to include but not limited to: • Receive health outcomes that The State Medicaid Agency (SMA) sends to a registry.
Result	• The SMA prepares and sends response to inquiry for health outcome. • The SMA prepares and sends updated health outcome. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive member's health outcome information. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 3. Validate that the provided information is authentic. 4. Prepare submittal for member's health outcome information to registry. 5. **END:** Send member's health outcome information to registry.

CM Case Management	
Manage Registry	
Item	**Details**
	Alternate Path: 1. **START:** Receive request for health outcome information. 2. Validate requestor has authorization to receive desired information. 3. Prepare submittal for member's health outcome information to requestor. 4. **END:** Send member's health outcome information to requestor.
Shared Data	Health Registry data store including health outcomes (e.g., immunizations, cancer, heart, diabetes, or disease) Data sources needed for validation of registry information Enterprise Master Patient Index (EMPI) for single and complete view of patient information
Predecessor	**Receive Inbound Transaction** ***Manage Case Information*** ***Manage Health Plan Information***
Successor	**Send Outbound Transaction** ***Manage Provider Communication*** ***Manage Contractor Communication***
Constraints	State and federal regulations regarding entities authorized to access registry information.
Failures	• The SMA is unable to find registry information to update. • Requestor does not have authorized access to the Registry.
Performance Measures	• Time to complete registry update = __days • Successful delivery rate of responses = __%

Perform Screening and Assessment

CM Case Management	
Perform Screening and Assessment	
Item	**Details**
Description	The ***Perform Screening and Assessment*** business process is responsible for the evaluation of member's health information, facilitating evaluations and recording results. This business process assesses for certain health and behavioral health conditions (e.g., chronic illness, mental health, substance abuse), lifestyle and living conditions (e.g., employment, religious affiliation, living situation) to determine risk

CM Case Management	
Perform Screening and Assessment	
Item	**Details**
	factors. This business process: • Establishes risk categories and hierarchy, severity, and level of need. • Screens for required fields. • Edits required fields. • Verifies information from external sources if available. • Establishes severity scores and diagnoses. • Associates with applicable service needs. Health Information Exchange (HIE) verifies a member's health information.
Trigger Event	Interaction based Trigger Events: • Receive new member enrollment alert from ***Enroll Member*** business process. • Receive redetermination of member enrollment alert from ***Enroll Member*** business process.
Result	• Member notified of applicable services as needed. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive new member or redetermination of member enrollment from ***Enroll Member*** business process. 2. Assign Care Manager. 3. Gather information for history and/or examinations. 4. Determine risk factors and establish risk categories. 5. Conduct needs assessment and determines level of need. 6. Determine health benefits that are appropriate for the member. 7. Staff records screening and assessment results. 8. Associate member to applicable services based on results. 9. **END:** Send alert to notify member of applicable services based on screening and assessment.
Shared Data	Member data store including demographic information Health Information Exchange (HIE) data store including health information, clinical record and clinical data Plan data store including policy information Health Benefit data store including program and service information Case History data store including action lists, journal notes, reviews and approvals

CM Case Management	
Perform Screening and Assessment	
Item	**Details**
Predecessor	***Enroll Member***
Successor	***Manage Case Information*** ***Manage Applicant and Member Communication***
Constraints	States may have different screening requirements and health benefits. Agencies do not coordinate between each other in order to share information. Potential political and inter-agency conflicts over appropriate use of health care information.
Failures	• Care Manager is unable to acquire history and/or examination information.
Performance Measures	• Timeliness to complete process = within __ days • Accuracy with which changes are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Manage Treatment Plan and Outcomes

CM Case Management	
Manage Treatment Plan and Outcomes	
Item	**Details**
Description	The ***Manage Treatment Plan and Outcomes*** business process uses federal and state specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes member and member population outcomes. It includes activities to track and assess effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. It also includes ongoing monitoring, management, and reassessment of services and treatment plans for need, appropriateness, and effectiveness, and monitoring of special member populations (e.g., pregnant women and children, and HIV/intravenous drug users). Health Information Exchange (HIE) monitors a member's health information.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receipt from Health Information Exchange (HIE) of a modification in member's health outcome. • Receive treatment plan from ***Establish Case*** business process. Environment-based Trigger Events to include but not limited to: • Periodic review of member's treatment plan is due.

CM Case Management	
Manage Treatment Plan and Outcomes	
Item	**Details**
	• Receive request to review member's treatment plan.
Result	• Member's treatment plan and outcomes are appropriate for their needs. • Send modification (e.g., creates, update, delete) to member's treatment plan sent to Health Information Exchange (HIE). • Member, provider and care coordinators notified of modifications in treatment plan or benefits. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive member's treatment plan from ***Establish Case*** business process. 2. Review of effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. 3. Determine if modifications are necessary for effective treatment outcome. 4. Record required modifications to member's treatment plan. 5. **END:** Send notification to member, provider and other care coordinators of modification in treatment or benefits. <u>Alternate Path:</u> 1. **START:** Receive treatment plan from Health Information Exchange (HIE). 2. Review of effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. 3. Determine if modifications are necessary for effective treatment outcome. 4. Record required modifications to member's treatment plan. 5. Send notification to member, provider, and other care coordinators of modification in treatment or benefits. 6. **END:** Send modification to member's treatment plan or benefits to Health Information Exchange (HIE).
Shared Data	Member data store including demographic and social information Health Information Exchange (HIE) data store including health information, medically-related social and support services, clinical record, and clinical data Case History data store including action lists, journal notes, reviews, and approvals
Predecessor	**Receive Inbound Transaction** ***Establish Case***

CM Case Management	
Manage Treatment Plan and Outcomes	
Item	**Details**
	Authorize Treatment Plan
Successor	**Send Outbound Transaction** ***Authorize Treatment Plan*** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication***
Constraints	Agencies do not coordinate amongst each other in order to share information. Potential political and inter-agency conflicts over appropriate use of health care information.
Failures	• Care Manager is unable to acquire treatment plan information.
Performance Measures	• Timeliness to complete process = within __ days • Accuracy with which changes are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Authorize Referral

CM Authorization Determination	
Authorize Referral	
Item	**Details**
Description	The ***Authorize Referral*** business process is responsible for referrals between providers that the State Medicaid Agency (SMA) approves for payment, based on state policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. The SMA uses this business process primarily for Primary Care Case Management programs where additional approval controls deemed necessary by the state. Most States do not require this additional layer of control. **NOTE:** MITA contains three (3) different authorization business processes: 1. ***Authorize Service*** – the standard process of prior authorization of services. 2. ***Authorize Treatment Plan*** – the approval of a treatment plan prepared by a care management team in a care management setting. 3. ***Authorize Referral*** – specifically the approval of a referral to another provider, requested by a primary care physician. The ***Authorize Referral*** business process may encompass both a pre-approved and post-approved referral request, especially in the case where the member required

CM Authorization Determination	
Authorize Referral	
Item	**Details**
	immediate services. This business process may include, but is not limited to, referrals for specific types and numbers of visits, procedures, surgeries, tests, drugs, durable medical equipment, therapies, and institutional days of stay. The SMA evaluates requests based on urgency, state priority requirements, and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state). It validates key information, and ensures that the referral is appropriate and medically necessary. After review, staff approves, modifies, suspends for additional information or denies the request. This business process sends an alert to ***Manage Case Information*** business process. A post-approved referral request is an editing/auditing function that requires review of information after the referral is complete. A review may consist of verifying documentation to ensure that the referral is appropriate, and medically and/or functionally necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the ***Process Claim*** or ***Process Encounter*** business processes.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive referral request from Health Information Exchange (HIE) via Accredited Standards Committee (ASC) X12 278 Health Care Services Review Request and Response transaction. • Receive referral request from requestor via ASC X12 278 Health Care Services Review Request and Response transaction. Environment-based Trigger Events to include but not limited to: • Provider submits a request to refer patient to other service providers in accordance with state policy. • Provider submits additional information for existing referral request.
Result	• Send the authorize referral response to the referring provider and the consulting provider. • Alert to send referral information to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Manage Applicant and Member Communication*** to send notification of authorized referral response. • Alert sent to ***Manage Case Information*** business process for purposes of responding to member inquiries about the status of a referral request or a filing of a grievance or an appeal about the referral response. • Tracking information as needed for measuring performance and business

CM Authorization Determination	
Authorize Referral	
Item	**Details**
	activity monitoring.
Business Process Steps	1. **START:** Receive referral request from authorized provider. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. 4. Assign a tracking number. 5. Prioritize Referral Authorization Request. 6. Validate the following: 7. Member eligibility– for social service model, this entails assessing member's health, functional, and socio-economic status 8. Eligibility for requesting and referral providers 9. Service coverage and referral requirements 10. Diagnosis code 11. Procedure code/or procedure groupings 12. Check for medical or functional necessity and appropriateness. 13. Check against current referral authorizations for duplicates. 14. Validate completeness of supporting documentation. 15. Deny based on insufficient/erroneous information for referral. Go to step 13. 16. Suspend the referral request based on need for additional information – send request for additional information. Go to step 13. 17. Approve referral request (this includes approved with modifications). 18. Send alert to send referral authorization to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. 19. **END:** Send alert to notify member, referring provider, and referred-to provider of authorization determination. <u>Alternate Path:</u> For the authorization of some services, States may use the post-approval rather than the prior authorization business process. The post-approval business process will cover all steps listed above, but they may execute in a different order depending on state rules.

CM Authorization Determination	
Authorize Referral	
Item	**Details**
Shared Data	Member data store including demographic information Provider data store including provider network Information Health Information Exchange (HIE) data store including health information, clinical record, and clinical data Claims data store including adjudication information Plan data store including health benefits information
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter***
Successor	**Send Outbound Transaction** ***Process Claim*** ***Process Encounter*** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Submit Electronic Attachment***
Constraints	The authorize referral request information will conform to the format and content in accordance with state-specific reporting requirements, e.g., using a HIPAA Transaction Standard Companion Guide.
Failures	• The SMA receives incomplete referral request information. • Requestor not authorized to make referral request. • Member not eligible for referred provider services.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which referral authorizations are approved or denied = ___% • Consistency of decisions in approving or denying referral authorizations = ___% • Error rate = __% or less

Authorize Service

CM Authorization Determination	
Authorize Service	
Item	**Details**
Description	The ***Authorize Service*** business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. Its primary use is in a fee-for-services setting. Prior authorization of a service request is a care management function and begins when a care manager requests a service request by mail, facsimile, telephone, or Accredited Standards Committee (ASC) X12 278 Health Care Services Review Information request transaction. The care manager evaluates requests based on state rules for prioritization such as urgency and type of service/taxonomy (e.g., durable medical equipment, speech, physical therapy, dental, and out-of-state), validates key information, and ensures that requested service is appropriate and medically necessary. After review, staff approves, modifies, denies or suspends for additional information the service requests. The State Medicaid Agency (SMA) sends the appropriate response information for the outbound ASC X12 278 Health Care Services Review Response transaction to the provider using the **Send Outbound Transaction.** **NOTE:** MITA contains three (3) different authorization business processes: 1. ***Authorize Service*** – the standard process of prior authorization of services. 2. ***Authorize Treatment Plan*** – the approval of a treatment plan prepared by a care management team in a care management setting. 3. ***Authorize Referral*** – specifically the approval of a referral to another provider, requested by a primary care physician. A post-approved service request is an editing/auditing function that requires review of information after the service is complete. A review may consist of verifying documentation to ensure that the services were appropriate and medically necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the ***Process Claim*** **or** ***Process Encounter*** business processes. **NOTE:** This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, and Off-label use of drugs, Social Service, Experimental Treatments, Out-of-State Services, and Emergencies.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive service request from Health Information Exchange (HIE) via ASC X12 278 Health Care Services Review Request and Response transaction. • Receive service request from requestor via ASC X12 278 Health Care Services Review Request and Response transaction. Environment-based Trigger Events to include but not limited to: • Provider submits a request for service in accordance with state policy. • Provider submits additional information for existing service authorization request.

CM Authorization Determination	
Authorize Service	
Item	**Details**
Result	• Service authorization response sent to requestor. • Alert to send service information to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Manage Applicant and Member Communication*** to send notification of authorized service response. • Alert sent to ***Manage Case Information*** business process for purposes of responding to provider or member inquiries about the status of service request or a provider or member filing of a grievance or an appeal about the service authorization response. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive service authorization request from authorized provider. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. 3. Validate that the provided information is authentic. 4. Assign a tracking number. 5. Prioritize Service Authorization Request. 6. Validate the following: 7. Member eligibility – for social service model, this entails assessing member's health, functional, and socio-economic status 8. Requesting and servicing providers 9. Service coverage and referral requirements 10. Diagnosis code 11. Procedure code/or procedure groupings 12. Check for medical or functional necessity and appropriateness. 13. Check against current service authorizations for duplicates. 14. Validate completeness of supporting documentation. 15. Deny based on insufficient/erroneous information or authorization for service not

CM Authorization Determination	
Authorize Service	
Item	**Details**
	medically necessary. Go to step 13. 16. Suspend the authorization request based on need for additional information. Go to step 13. 17. Approve service authorization request (this includes approved with modifications. 18. Send alert to send service authorization to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. 19. **END:** Send alert to notify member and requesting provider of service authorization determination. <u>Alternate Path:</u> For the authorization of some services, States may use the post-approval rather than the prior authorization business process. The post-approval business process includes all steps listed above, but process executes in a different order depending on state rules.
Shared Data	Member data store including demographic information Provider data store including provider network Information Health Information Exchange (HIE) data store including health information, clinical record, and clinical data Plan data store including health benefits information Claims data store including adjudication information
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter***
Successor	**Send Outbound Transaction** ***Process Claim*** ***Process Encounter*** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Submit Electronic Attachment***
Constraints	The authorize service request information will conform to the format and content in accordance with state-specific reporting requirements, e.g., using a HIPAA Transaction Standard Companion Guide.

CM Authorization Determination	
Authorize Service	
Item	**Details**
Failures	• The SMA receives incomplete service authorization request. • Requestor (provider) is not eligible for enrollment or does not have authority to make service authorization request for particular service. • Member is not eligible for services.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which service authorizations are approved or denied = __% • Consistency of decisions in approving or denying service authorizations = __% • Error rate = __% or less

Authorize Treatment Plan

CM Authorization Determination	
Authorize Treatment Plan	
Item	**Details**
Description	The ***Authorize Treatment Plan*** business process encompasses both a prior authorization and post-approved treatment plan. The State Medicaid Agency (SMA) uses the Authorize Treatment Plans primarily in the care coordination setting where the care management team assesses the member's needs, decides on a course of treatment, and completes the treatment plan. **NOTE:** MITA contains three (3) different authorization business processes: 1. ***Authorize Service*** – the standard process of prior authorization of services. 2. ***Authorize Treatment Plan*** – the approval of a treatment plan prepared by a care management team in a care management setting. 3. ***Authorize Referral*** – specifically the approval of a referral to another provider, requested by a primary care physician. A treatment plan prior-authorizes the named providers or provider types and services or category of services. The SMA prior authorizes individual providers for the service or category of services, and they do not have to submit their own prior authorizations or service requests. A treatment plan typically is a schedule of medical, therapeutic, and /or psychological procedures and appointments that spans a length of time designed to restore a patient's specific health condition. In contrast, the SMA limits an individual service request, primarily associated with fee-for-services payment, to focus on a specific visit, services, or products (e.g., a single specialist office visit, approval for a specific test or particular piece of Durable Medical Equipment (DME)). The prior authorized treatment plan generally begins with the receipt of an authorize treatment plan request from the care management team. The SMA staff then evaluates it based on urgency, state priority requirements, and type of service/taxonomy (speech, physical therapy, home health, behavioral, social), and

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	validates key information, and ensures that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, staff approves, modifies, suspends for additional information or denies the request. Business process sends an alert to ***Manage Case Information*** business process. A post-approved treatment plan is an audit function that reviews suspended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive treatment plan request from Health Information Exchange (HIE) via Accredited Standards Committee (ASC) X12 278 Health Care Services Review Request and Response transaction. • Receive treatment plan request from requestor via ASC X12 278 Health Care Services Review Request and Response transaction. Environment-based Trigger Events to include but not limited to: • Care manager submits a request for treatment plan authorization. • Provider submits a request for treatment plan authorization in accordance with state policy. • Provider submits additional information for existing treatment plan request.
Result	• The SMA sends the authorization response to requestor. • Alert sent with treatment plan information to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Manage Applicant and Member Communication*** to send notification of authorized treatment plan response. • Alert sent to ***Manage Case Information*** business process for purpose of responding to provider or member inquiry about the status of a treatment plan authorization or member filing of a grievance or an appeal about treatment authorization response. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for Treatment Plan authorization for authorized provider or care manager. 2. Assign a tracking identifier. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all

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	required fields. 4. Validate that the provided information is authentic. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. 5. Prioritize authorize treatment plan request. 6. Validate the following: 7. Member eligibility 8. Eligibility for requesting and servicing providers 9. Service coverage and plan of treatment requirements 10. Diagnosis code 11. Procedure codes/or procedure groupings 12. Check for medical, social, and behavioral appropriateness. 13. Check against currently authorized treatment plans and service requests for duplication. 14. Coordinate services (check for duplicates) across programs and systems. 15. Validate completeness of supporting documentation. 16. Deny based on insufficient/erroneous information or treatment plan identifying services not medically, socially, and/or behaviorally necessary. Go to step 14. 17. Suspend the treatment plan request based on the need for additional information. Send a request for additional information. Go to step 14. 18. Approve plan of treatment request (this includes approved with modifications) and send approval response information to requesting parties. 19. Send alert to send treatment plan authorization to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. 20. **END:** Send alert to notify member, care manager, and provider of authorization determination.
Shared Data	Member data store including demographic information Provider data store including provider network Information Health Information Exchange (HIE) data store including health information, clinical record, and clinical data Plan data store including health benefits information Claims data store including adjudication information
Predecessor	**Receive Inbound Transaction**

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	Establish Case ***Manage Case Information*** ***Manage Treatment Plan and Outcomes***
Successor	**Send Outbound Transaction** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Submit Electronic Attachment*** ***Manage Treatment Plan and Outcomes***
Constraints	The authorize treatment plan information will conform to the format and content in accordance with state-specific reporting requirements, e.g., using a HIPAA Transaction Standard Companion Guide.
Failures	• Invalid beneficiary, invalid provider, invalid service, invalid dates, conflicting diagnosis, and treatment plan.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which the SMA approves treatment plan = __% • Consistency of decisions in approving or denying treatment plans = __% • Error rate = __% or less