

# **Chapter 8**

## **Authorizations**



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## **GENERAL INFORMATION**

Many non-emergent services require prior authorization from the AHCCCS Administration, either from the Prior Authorization Unit for acute care services or from the recipient's case manager for ALTCS services.

Determination for prior authorization (PA) for acute services is based upon:

- The recipient's eligibility status at the time of the PA request,
- The provider's status as an AHCCCS-registered fee-for-service provider, and
- The service's status as an AHCCCS-covered service that requires PA.

PA for specific services from the AHCCCS PA Unit or the ALTCS case manager is required for all fee-for-service recipients, including fee-for-service Indian Health Service recipients, unless:

- The recipient has Medicare, third party liability (TPL), or commercial insurance coverage *and* the services are covered by Medicare, TPL, or commercial insurance, or
- Services were provided prior to posting of recipient retroactive eligibility, or
- Services are provided by an IHS or 638 facility, or
- The service is an emergency.
  
- The member is FES and has been admitted to a hospital. Effective 8/2/2011, pursuant to R9-22-217, authorization for continued stay of an inpatient FES member will not be required and concurrent review will no longer be performed.

Issuance of an authorization does not guarantee payment. The medical condition for which the authorization was issued must be supported by medical documentation, and the claim must be otherwise clean and timely submitted.

## **PRIOR AUTHORIZATION PROCEDURES**

Providers may phone or fax the AHCCCS PA Unit to request authorization. To obtain PA by telephone, providers must call between 9:00 AM to 11:30 PM and 12:30- 4:00PM, Monday – Friday:

(602) 417-4400 (Phoenix area) Providers in area codes 602, 480, and 623 **must** use this number.

1-800-433-0425 (within Arizona) This number is blocked for callers in area codes 602, 480, and 623.

1-800-523-0231 (outside Arizona)



AHCCCS PA Unit's fax number: (602) 256-6591.

Utilization Review fax: (602) 254-2304

Long Term Care fax: (602) 254-2426

Transportation providers only fax: (602) 254-2431

Prior Authorization Mandatory Fax Forms:

<http://www.azahcccs.gov/commercial/FFSclaiming/priorauthorization/priorauthorization.aspx>

**PA Web Portal:**

The AHCCCS Fee-For-Service Web Portal is now online. The portal may be accessed 24 hours a day/ 7 days a week. It allows you the ability to not only verify eligibility, but to enter your own authorization information that will subsequently be reviewed by the Prior Authorization staff. This process provides an immediate **pending** authorization.

**Note: This portal does not apply to ALTCS services that are authorized by the ALTCS Case Managers.**

**Prior Authorization Web Portal User Manual:**

<http://www.azahcccs.gov/commercial/Downloads/FFSTechnicalAssistance/PA>

Providers who fax documentation to the AHCCCS PA Unit must ensure that a Prior Authorization mandatory fax form accompanies the request.

Whether requesting information by telephone or fax, providers should be prepared to supply the following information:

- Requester's name
- Provider's name and NPI (if applicable) or AHCCCS ID number
- Recipient's name and AHCCCS ID number
- Type of service and service date(s)
- ICD-9 CM diagnosis code



- CPT/HCPCS/ADA procedure code (if applicable)
- Tier level (if applicable)
- Estimated charges/professional services (if there is no AHCCCS fee schedule)
- Medical justification for services

AHCCCS PA staff member will either issue an approval, a denial, or a provisional PA number pending the receipt of required documentation to substantiate compliance with AHCCCS criteria.

AHCCCS generates a PA confirmation letter with appropriate approval, denial, or provisional information (See Exhibit 8-1). The letter is mailed to the provider by the next working day. When a PA is denied concurrently, AHCCCS also generates a Notice of Action letter that is mailed to the recipient within three working days of the request. No denial letters are sent to recipients for retro denials

## **CLAIM SUBMISSION DIRECTIONS**

It is not necessary for the provider to enter the PA number on the claim form. If a valid PA exists for the service, the AHCCCS claims system will automatically match the claim information against established PAs and choose the correct one.

The information entered on the claim form must match what has been prior authorized and listed on the PA confirmation letter. If there are any discrepancies, the system will not find the appropriate PA, and claim will be denied. Providers may call or fax the PA Unit prior to submitting a claim to correct any discrepancies.



## **PRIOR AUTHORIZATION OF ACUTE SERVICES**

### **Prior to 8/2/2011:**

The following list identifies acute services requiring prior authorization. ALTCS authorization requirements are discussed in Chapter 21, ALTCS Services

- Abortions
- Ambulatory surgery centers
- Apnea management and training
- Behavioral health services
- Dental services
- Dialysis (FES recipients must have extended services plan)
- DME and supplies
- Home health services
- Hospital admissions
- Hysterectomy services
- Inpatient services
- Non-emergency transportation
- Nursing facilities
- Observation services
- Podiatry
- Rehabilitative services ( Effective 1/1/2011 no authorization required for outpatient rehab services for members 21 years and older)
- Surgeons
- Total parenteral nutrition (TPN)



**Effective 8/2/2011:**

**Pursuant to R9-22-204, 211 and 215 the following list identifies acute services requiring prior authorization. ALTCS authorization requirements are discussed in Chapter 21, ALTCS Services**

- Abortions
- Ambulatory surgery centers
- Apnea management and training (excluding the first 12 months of life)
- Acute Behavioral health services for Tribal ALTCS members
- Dental services
- DME and supplies
- Home health services
- Hospital admissions (non FES members)
- Hysterectomy services
- Transplant services
- Non-emergency transportation greater than 100 miles
- Nursing facilities
- Observation services > 23 hours (non-FES)
- Podiatry- for adult recipients 21 years of age not covered
- Surgeons
- Total parenteral nutrition (TPN)

**Pursuant to R9-22-204, 211 and 215 the following list identifies acute services that no longer require prior authorization:**

- Voluntary sterilization
- Dialysis shunt placement
- Arteriovenous graft placement for dialysis
- Angioplasties or thrombectomies of dialysis shunts



- Angioplasties or thrombectomies of arteriovenous grafts for dialysis
- Eye surgery for the treatment of diabetic retinopathy
- Eye surgery for the treatment of glaucoma
- Eye surgery for the treatment of macular degeneration
- Home health visits following an acute hospitalization (limited up to five visits)
- Hysteroscopy's (up to to, one before and one after) when associated with a family planning diagnostic code and done within 90 days of hysteroscopic sterilization
- Physical therapy up to 15 outpatient visits per benefit year
- Facility services related to wound debridement
- Apnea management and training for premature babies up to the age of one
- Hospitalization for vaginal delivery that does not exceed 48 hours
- Hospitalization for cesarean section delivery that does not exceed 96 hours
- Other services identified by the Administration through the Provider Participation Agreement

**Please refer to the AHCCCS Medical Policy Manual (AMPM) at [www.azahcccs.gov](http://www.azahcccs.gov) for specific covered services.**



## **AUTHORIZATION REQUIREMENTS FOR SPECIFIC SERVICES**

- Abortions
  - ✓ All medically necessary abortions require PA except in cases of medical emergency.
    - In the event of a medical emergency, all documentation of medical necessity must accompany the claim when submitted for reimbursement.
  - ✓ The request for PA must be accompanied by a completed Certificate of Medical Necessity for Pregnancy Termination (See *AMPM*, Exhibit 410-1).
  - ✓ The AHCCCS PA Unit will review the request and the certification and shall authorize the procedure if medically necessary.
  
- Ambulatory surgery centers
  - ✓ Ambulatory surgical facilities furnishing non-emergency surgical services must obtain a PA number for scheduled ambulatory surgery except voluntary sterilization procedures and certain dialysis related services including FES on Extended Services.
  - ✓ The PA number is separate from the surgeon's PA number.
  
- Apnea management and training
  - ✓ No PA is required for the first 12 months of life.
  - ✓ Apnea management, training, and use of the apnea monitor must be billed using procedure code E0618 or E0619 and the RR modifier and must be prior authorized.
  - ✓ PA requests must include the charge for the service, including the charges for management, training, and use of the apnea monitor.
  
- Behavioral health services
  - ✓ For non-Medicare recipients enrolled with a Tribal ALTCS program contractor, notification of an admission into an acute hospital or an acute care psychiatric hospital must be made to the AHCCCS Prior Authorization Unit.
  - ✓ For all other behavior health services, see Chapter 19, Behavioral Health Services.
  
- Dental services
  - ✓ PA is not required for preventive/ therapeutic dental services for EPSDT recipients except for:
    - Removable dental prosthetics, including complete dentures and removable partial dentures
    - Cast crowns
    - Orthodontia services



- ✓ Medically necessary dental surgery services for EPSDT recipients require PA.
- ✓ Medically necessary pre-transplant dental services for EPSDT and adults (these services require PA by the AHCCCS transplant coordinator and review by the AHCCCS Dental Director or Designee.)
- ✓ Surgical services provided by a dentist to an adult (only to the extent that such services may be performed under State law by either a physician or a dentist and the services would be considered physician services if furnished by a physician) require PA.
  
- Dialysis
  - ✓ PA is not required for monthly dialysis supervision or services. See Chapter 15.
  - ✓ FES members are required to have a monthly Certification of Medical Need kept on file in the physician's office.
  
- DME and supplies
  - ✓ DME purchases and prosthetic devices when the value for the item exceeds \$300 require PA.  
(Orthotics no longer covered for adults 21 years and older)
  - ✓ Consumable medical supplies (supplies which have limited potential for re-use) require PA when the cost exceeds \$100 per month.
  
- Home health services
  - ✓ All home health services for acute care recipients (excluding up to the first 5 visits post acute hospitalization)
  - ✓ All home health services for ALTCS recipients require case manager authorization.
  
- Hospital admissions
  - ✓ Prior authorization is required prior to all non-emergency and elective admissions.
  - ✓ Notification to the PA Unit must be provided no later than 72 hours of an emergency hospitalization. (This does not apply to FES inpatient admissions)
    - If the required notification day falls on a weekend or state holiday, notification must be provided no later than the next working day.
    - If approved, the PA nurse will authorize the length of stay.
    - Continued authorization/approval of services is determined through concurrent review.



- ✓ When a recipient's eligibility is posted after the beginning date of service and prior to the end date of service on the claim:
  - ☒ Notification must be provided no later than 72 hours after the eligibility posting date of an emergency hospitalization.
  - ☒ If the required notification day falls on a weekend or state holiday, notification must be provided no later than the next working day.
  - ☒ This policy does not apply if any eligibility is posted at the time services are rendered and there is a subsequent posting of retroactive eligibility.
  - ☒ If notification is not provided as required, AHCCCS may deny any portion of the stay dependent on medical review.
  
- ☒ Hysterectomy services
  - ✓ Non-emergency medically necessary hysterectomy services require PA.
  - ✓ The member must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children.
    - Exceptions:
      - ☒ The member was already sterile before the hysterectomy. The physician must certify in writing that the member was already sterile at the time of the hysterectomy and specify the cause of sterility.
  
      - ☒ The member requires a hysterectomy because of a life threatening emergency situation in which the physician determines that the prior Acknowledgement is not possible. The physician must certify in writing that the hysterectomy was performed under a life threatening emergency situation in which the physician determined that prior acknowledgement was not possible.
  - ✓ In a life-threatening emergency PA is not required.
  
- ☒ Inpatient services
  - ✓ Prior authorization is required for:
    - ☒ All organ and tissue transplantation services.
  
- ☒ Non-emergency transportation
  - ✓ Non-emergency transportation provided by ground ambulance, air ambulance, and non-ambulance vehicles require PA over 100 miles.
  - ✓ Only codes for the base rate, mileage, and waiting time (not covered under 100 miles) will be prior authorized.
  - ✓ See Chapter 14, Transportation Services



- Nursing facilities
  - ✓ PA must be obtained before admission of an acute care recipient unless another insurance or Medicare is primary, or the recipient becomes retroactively eligible for AHCCCS.
    - No PA is required during the retro period, but the stay is subject to medical review.
  - ✓ Initial authorization will not exceed the recipient's anticipated fee-for-service enrollment period or a medically necessary length of stay; whichever is shorter.
  - ✓ Reauthorization for continued stay is subject to concurrent utilization review by AHCCCS or its designee.
  - ✓ AHCCCS will allow up to 90 days (including Medicare days) of nursing facility care in a contract year (10/01 – 09/30).
  - ✓ As a part of discharge planning, prior authorization staff may request hospital personnel to initiate an ALTCS application for potentially eligible recipients.
  
- Observation services
  - ✓ Extensions to the 23-hour limit for observations services should be prior authorized for non-FES members.
  
- Pharmacy
  - ✓ See Chapter 12, Pharmacy Services for PA information.
  
- Rehabilitative services
  - ✓ Speech therapy and occupational therapy are not covered for non-ALTCS recipients over age 20):
  - ✓ Physical therapy visits are limited to 15 visits per contract year (10/1-9/30 of the following year) & do not require authorization after 1/1/2011..
  
- Surgeons
  - ✓ Surgeons must obtain a separate and distinct PA from that of the hospital for:
    - Elective or non-emergency inpatient or ambulatory surgery, except sterilization.
    - Both the primary surgical procedure and any surgical procedure designated in the *CPT Manual* as a separate procedure
    - Surgeries scheduled more than 72 hours after initial emergency admission of a continuous hospitalization
    - Organ transplantation not covered by Medicare



- ✓ Assistant surgeons and anesthesiologists do not require separate PAs.
  
- ☑ Total parenteral nutrition (TPN)
  - ✓ Facilities and agencies furnishing outpatient TPN services must obtain PA at least one working day prior to initiation of services.
  - ✓ Telephone requests are given provisional PA.
  - ✓ The following documentation must be received by the AHCCCS PA Unit within five working days of the initial TPN authorization request:
    - ☑ History and physical which describe recipient's condition and diagnosis
    - ☑ Physician's orders
    - ☑ Dietary assessment, including recipient's weight
    - ☑ Any pertinent progress notes (nursing/physician) which reflect the recipient's dietary, eating, and functional status
    - ☑ Physician progress notes indicating expected outcome of treatment
    - ☑ Nursing home records showing percentage of recipient's meal consumption

## **IHS**

AHCCCS recipients who are enrolled with the American Indian Health Program may receive services from AHCCCS fee-for-service providers if the services are not available through IHS or a tribally operated 638 facility.

Non-IHS/638 tribal providers must obtain authorization from the AHCCCS PA Unit before they can provide certain medically necessary services to American Indian Health Program members; refer to the FFS prior authorization list.



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Exhibit 8-1

**SAMPLE PA CONFIRMATION LETTER**



**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**Janice K. Brewer**  
Governor

**Thomas J. Betlach**  
Director

01/01/2011

654321  
HOLLIDAY, DOC  
123 OK CORRAL DRIVE  
TOMBSTONE, AZ 89999

CORRESPONDENCE REQUEST NUMBER: 123123 PA LETTER (PROVIDER APPROVAL)  
PRIOR AUTHORIZATION NUMBER: 00009999999

TO HOLLIDAY, DOC

WE HAVE RECEIVED A REQUEST FOR PRIOR AUTHORIZATION OF THE FOLLOWING  
MEDICAL SERVICES. THESE SERVICES HAVE BEEN APPROVED PER ARIZONA  
ADMINISTRATIVE CODE, R9-22-101 THROUGH R9-22-217 OR R9-28-101 THROUGH  
R9-28-206.

PRIOR AUTHORIZATION NUMBER : 0000999999  
RECIPIENT ID/NAME : A123456789 (EARP, WYATT DOB: 10/01/66 SEX: M)  
SERVICE CODE : 27447 (ARTHROPLASTY, KNEE, CONDYLE AND PLATE)  
DIAGNOSIS CODE : 715.96 (OSTEOARTHRISIS, UNSPECIFIED WHETHER )  
UNITS : 1.00  
MODIFIER :  
FROM SERVICE DATE : 1/15/2011  
THRU SERVICE DATE : 1/15/2011

IF ANY OF THE ABOVE RECORDED INFORMATION IS IN ERROR OR NEEDS TO BE  
REVISED, PLEASE CONTACT THE PRIOR AUTHORIZATION UNIT. IF YOU AGREE WITH  
THIS NOTICE, NO FURTHER ACTION IS NECESSARY AND THIS WILL BE THE LAST  
NOTICE YOU WILL RECEIVE. PLEASE NOTE, "OBTAINING PRIOR AUTHORIZATION  
DOES NOT GUARANTEE PAYMENT."

SINCERELY,

AHCCS ADMINISTRATION

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