

Clinical Services

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Our mission is to promote excellence in health care through education and evaluation.

- Core Service
 - Conduct timely review of medical records/information to determine if healthcare services requested/rendered to Medicaid beneficiaries are medically necessary, meet professionally recognized standards, and are delivered in the appropriate setting.

Before you submit

- Prior Authorizations and Concurrent Reviews
 - Does the code require a PA?
 - Does the beneficiary have coverage?
 - Are the requested dates of services within the timely filing deadline?
 - If needed, have you obtained a waiver?
 - Do you have all of the required documentation gathered?
- Retrospective Reviews
 - Do you have the ENTIRE medical record for that specific visit?

Types of Reviews Performed

- Prospective Reviews
 - Anesthesia
 - Assistant Surgeon
 - Hyperalimentation
 - Hyperbaric Oxygen Therapy
 - Inpatient Services
 - Continued Inpatient Services (MUMP)
 - Acute Crisis Unit
 - Lab Molecular Pathology
 - Orthotics and Prosthetics
 - Physician Administered Drugs
 - Professional Services
 - Surgical Procedures
 - Ventilators and Equipment
 - Viscosupplementation

Types of Reviews Performed continued

- Retrospective Reviews
 - Lab and Radiology
 - Professional Services
 - Extension of Benefits for office visits
 - Inpatient Retro
 - Emergency Room Visits
 - Hospital Acquired Conditions
- Concurrent Reviews
 - Inpatient Services
 - Continued Inpatient Services (MUMP)
 - Acute Crisis Unit

Electronic Submission

- AFMC ReviewPoint
 - For Inpatient Retro, Emergency Room, and Hospital Acquired Condition Reviews
- MMIS/interChange Healthcare Portal
 - For all other process/review types

Benefits of Electronic Submission

- Can be accessed 24/7
- Records can be directly attached to the request
- Secure and HIPAA compliant
- Reduces time and expense associated with paper submissions
- FREE

Review Process

- Request received via MMIS HealthCare Portal or AFMC ReviewPoint
- Initially reviewed by a Clinical Services Specialist- RN
- Referred to physician advisor, if necessary, for medical necessity determination
- Letters are mailed to the address on file with Arkansas Medicaid
 - Important – Read the denial rationales on the letters

Time Frames

- Concurrent Reviews
 - 72 hours
- Prospective Reviews
 - 15 calendar days
- Retrospective Reviews
 - 30 calendar days
- Reconsideration Reviews
 - 30 calendar days
- Urgent/Expedited Requests
 - 72 hours

Denials

- Reconsiderations
 - Reconsideration rights are listed on initial denial letter
 - Submit the requested information through the portal
 - Must be submitted within 35 days from the date of the letter
 - Include a copy of the denial letter
 - Denials and partial denials are determined by a Physician Advisor
- Appeal options
 - Appeal rights are listed on the initial denial letter

Suspended Reviews

- Not a denial
- On hold
- Attach/submit additional information

Contact Information

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Questions?

- Does anyone have any?