State of Arkansas Department of Human Services
710-19-1002 Prior Authorization Reviews
Attachment B
Written Questions

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Instructions

This Response Template must be used for submission of written questions. All questions should provide the requested information. Those that do not, may not be answered by DHS. The Vendor may add as many lines as needed. DHS would strongly prefer the Vendor to ask multi-part questions as individual questions on separate lines.

Instructions: Complete all cells of each question asked in the Table below. Clearly identify the referenced section or text.

Question ID	IFP Reference (page number, section number, paragraph)	Specific RFP Language	Question	Question ID	Answers
Example	*page 3 Section 1.9 "A"*	States to submit to the Buyer on page 1	*How does the State wish to have the questions submitted?*	*Example*	*Submit via email the form, attachment B, to the Buyer's email address shown on page 1*
1	Page 8, Section 1.23, B	Technology Access…Prospective Contractor expressly represents and warrants to the State of Arkansas through the procurement process by submission of a Voluntary Product Accessibility Template (VPAT) (see Attachment J)…that the technology provided to the State for purchase is capable, either by virtue of features included within the technology, or because it is readily adaptable by use with other technology, of...	At what point during the procurement process is the VPAT to be submitted? It is not listed in Section 1.7.3 (IFP page 3) as a component of the Bid Response Packet.	1	With the bid submission.
2	Page 11, Section 2.3	Scope of Work - General Question	What is the 2017 denial rate for each review type on the current contract?	2	Unknown.
3	Page 11, Section 2.3	Scope of Work - General Question	What are the number of calls coming to the current contractor on a monthly basis related to the scope of work on contract from providers and beneficiaries?	3	Unknown.
4	Page 11, Section 2.3	Scope of Work - General Question	What national guidelines (e.g., InterQual), if any, does the current Contractor use for this contract? If national guidelines are not in use what is the source of the criteria; Contractor, state or a combination?	4	See IFB Sections 2.5, 2.6 and 2.7.
5	Page 11, Section 2.3, A.2	The collective term "Retrospective Review" (RR) shall apply to all reviews of submitted or paid claims based on medical necessity, proper standard of care or other standard for review.	How will claims be provided to vendor?	5	See the updated IFB and attached interface document for file layout for Vendor to receive claims data.
6	Page 11, Section 2.3, A.2	The collective term "Retrospective Review" (RR) shall apply to all reviews of submitted or paid claims based on medical necessity, proper standard of care or other standard for review.	What file format will be used to transfer claims information to the Contractor?	6	See answer to Question 5.
7	Page 11, Section 2.3, A.2	The collective term "Retrospective Review" (RR) shall apply to all reviews of submitted or paid claims based on medical necessity, proper standard of care or other standard for review.	What is the standard timeframe for delivery of claims information?	7	See answer to Question 5.
8	Page 11, Section 2.3, A.2	The collective term "Retrospective Review" (RR) shall apply to all reviews of submitted or paid claims based on medical necessity, proper standard of care or other standard for review.	Will field mapping and other claim file documentation be provided to ensure understanding of the claims process and accurate application of random sampling?	8	See answer to Question 5.
9	Page 11, Section 2.3, A.2	The collective term "Retrospective Review" (RR) shall apply to all reviews of submitted or paid claims based on medical necessity, proper standard of care or other standard for review.	Is there specific criteria the state would like to be used for claim selections?	9	DHS will work with the vendor to finalize RR claims selection criteria.
10	Page 12, Section 2.3, B. 1	Inpatient and Outpatient Services	Is there a list of inpatient and outpatient services and associated codes that require PA/RR?	10	Applicable codes will be listed in the AR Medicaid Manuals but may not reflect the exhaustive listing. DHS will work with the vendor to finalize PA/RR processes.

11	Page 12, Section 2.3, B.6	ARWorks Mid-Year Transition Requests	Please describe the AR Works Midyear Transition Request.	11	See updated Attachment H.
12	Page 12, Section 2.3, B.7	Emergency Room/Emergency Department (ER/ED)Retrospective Reviews	Is the Contractor providing medical necessity and quality review only, or is there a claims review component for appropriateness and accuracy of charges as well?	12	Under this Section, this contract does not require the vendor to review the accuracy of charges.
13	Page 12, Section 2.3, B.7	Emergency Room/Emergency Department (ER/ED)Retrospective Reviews	Does the MMIS system support review of appropriate billing practices by providers for services delivered or does the Contractor review down to the individual service billed level?	13	See answer to Question 12.
14	Page 12, Section 2.3, C.2	Suspended Claims	Please indicate the circumstance that would result in a "suspended review" being selected for review by the Contractor. Who makes the determination that a "suspended review" should come to the Contractor? Is it a DHS or DXC decision?	14	1) These are determined on a case-by-case basis. 2) DHS makes the determination.
15	Page 12, Section 2.3, D	Ad Hoc Reviews	Please define "Ad Hoc Reviews"	15	See updated IFB including Section 2.7 and Attachment H.
16	Page 12, Section 2.3, D	Vendor shall perform Ad hoc Reviews for an array of services and claims including but not limited to:	Is there a quantity estimate for ad hoc reviews?	16	See updated Attachment H.
17	Page 12, Section 2.3, D	Vendor shall perform Ad hoc Reviews for an array of services and claims including but not limited to:	How frequently has the prior vendor completed ad hoc reviews?	17	See answer to Question 16 regarding quantity of estimate for ad hoc reviews.
18	Page 13, Section 2.3, E.4	Participation in all activities related to administrative appeals of adverse actions and litigation…	Please provide information as to: - Number of administrative appeals annually - Percentage of administrative appeals by review volume for various per review types - Percentage of appeals upheld per review type - Please provide information related to any current or known future litigation applicable to this language section - Number of litigation actions annually - Percentage of litigation actions by review volume for various per review types - Percentage of appeals upheld per review type	18	1) For SFY2017, there were 117 Fair Hearing appeals. 2) Unknown. 3) Unknown. 4) Unknown. 5) Unknown. 6) Unknown. 7) Unknown.
19	Page 13, Section 2.3, E.4	Participation in all activities related to administrative appeals of adverse actions and litigation…	How many administrative appeals or hearings occurred during 2017 that required Contractor participation?	19	Unknown.
20	Page 13, Section 2.3, E.4	Participation in all activities related to administrative appeals of adverse actions and litigation…	How many of the Contractor's adverse determinations resulted in the Contractor being required to provide attorney representation? How many of these were due to litigation?	20	Unknown.
21	Page 13, Section 2.3, E.6	Development and provision of all forms and documents…	What is the extent of the documentation the Contractor is responsible for providing for the administrative appeals? Only documentation relevant to the decisions made by the Contractor or are there additional document requirements?	21	See Section 2.10.
22	Page 13, Section 2.3, E.6	Development and provision of all forms and documents…	Is the Contractor responsible for providing only documentation relevant to the decisions made by the Contractor or are there additional document requirements?	22	Yes. The Contractor is responsible for providing documentation relevant to the decisions made by the Contractor.
23	Page 13, Section 2.3, F.4	Adhere to timeframes for each review type….	In Attachment I for inpatient prior authorization, if the level 1 review is allowed 24 hours and the case is referred to level 2 review, is that an additional 24 hours or the same 24 hours allowed to complete the review?	23	Level 1 and Level 2 timeframes are set out separately unless otherwise indicated.
24	Page 14, Section 2.4, A	MMIS/Interchange process	Does the Contractor complete the entire review process within the MMIS system or just receive the provider review request and documentation through the MMIS provider portal?	24	•For PAs, the reviews will be conducted completely within MMIS. •For RR process, see updated IFB, Section 2.6 (KB addition). Interfaces are required in the RR process. •For MCR/Ad Hoc review processes, see updated IFB, Section 2.7 (KB addition). Secure transmission capabilities are required.
25	Page 14, Section 2.4, B	Requests initiated outside MMIS interChange	What is the percent of reviews received into the MMIS as opposed to those otherwise submitted to the Contractor directly?	25	Unknown. This is a new process.
26	Page 14, Section 2.4	Use of AR Medicaid MMIS	What % of review requests are assigned via AR MMIS/Interchange vs through requests initiated outside the MMIS/Interchange?	26	See answer to Question 25.
27	Page 14, Section 2.4	Use of AR Medicaid MMIS	Which specific PA, RR, MRCs and Ad Hoc requests are initiated outside the MMIS/Interchange?	27	For any PAs initiated outside the Provider Portal, DMS expects the vendor to enter the PA into MMIS/InterChange, and then work on the PA through MMIS/InterChange. RR/MRC/Ad Hoc processes for the vendor will be initiated and worked outside of MMIS/InterChange. See updated IFB.
28	Page 14, Section 2.4, B	Requests initiated outside MMIS interChange	If reviews are submitted directly to the Contractor, are any submitted via a web portal?	28	Yes. See updated IFB Sections 2.4 and 2.5.
29	page 14, Section 2.4, B.5	Emergency PAs, MRCs and Ad Hoc requests…	What is the volume of and turnaround time expectation for these emergency requests?	29	DHS and Vendor will collaborate to determine the appropriate timeframe.

30	page 14, Section 2.4, B.5	Emergency PAs, MRCs and Ad Hoc requests…	Are there parameters defining "emergency" that providers are to keep in mind when making such a request?	30	See Section IV – Glossary of the Arkansas Medicaid Manual for the definition of "emergency"; see updated IFB.
31	Page 16, Section 2.5, E	Vendor shall work with the incumbent vendor to transition and expedite actions and services related to in-progress PAs	What is the anticipated volume of in-process PAs that will require the incumbent and new Vendor to transition and expedite?	31	Unknown at this time.
32	Page 16, Section 2.6	Retrospective Review - General Question	Are retrospective reviews initiated and completed in the MMIS system or the Contractors system?	32	See answer to Question 5.
33	Page 16, Section 2.6, C	….identify claims for which recoupment will be undertaken……	What is the current recoupment process? What parts of the process is the Contractor's responsibility?	33	See updated IFB Section 2.6.
34	Page 16, Section 2.6.2 Retrospective Reviews	Retrospective Review - General Question	Is the Vendor required to reimburse providers for copying/mailing costs? If reimbursement rates are set by the state, please provide rates.	34	No.
35	Page 16, Section 2.6.2 Retrospective Reviews	Vendor shall transmit to DHS all RR determinations via agreed-up methodology	What methodology is the incumbent currently using to transmit RR determinations?	35	Irrelevant for purposes of bid.
36	Page 17, Section 2.7, D	Vendor shall work with the incumbent vendor to transition and expedite actions and services related to in-progress MRCs	What is the anticipated volume of in-process MRCs that will require the incumbent and new Vendor to transition and expedite?	36	Unknown at this time.
37	Page 17, Section 2.8, A.3	Vendor's notices must be approved by DHS and must conform to the requirements of federal and state law and the controlling Medicaid Manual(s).	Please clarify if "notice" refers to the form/template used by the vendor, not each individual notice?	37	"Notice" refers to the form/template.
38	Page 18, Section 2.8, B.1,2	Notices to beneficiaries	Is the Contractor responsible for mailing approval and denial notices created in the MMIS system to beneficiaries? If not, what is the process? If so, are the letters printed by the Contractor from the MMIS system or sent electronically to the Contractor from the MMIS system for mailing?	38	1) See updated IFB. No, vendor does not mail notices generated in MMIS/InterChange. 2) See updated IFB. For notices generated in MMIS/InterChange, DXC will generate and mail the notices. 3) n/a
39	Page 19, Section 2.8, C.7	Notices to providers	Are authorization and denial letters sent automatically to providers for reviews performed in the MMIS system once the letter is created by the Contractor?	39	See answer to Question 38.
40	Page 19, Section 2.8, D.1	Notifications to DHS Fiscal Agent, "transmitted electronically"	Are all review decisions "transmitted electronically" to the MMIS system from the current Contractor, even those reviews for which data is entered into the MMIS system directly?	40	PA approvals are required to be transmitted to the Fiscal Agent for payment in MMIS. Under this contract, PAs will be entered into MMIS. When the vendor approves a PA request, notification to the Fiscal Agent will occur automatically as part of the process.
41	Page 19, Section 2.9, A. 5	Vendor shall respond to any informal inquiry related to an adverse PA, RR or MRC determination that is not a part of the official DPR.	Please define "informal inquiry"	41	Any inquiry that is not part of the official Due Process Reconsideration.
42	Page 19, Section 2.9, B	Due Process Reconsiderations Procedure	What percentage of PA DPRs are represented by legal counsel?	42	Unknown.
43	Page 19, Section 2.9, B	Due Process Reconsiderations Procedure	What percentage of MRC DPRs are represented by legal counsel?	43	See answer to Question 42.
44	Page 19, Section 2.9, B	Due Process Reconsiderations Procedure	What percentage of RR DPRs are represented by legal counsel?	44	See answer to Question 42.
45	Page 19, Section 2.9, B	Due Process Reconsiderations Procedure	If DPR volumes are different than appeal volumes please provide the: - Number of DPRs annually for PAs, RRs and MCRs - Percentage of DPRs by review volume for various per review types - Percentage of DPRs upheld per review type	45	1) See answer to Question 2. 2) See answer to Question 2. 3) Unknown.
46	Page 20, Section 2.9, B.6	Vendor's notice of a DPR determination to a Provider or Beneficiary must be approved by DHS prior to use, and must conform to the requirements of federal and state law, and the controlling Medicaid Manuals, and must include proper notice of the right to appeal an adverse action.	Please clarify if "notice" refers to the form/template used by the vendor, not each individual notice.	46	See answer to Question 37.
47	Page 20, Section 2.9, C	Vendor shall work with the incumbent vendor to transition and expedite actions and services related to in-progress DPRs	What is the anticipated volume of in-process DPRs that will require the incumbent and new Vendor to transition and expedite?	47	Unknown at this time.
48	Page 20, Section 2.10	Appeals of Adverse Decisions	Please provide the estimated number of appeals by review type (prior authorization, retrospective review, and medical review/consult) similar to that provided for reconsiderations in the Official Proposal Price Sheet.	48	Unknown at this time.

49	Page 20, Section 2.10	Vendor shall participate in all activities related to any appeal of its determinations or actions, and make documents and witnesses available for the defense of adverse decisions and litigation based in whole or in part on Vendor's acts or omissions	Please provide information as to: Number of administrative appeals annually Percentage of administrative appeals by review volume for various per review types Percentage of appeals upheld per review type Please provide information related to any current or known future litigation applicable to this language section Number of litigation actions annually Percentage of litigation actions by review volume for various per review types Percentage of appeals upheld per review type	49	See answer to Question 18.
50	Page 20, Section 2.10, D	Appeals of advese decisions	Of the total appeals requiring participation by the vendor during 2017, how many required onsite Contractor participation vs. telephonic participation?	50	Unknown.
51	Page 20, Section 2.10, D	Appeals of advese decisions	What is the average time spent by the Contractor for each appeal or hearing?	51	Unknown.
52	Page 20, Section 2.10, F	Appeals of advese decisions	Please provide an example of a circumstance in which a letter response regarding an adverse decision would be requested from the Contractor that is outside of the appeal or hearing request process. How many of these requests occurred during 2017?	52	1) See updated IFB, Section 2.11. 2) Unknown.
53	Page 21, Section 2.10, G	Vendor shall be responsible for taking any required actions transpiring within the specified timeframes for an appeal or hearing. In the event a case is remanded for payment due to Vendor error or neglect, Vendor shall be held responsible for payment of the claim	How and by whom is the determination of Vendor's "error or neglect" made?	53	The determination is made by Arkansas Medicaid.
54	Page 21, Section 2.10, G	Vendor shall be responsible for taking any required actions transpiring within the specified timeframes for an appeal or hearing. In the event a case is remanded for payment due to Vendor error or neglect, Vendor shall be held responsible for payment of the claim	Please provide information as to: Number appeals/hearings in which vendor was responsible for payment Average dollar amount of claims Vendor for which vendor was responsible for payment Percentage of appeals/hearings in which vendor was responsible for payment Total dollar annual dollar amount of claims Vendor was responsible for over period of current contract.	54	Unknown.
55	Page 21, Section 2.10, G	Vendor shall be held responsible for payment of the claim	Does this mean the act of paying a claim or the vendor being financially responsible for the medical costs related to a claim?	55	See updated IFB, Section 2.10(H).
56	Page 21, Section 2.10, H	Vendor shall work with the incumbent vendor to transition and expedite actions and services related to in-progress Appeals .	Is there an anticipated volume of appeals?	56	Unknown at this time.
57	Page 21, Section 2.11, C.2	Vendor shall reply in writing within five (5) calendar days of receipt to all written complaints received directly by Vendor, and sends a copy of the complaint and response to DHS.	Is this a report request or will email notification suffice?	57	Email will suffice.
58	Page 23, Section 2.13	Provider Type	Provider type is specified for a few report requirements - how is this metric defined?	58	The professional providing the service and/or requesting the PA/RR/MRC.
59	Page 23, Section 2.13, A	Reports	What reporting capabilities will the Contractor have access to in the MMIS System, if any?	59	DHS will work with the vendor to determine appropriate reporting capabilities and access.
60	Page 23, Section 2.13, B.1.E	Associated costs of reviews	How is this metric defined?	60	See updated IFB, Section : "For the RR report, the amount recouped (amount overall, and by procedure code)"
61	Page 26, Section 2.13, B.9	Data Correction	Please explain what data corrections are.	61	Any corrections to data/information entered into or transmitted to MMIS/InterChange, or provided to DHS, Providers or Beneficiaries due to entry error or any other reason.
62	Page 26, Section 2.13, B.9	Data Correction	Are data corrections related to transfer submissions? If MMIS direct entry how is this tracked by existing vendor?	62	1) See answer to Questions 61 and 65. Data Correction report will include, but is not limited to, data being changed (e.g., dates, modifiers, procedure codes, etc.) as well as the reason for the data changes. 2) Not applicable, as a new PA procedure is currently being put in place.
63	Page 26, Section 2.13, D	Special and Ad Hoc Reports	How many ad hoc or special reports were requested during 2017 from the Contractor?	63	Unknown
64	Page 26, Section 2.13, D	Special and Ad Hoc Reports	In 2017, was there any data requested in the reports that was not already being gathered for existing reports on contract? If so, how may reports required further report creation in view of a new data request?	64	Unknown

65	Page 30, Section 2.17, B.1	Vendor shall be responsible for updating MMIS/interChange with any data corrections within twenty-four (24) hours .	What is the event that begins the 24 hour period?	65	The discovery of any error in the data.
66	Page 30, Section 2.17, C.2	Certain interfacing/communication may require Vendor to log in to another vendor's system or receive a feed from another vendor. Vendor and DHS shall work to identify any necessary interface/communication processes and the current vendor's requirements....	Please describe the types of such interfaces/communications the incumbent vendor is using/receiving today.	66	Not applicable, as new procedures are currently being put in place.
67	Page 34, Section 3.3, B	The vendor shall indemnify and save harmless the agency and all its officers, representatives, agents, and employees against any claim or liability arising from or based upon the violation of any such law, ordinance, regulation, order or decree by an employee, representative, or subcontractor of the vendor.	Will the state please add the following, or similar language to this indemnification clause "This provision shall not apply to liability of any nature arising solely from the Agency's failure to meet its duties under this Contract or solely from any actions or omissions undertaken in compliance with the Agency's directions or requests."?	67	No.
68	Page 35, Section 3.7 Price Escalation	A. Price increases will be considered at the time of contract renewal.	Will such increases be considered at the time of each Optional renewal period?	68	Yes
69	Page 35, Section 3.7 Price Escalation	A. Price increases will be considered at the time of contract renewal.	How long before the renewal of each optional year begins must the vendor request a price increase?	69	Will vary, minimum of 90 days.
70	Attachment D, Page 1 of 11	Financial Terms Table	What are the financial terms for the services described under this RFP?	70	Actual Cost Reimbursement, Final Negotiated Rate, etc.
71	Attachment D, Page 4, Confidentiality of Information	In addition, the Contractor shall comply with the Business Associate Agreement between the parties, incorporated herein by reference, and shall disclose any breaches of privacy or security by contacting the Information Technology Security Officer within one (1) business day of the breach by notification to the following e-mail address: dhs-it-security@arkansas.gov.	Would the state please confirm that breaches of privacy or security are to be reported within ten calendar days as outlined in the Business Associate Agreement?	71	Confirmed.
72	Attachment D, Page 5, Indemnification Clause	The Contractor agrees to indemnify, defend, and save harmless the State, the Department, its officers, agents and employees from any and all damages, losses, claims, liabilities and related costs, expenses, including reasonable attorney's fees and disbursements awarded against or incurred by the Department arising out of or as a result of:	Will the state add the following, or similar language to this indemnification clause "This provision shall not apply to liability of any nature arising solely from the Agency's failure to meet its duties under this Contract or solely from any actions or omissions undertaken in compliance with the Agency's directions or requests."?	72	See answer to Question 67.
73	Attachment H, Prior Authorization Reviews, Retrospective Reviews and Medical Reviews/Consults	Prior Authorization Review Grid	There are number in parenthesis - what does this indicate? For example Medical and Surgical Procedures (7,310/20)	73	7,310 = Number of Reviews for SFY2017 20 = Number of Reconsiderations for SFY2017
74	Attachment H, Prior Authorization Reviews, Retrospective Reviews and Medical Reviews/Consults	Prior Authorization Review Grid	The volumes are listed as "cases" - Please confirm that "cases" represent each service review request.	74	Confirmed.
75	Official Proposal Price Sheet	Application Denial Reviews	Where are Application Denial Reviews services described in section 2.3 of the RFP?	75	See updated IFB, Section 2.3(C) and Attachment H.
76	Official Proposal Price Sheet	Official Proposal Price Sheet - General Question	RFP Section 2.3.D.3 described Non-Standard Care Ad Hoc services, however, these services have not been listed on the Official Proposal Price Sheet. How should pricing for these services be submitted in our response?	76	See updated IFB, response packet and attachment H.

77	Business Associate Agreement (BAA)-General Language	General Language	Would the state please add the following, or similar, language to the BAA: "Definition of Access Attempts. When Information Systems are the target of probes, scans, "pings" and other activities which may or may not indicate threats, whose sources may be difficult or impossible to identify and whose motives are unknown, and which do not result in access or risk to any Information System or Protected Health Information ("Access Attempts"). Notification of Access Attempts. Access Attempts are recorded in various system logs, and fall under the definition of "Security Incident" in the Security Rule. Because PHI is not Used or Disclosed in an Access Attempt, they do not fall under the definition of Unauthorized Use or Disclosure. The Contractor's reporting and the State's review of records of Access Attempts would be materially burdensome to both parties without reducing risks to Information Systems or PHI. Therefore, provided that Contractor ensures that there is appropriate review of logs and other records of Access Attempts, and investigates Security Incidents, Contractor shall not be required to provide further notification of Access Attempts."?	77	No.
78	One Page Description of IFB	(1) Invitation for Bid (IFB) for PA/RR services and Medical Review/Consults (MRC) (2) Request for Proposal (RFP) for PA/RR services specifically for special needs populations, including services for Behavioral Health (BH), Developmental Disabilities (DD) and Aging (DAAS) populations.	The draft procurement for therapy and behavioral health services is an RFP but the draft procurement for clinical review is an IFB. The services to be procured in both cases are medical necessity reviews. To enable a proposal that better meets DHS objectives, would the State explain why price is 30% in one case and 100% in the other?	78	Not relevant for purposes of bid.
79	Page 3, Response Documents §1.7 A. 3. and 4. Page 11. Scope of Work §2.3	3.d. Documentation that vendor meets the minimum qualifications outlined in this IFB. (See Minimum Qualifications.) 4. DO NOT include any other documents or ancillary information, such as a cover letter or promotional/marketing information.	Please provide guidance on how Vendor responses can comply with this requirement to provide only documentation about minimum qualifications in the response packet and also provide information about how the Vendor proposes to complete the Scope of Work requirements. DHS would need information on how Vendor intends to complete the SOW in order to help judge the reasonableness of price bids. Where in the response packet should Vendor include SOW information?	79	1) Vendor is only required to submit prior SOW information as proof of meeting the minimum qualification stated in section 2.2 (A) 2) See section 1.7 (3)
80	Page 10, §2.2 Minimum Qualification, (C) seventh bullet	They shall not be from current DHS employees.	Can a current DHS employee sign a letter of reference? If so, there is a conflict between C.2. and the seventh bullet.	80	See updated IFB.
81	Page 11, §2.3 Scope of Work, (A)(1)	"As applied in this IFB, the term "Prior Authorizations" includes without limitation the following: Extensions of Benefits..."	It is our understanding that this IFB will treat Extension of Benefits as prior authorization. Is that correct?	81	This IFB covers Extension of Benefits requests for the listed PAs.
82	Page 13, §2.3 Scope of Work, (E)(2)	Reconsiderations of review determinations requested by Providers or Beneficiaries;	Reconsideration requests allow providers to: 1) supplement health care information by furnishing records that may have been omitted in the provider's original submission; and 2) challenge/rebut the reviewer's analysis/rationale. For beneficiary requests, will the onus of providing supplemental information and rationale rebuttals be on the beneficiary? If so, what systems will be used to securely communicate these messages with beneficiaries?	82	See updated IFB.
83	Page 13, §2.3 Scope of Work, (F)(4)(c.)	Adherence to timeframes must be reported to DHS in monthly reports, and shall be considered in Vendor's Quality Assurance/Performance Improvement activities set out herein.	If reviews are performed within MMIS interChange, will the contracted fiscal agent produce the required monthly reports? If not, how will the reports be produced?	83	DHS will work with the vendor to finalize reporting procedures.
84	Page 14, §2.3 Scope of Work, (F)(7)	Vendor shall complete, file, retain, and make available to DHS upon request all records related to this IFB without limitation in a secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant manner.	Will all records be uploaded and retained within MMIS interChange or will the contracted Vendor be responsible for retention and availability of records related to this IFB?	84	Not all records will be uploaded and retained in MMIS/InterChange, and Vendor will not be responsible for preservation and maintenance of documents uploaded to MMIS/InterChange. DHS will work with the vendor to finalize data retention requirements.

85	Page 14, §2.3 Scope of Work, (F)(7)	Vendor shall complete, file, retain, and make available to DHS upon request all records related to this IFB without limitation in a secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant manner.	If all records are uploaded and retained within MMIS interChange, is the fiscal agent also responsible for making IFB-related records available to DHS?	85	See answer to Question 84. DHS will have access to all records retained within MMIS related to this IFB.
86	Page 14, §2.3 Scope of Work, (F)(7)	Vendor shall complete, file, retain, and make available to DHS upon request all records related to this IFB without limitation in a secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant manner.	If the Vendor is responsible for making IFB-related records available to DHS, how will the fiscal agent make records available to the Vendor, and in what format?	86	See updated IFB.
87	Page 14 §2.4 Use of Arkansas Medicaid MMIS (A)	MMIS/InterChange Processes	How will DHS record/pay/reimburse the Vendor for reviews performed in MMIS InterChange?	87	See updated IFB. DHS will work with the vendor to finalize this process.
88	Page 14 §2.4 Use of Arkansas Medicaid MMIS (A)	MMIS/InterChange Processes	MMIS does not process a new claim for retrospective reviews, so those would not already be acted upon by the MMIS system. What systems does the State envision being in place to accommodate the retrospective review function?	88	See updated IFB.
89	Page 14 §2.4 Use of Arkansas Medicaid MMIS (A)	MMIS/InterChange Processes	Should the Vendor plan to provide and operate necessary case selection software for retrospective reviews? If not, who has that responsibility, and how can the vendor be held accountable for appropriate sampling?	89	1) Yes. See updated IFB. DHS will work with the vendor to finalize RR procedures including the use of case selection software to randomly select cases for RRs. 2) N/A
90	Page 14 §2.4 Use of Arkansas Medicaid MMIS (A)	MMIS/InterChange Processes	The State routinely requests ad-hoc reports regarding, for example, review denial and approval rates, which requires programmatic functionality beyond current MMIS capabilities. Should the Vendor expect to produce reports to the State regarding approvals, denials, referrals, partial approvals or reconsiderations?	90	Yes. See updated IFB. DHS will work with the vendor to finalize reporting procedures.
91	Page 14 §2.4 Use of Arkansas Medicaid MMIS (A)	MMIS/InterChange Processes	The IFB requires URAC or similar accreditation. URAC, for example, requires documentation of numerous internal processes and processing times to maintain accreditation. The MMIS system lacks the capability to record and report these processes. Should the Vendor plan to establish and maintain systems necessary to maintain URAC accreditation? Will DHS require modifications to the MMIS system to enable interoperability with separate systems required for URAC accreditation?	91	It is the vendor's responsibility to determine how it will maintain URAC accreditation unrelated to PA review processes.
92	Page 14 §2.4 Use of Arkansas Medicaid MMIS (A)	MMIS/InterChange Processes	How does DHS plan to facilitate collaboration with the fiscal agent to ensure this Vendor can achieve acceptable performance of service requirements by contract start date?	92	DHS expects all vendors to act in good faith and promptly to achieve acceptable performance including, but not limited to, collaborating with each other.
93	Page 14, §2.4 Use of Arkansas Medicaid MMIS (A)(1)	For PAs, RRs, and certain MCRs, Vendor's clinicians, other medical professionals and supervisors shall log in to Arkansas Medicaid MMIS in order to work through an assigned workflow queue and perform other tasks.	Who fills/prepopulates the workflow queue?	93	See updated IFB.
94	Page 14, §2.4 Use of Arkansas Medicaid MMIS (A)(1)	For PAs, RRs, and certain MCRs, Vendor's clinicians, other medical professionals and supervisors shall log in to Arkansas Medicaid MMIS in order to work through an assigned workflow queue and perform other tasks.	What are the "other tasks" to be performed?	94	Other tasks may include, but are not limited to, forward claims for review to other reviewers, issue letters, respond to inquiries.
95	Page 14, §2.4 Use of Arkansas Medicaid MMIS (A)(1)	For PAs, RRs, and certain MCRs, Vendor's clinicians, other medical professionals and supervisors shall log in to Arkansas Medicaid MMIS in order to work through an assigned workflow queue and perform other tasks.	Will the State provide a list of proposed other tasks that the Vendor's clinicians, other medical professionals, and supervisors will perform?	95	See answer to Question 94.
96	Page 14, §2.4 Use of Arkansas Medicaid MMIS (A)(5)	Vendor shall make notes on a file, send and receive messages, send and receive files/claims/requests for review, and perform other tasks for completion of work required under this IFB.	What media and software systems will the Vendor use for files, messages, claims, requests for review, and other tasks?	96	See updated IFB.

97	Page 14, §2.4 Use of Arkansas Medicaid MMIS (A)(5)	Vendor shall make notes on a file, send and receive messages, send and receive files/claims/requests for review, and perform other tasks for completion of work required under this IFB.	Please describe and detail the interaction and level of effort that will be required between the Vendor and the MMIS contractor to ensure MMIS functionality required to successfully meet contract deliverables.	97	See updated IFB. DHS is currently working with MMIS/InterChange vendor to ensure necessary functionality is in place for work to be conducted within MMIS/InterChange. For work conducted by vendor outside of MMIS/InterChange, DHS will work with the vendor to finalize all processes, including implementation of necessary interfaces.
98	Page 14, §2.4 Use of Arkansas Medicaid MMIS (A)(7)	All actions will be automatically date- and time-stamped in MMIS to assist Vendor and DHS with tracking timeframes related to all activities.	As discussed in question #14, the MMIS does not currently track "all activities" necessary for vendors to maintain utilization review accreditation. Will DHS require modifications to the MMIS system to enable interoperability with separate systems required for necessary tracking and reporting?	98	For reviews completed within MMIS, this data should be available. For reviews or other activities completed outside of MMIS, the contractor will have to track the data.
99	Page 14, §2.4 Use of Arkansas Medicaid MMIS (B)(2)	In collaboration with DHS, Vendor shall develop a process to allow requests to be made by providers, including hospitals, via telephone, US mail or facsimile.	Is the State supportive of all requests being submitted 100% electronically via the MMIS Provider Portal or the contracted Vendor's secure HIPAA-compliant portal and eliminating via telephone? Will DHS change "via telephone, US mail or facsimile" to read "via email, secure electronic messaging, US mail or facsimile?"	99	At this time, DHS does not intend to eliminate phone requests.
100	Page 15, §2.5 Prior Authorization Reviews, (A)(1)	The PA process shall commence upon Vendor's receipt of a request from a Provider or Beneficiary in the appropriate MMIS workflow queue.	Beneficiary submission of PA requests is a new concept. How does the Arkansas Medicaid Fairness Act affect this process?	100	See updated IFB.
101	Page 15, §2.5 Prior Authorization Reviews, (A)(1)	The PA process shall commence upon Vendor's receipt of a request from a Provider or Beneficiary in the appropriate MMIS workflow queue.	Beneficiaries typically do not have necessary PA information such as Medicaid provider numbers, ICD-10 codes, CPT/HCPCS codes, or relevant health care documentation. How will beneficiaries gather and securely submit the necessary information for a medical necessity review?	101	See answer to Question 100.
102	Page 15, §2.5 Prior Authorization Reviews, (A)(1)	The PA process shall commence upon Vendor's receipt of a request from a Provider or Beneficiary in the appropriate MMIS workflow queue.	Regarding the beneficiary requests, is it the State's intent for the beneficiary to bill for these services? If so, how will the beneficiary interact with the PA process?	102	See answer to Question 100.
103	Page 15, §2.5 Prior Authorization Reviews, (A)(1)	The PA process shall commence upon Vendor's receipt of a request from a Provider or Beneficiary in the appropriate MMIS workflow queue.	How will the Beneficiary obtain the necessary medical record documentation as well as securely upload that information to MMIS interChange and workflow queue?	103	See answer to Question 100.
104	Page 15, §2.5 Prior Authorization Reviews, (A)(3)(b)	Vendor shall also authorize notification to be given to the Provider and Beneficiary through the appropriate means (electronic or US Mail) according to the Notification section of this IFB.	Do you expect the authorization to be a step in addition to entering the data that triggers the notification?	104	See updated IFB. After PA request data has been entered in MMIS/InterChange, vendor must select an action, including approve, modify or deny the PA request. These selections will automatically trigger a notification-related processes in MMIS.
105	Page 15, §2.5 Prior Authorization Reviews, (A)(5)	If a provider or Beneficiary fails to provide the "Required Documentation" necessary to perform a PA review, Vendor must notify the Provider or Beneficiary within forty-eight (48) hours in order for the review to be conducted in a timely manner. If the Provider or Beneficiary fails to submit the required documentation within a reasonable time determined on a case-by-case basis with input from DHS, said failure shall be a justifiable cause for Vendor to deny a PA review. In its denial, Vendor shall note the missing required documentation and steps undertaken to obtain missing documentation.	Do the 24- and 48-hour time limits include weekends and Arkansas state holidays?	105	See Section 2.3 (E)(4).

106	Page 15, §2.5 Prior Authorization Reviews, (A)(5)	If a provider or Beneficiary fails to provide the "Required Documentation" necessary to perform a PA review, Vendor must notify the Provider or Beneficiary within forty-eight (48) hours in order for the review to be conducted in a timely manner. If the Provider or Beneficiary fails to submit the required documentation within a reasonable time determined on a case-by-case basis with input from DHS, said failure shall be a justifiable cause for Vendor to deny a PA review. In its denial, Vendor shall note the missing required documentation and steps undertaken to obtain missing documentation.	How will beneficiaries be educated to submit electronic or paper requests?	106	See answer to Question 100.
107	Page 15, §2.5 Prior Authorization Reviews, (A)(5)	If a provider or Beneficiary fails to provide the "Required Documentation" necessary to perform a PA review, Vendor must notify the Provider or Beneficiary within forty-eight (48) hours in order for the review to be conducted in a timely manner. If the Provider or Beneficiary fails to submit the required documentation within a reasonable time determined on a case-by-case basis with input from DHS, said failure shall be a justifiable cause for Vendor to deny a PA review. In its denial, Vendor shall note the missing required documentation and steps undertaken to obtain missing documentation.	Will DHS designate a point of contact and a back-up point of contact for case-by-case input given that lack of documentation is a common occurrence?	107	DHS will work with vendor to establish an appropriate procedure.
108	Page 15, §2.5 Prior Authorization Reviews, (B)(2)	If the Beneficiary is not eligible for Medicaid, Vendor shall notify the requesting Provider within twenty-four (24) hours of the determination	If the beneficiary is not eligible, Medicaid will not provide medical assistance, emergent or otherwise, so why is the 24-hour limit necessary?	108	So that the beneficiary does not receive services for which the Provider cannot bill Medicaid
109	Page 15, §2.5 Prior Authorization Reviews, (B)(2)	If the Beneficiary is not eligible for Medicaid, Vendor shall notify the requesting Provider within twenty-four (24) hours of the determination	How can the Vendor rely on MMIS interChange to accommodate these requests when beneficiaries do not exist in the MMIS system, if they are not Medicaid-eligible?	109	The PA Provider Portal does not edit beneficiary eligibility. Therefore, the vendor must verify current eligibility status as part of their review.
110	Page 16, §2.5 Prior Authorization Reviews, (F)	Vendor shall submit to DHS a regular monthly report pertaining to all PA and PA-related activities performed under this section.	IFB indicates that most requests will be performed within MMIS interChange. Must the Vendor have the ability using MMIS at contract start date, to produce all required reports pertaining to all PA and PA-related activities performed within interChange?	110	DHS will work with the Vendor to establish start dates for all reports.
111	Page 16, §2.6 Retrospective Reviews, (D)(2)	Vendor shall transmit to DHS all RR determinations via an agreed-upon methodology.	Can DHS create MMIS dashboards to obtain this information without additional steps?	111	See updated IFB. DHS does not plan at this time to create dashboards.
112	Page 17, §2.6 Retrospective Reviews, (F)	Vendor shall submit to DHS a regular monthly report pertaining to all RR and RR-related activities under this section.	If all reviews will be in MMIS, does Vendor still need to submit reports based on their systems? Or will the fiscal agent develop and produce all reports?	112	See updated IFB.
113	Page 17, §2.7 Medical Reviews/Consultations, (A)(1)	Upon request by DHS, Vendor shall perform medical reviews or consultations to confirm denial or approval of a benefit or service made through a PA request or an application, which may include a non-standard request.	Will all MCR requests be performed by the Vendor's medical professionals within MMIS interChange? If so, will MMIS InterChange be available to the Vendor's medical professionals at contract start date?	113	See updated IFB.
114	Page 17, §2.8 Notifications, (A)(1)	All notifications of review determinations shall be sent on the same day that the determination is made.	If notifications are done in MMIS, will the fiscal agent send out the notification on the same day?	114	See updated IFB.
115	Page 17, §2.8 Notifications, (A)(1)	All notifications of review determinations shall be sent on the same day that the determination is made.	If a review determination is made at 4:30 p.m., will the notification still go out on the same day?	115	See answer to Question 114.
116	Page 17, §2.8 Notifications, (A)(1)	All notifications of review determinations shall be sent on the same day that the determination is made.	May all notifications be sent electronically?	116	Notifications to beneficiaries must be mailed through the US postal system.
117	Page 18, §2.8 Notifications, (A)(4) (c.)	The PA control number.	Will MMIS issue a vendor-specific PA number?	117	Yes. The first character of the PA control number will identify the vendor.

118	Page 18, §2.8 Notifications, (A)(4) (e.)	Signature of Vendor's reviewer including credentials for the determination and date.	The 8th Circuit Court of Appeals has ruled that the identities of peer reviewers for QIO/QIO-like entities may be disclosed only with the reviewers' written consent. Will the State create an exception so as not to disadvantage such highly qualified entities?	118	The state will comply with all applicable state and federal confidentiality laws and regulation
119	Page 18, §2.8 Notifications, (A)(7)	Errors or omissions in notifications to Providers or beneficiaries must be corrected and notice submitted electronically or by telephone to the Provider or Beneficiary within forty-eight (48) hours of the discovery of the error or omission, with a follow-up written notice to the Provider and Beneficiary within five (5) business days if the initial notice is by telephone.	Can the follow-up written notice be sent electronically if a valid beneficiary email address is on file or must it be paper, sent by U.S. postal mail?	119	See answer to Question 116.
120	Page 18, §2.8 Notifications, (A)(7)	Errors or omissions in notifications to Providers or beneficiaries must be corrected and notice submitted electronically or by telephone to the Provider or Beneficiary within forty-eight (48) hours of the discovery of the error or omission, with a follow-up written notice to the Provider and Beneficiary within five (5) business days if the initial notice is by telephone.	Is it the State's intent to allow electronic notification in the general notifications section, errors and omissions? See the following two questions which require mail notifications.	120	See IFB Section 2.8(A)8.
121	Page 18, §2.8 Notifications, (B)(2)	Notices shall be sent by U.S. postal mail	Why are electronic notices prohibited?	121	Irrelevant for purposes of bid.
122	Page 18, §2.8 Notifications, (B)(2)	Notices shall be sent by U.S. postal mail	Can the Beneficiary notice be sent electronically if there is a valid email address on file for the Beneficiary within MMIS interChange?	122	See answer to Question 116.
123	Page 18, §2.8 Notifications, (B)(2)	Notices shall be sent by U.S. postal mail	Is the Vendor or the fiscal agent responsible for producing and mailing letters?	123	See updated IFB and answer to Question 38.
124	Page 18, §2.8 Notifications, (C)(1) and (2)	MMIS interChange will generate and mail the Notice.	C.1. says the Vendor will create the appropriate notification. C.2. says the MMIS will generate and mail the notice. Please reconcile these requirements.	124	See updated IFB. For PA notices generated in MMIS/InterChange, vendor will create the template with DHS approval. Vendor's actions will trigger MMIS/InterChange to populate the template from the appropriate fields and mail the notice.
125	Page 18, §2.8 Notifications, (C)(1) and (2)	MMIS interChange will generate and mail the Notice.	Will there be a template within MMIS to accommodate a case-specific rationale and any due process rights?	125	The template letters within MMIS/InterChange provide for free-form text or codes to accommodate case-specific rationale.
126	Page 18, §2.8 Notifications, (C)(1) and (2)	MMIS interChange will generate and mail the Notice.	Will this capability be accessible in MMIS at start date of contract?	126	DHS anticipates that the PA process will fully be in place at the start of the contract, and will work with the vendor to finalize all processes.
127	Page 20, §2.9 Due Process Reconsideration Procedures, (B)(7)	Vendor must notify the Provider and Beneficiary by US Mail within three (3) days of the DPR determination. The notice must include the outcome of all DPR requests and must accurately state the reviewing physician's rationale for any requested service that was not approved. The rationale must be case-specific; general or generic rationale is not acceptable.	May reconsideration notifications be sent via secure electronic mail if there is a valid email address within MMIS interChange for the Provider or Beneficiary?	127	See answer to Question 116 regarding beneficiaries. DHS will work with vendor on processes for notifying providers.
128	Page 20, §2.9 Due Process Reconsideration Procedures, (B)(7)	Vendor must notify the Provider and Beneficiary by US Mail within three (3) days of the DPR determination. The notice must include the outcome of all DPR requests and must accurately state the reviewing physician's rationale for any requested service that was not approved. The rationale must be case-specific; general or generic rationale is not acceptable.	Will postage expenses for this contract continue to be a pass-thru cost to the State? If not, please specify the anticipated cost of postage to the Vendor.	128	See updated IFB. For notifications generated by MMIS/InterChange and mailed by DXC, postage will not be passed through to the vendor at this time. Otherwise, vendor is responsible for postage.
129	Page 21, §2.11 Contact/Correspondence and Complaint Resolution, (B)(2)	Vendor shall respond by letter to any correspondence resulting from any review determination.	May the Vendor communicate with the Provider or Beneficiary electronically if there is a valid email address in MMIS interChange?	129	See answer to Question 127.
130	Page 23, §2.13 Reports, (A)(4)	Vendor shall base all reports on data, records and information collected and maintained by Vendor during fulfilling this contract.	See previous questions #33 and #35. Does the State expect vendors to create independent systems to collect and maintain this data?	130	See updated IFB. DHS does not expect the vendor to duplicate data contained within MMIS/InterChange as vendor will be able to access the data.

131	Page 28 §2.14 Staffing, (C)(2)(a.)	Licensed physicians with a minimum of five (5) years post graduate practice, board certified or board eligible in each specialty, and who are engaged in active practice within a specified region contiguous to Arkansas (contiguous region is defined as within fifty (50) miles of the Arkansas border, i.e.: Poplar Bluff, MO; Memphis, TN; Texarkana, TX) and have experience with the types of PA reviews, Retro reviews and Medical reviews/consults described herein.	Is this intended to preclude initial review by healthcare professionals who are not Board-certified physicians?	131	Yes.
132	Page 28 §2.14 Staffing, (C)(2)(a.)	Licensed physicians with a minimum of five (5) years post graduate practice, board certified or board eligible in each specialty, and who are engaged in active practice within a specified region contiguous to Arkansas (contiguous region is defined as within fifty (50) miles of the Arkansas border, i.e.: Poplar Bluff, MO; Memphis, TN; Texarkana, TX) and have experience with the types of PA reviews, Retro reviews and Medical reviews/consults described herein.	Can the State please define “active practice?”	132	See updated IFB.
133	Page 28, §2.14 Staffing, (C)(2)(c.)	Physician advisor who is an Arkansas-licensed medical physician, to be located in the Contractor's Little Rock office…	Minimum Qualifications on p.10, §2.2, do not state that a Contractor must have a Little Rock office. Is a Little Rock office required or will the State accept an office anywhere in Arkansas?	133	1) Yes. 2) Vendor may have multiple offices in addition to the Little Rock office.
134	Page 28 §2.14 Staffing, (C)(2)(c.)	Physician advisor who is an Arkansas-licensed medical physician, to be located in the Contractor’s Little Rock office and available via phone and email, at a minimum of .75 full-time equivalent (FTE) per month. At a minimum, the physician advisor must: 1) Be currently engaged in clinical practice;	The requirements state that a physician advisor must currently be involved in active practice but also must have a minimum commitment of .75 full-time equivalent to this project. What is the minimum amount of practice necessary to be “engaged in clinical practice?”	134	See updated IFB.
135	Page 30, §2.17 Data Maintenance and Retention, (B)(1)	Vendor shall be responsible for updating MMIS/Interchange with any corrections within twenty-four (24) hours.	Will the fiscal agent prepare all necessary triggers to ensure specified timeliness?	135	No.
136	Page 30, §2.17 Data Maintenance and Retention, (B)(1)	Vendor shall be responsible for updating MMIS/Interchange with any corrections within twenty-four (24) hours.	Will the Vendor have edit rights within interChange to make immediate changes?	136	Yes, depending upon approved security levels.
137	Attachment C, Page 6, Service Criteria, PA Reviews, (5)	Physician-Administered Drugs A. Vendor shall review requests for providing certain drugs by physicians based on medical necessity and other factors to be determined by DHS and Vendor. B. Medical necessity determinations shall be based on developed review criteria unique to the specific drug or class of drugs. Vendor shall collaborate with DHS in order to develop the review criteria.	By contract start date, will the State establish a point of contact and point of final decision authority for the establishment of factors and criteria?	137	DHS will work with vendor to establish a Review Committee to develop the criteria.

138	Attachment C, Page 6, Service Criteria, PA Reviews, (5)	Physician-Administered Drugs A. Vendor shall review requests for providing certain drugs by physicians based on medical necessity and other factors to be determined by DHS and Vendor. B. Medical necessity determinations shall be based on developed review criteria unique to the specific drug or class of drugs. Vendor shall collaborate with DHS in order to develop the review criteria.	How will the Arkansas Medicaid Fairness Act affect criteria establishment?	138	All applicable statutes and rules will be applied.
139	Attachment H, Page 5	Ad Hoc Review: Code Set Reviews	Ad hoc reviews and code set reviews are time and labor intensive. How many ad hoc code set reviews does the State anticipate?	139	Unknown at this time.
140	Attachment I, Page 1	Applicable Timeframes	Are these timeframes for initial reviews only? What are the timeframes for reconsiderations?	140	See Section 2.9.
141	Attachment I, Page 1	Applicable Timeframes	For outpatient Extension of Benefits, the document states that 24 hours is max timeframe for a Level 1 (RN) review; however, the timeframe is 30 days for a level 2 (MD) review. Is the EOB timeframe 30 days plus 24 hours whenever level 2 review is required?	141	See answer to Question 23.
142	Attachment I, Page 1	Applicable Timeframes	Will the Vendor be able to fully rely on the fiscal agent to create all timeliness triggers in MMIS?	142	See answer to Question 135.
143	Attachment I, Page 1	Prior Authorization Reviews *Inpatient Services Lab, x-ray, and professionals services (inpatient and outpatient) *Extension of Benefits for lab, x-ray, and professional services (inpatient and outpatient) *Extension of benefits for outpatient procedures and services *Lab, x-ray and professional services (outpatient) *Extension of benefits for lab, x-ray, and professional services (outpatient)	Extension of Benefits currently has a 30-day review timeframe. This IFB indicates that the EOB timeframe will be compressed to 24 hours (max) for all EOBs. For post-service reviews, is a 24-hour timeframe needed or realistic?	143	DHS will consider vendor's request to modify timeframes, including the basis for the request
144	Attachment I, Page 1	Prior Authorization Reviews *Inpatient Services Lab, x-ray, and professionals services (inpatient and outpatient) *Extension of Benefits for lab, x-ray, and professional services (inpatient and outpatient) *Extension of benefits for outpatient procedures and services *Lab, x-ray and professional services (outpatient) *Extension of benefits for lab, x-ray, and professional services (outpatient)	For pre-service reviews, why is there no distinction between emergent and non-emergent care?	144	See answer to Question 143.
145	Attachment I, Page 1	Prior Authorization Reviews: Independent laboratories including molecular pathology.	Molecular Pathology currently has a 15-day timeframe for review. This IFB indicates that the timeframe for Molecular Pathology will be compressed to 24 hours (max). Please explain the rationale for the 24-hour timeframe.	145	See answer to Question 143.
146	Attachment I, Page 2 – 3	"See note"	Some entries refer to a "note." To what "note" do these entries refer?	146	The Note (additional information) is contained in the description of the review type.