

AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Health Plans

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This memo outlines the updated AHCCCS prior authorization and concurrent review standards for AHCCCS health plans in response to Governor Ducey's declaration of a public health emergency for COVID-19. *These standards are subject to change as the emergency conditions evolve.*

All services reimbursed must be medically necessary, cost-effective, federally and state reimbursable, and will be subject to post-payment review.

I. Behavioral Health Services

- A. Initial prior authorization is still required for Residential Treatment Center (RTC), Behavioral Health Residential Facility (BHRF) and Therapeutic Foster Care (TFC) levels of care.
- B. Health plans may continue with current standard operating procedures or have the flexibility to extend concurrent reviews from 30 to 90 days for Residential Treatment Center (RTC), Behavioral Health Residential Facility (BHRF) and Therapeutic Foster Care (TFC) levels of care. The focus should be on monitoring continued stays and making decisions based on the clinical status of the individual, their progress and their ability to transition to the appropriate level of care.
- C. Clinical staffings, Child and Family Teams (CFTs), Adult Recovery Team (ARTs), and coordination of care between facilities and outpatient providers should continue to inform appropriate levels of care and continued stay. Telehealth and telephonic modalities are strongly encouraged for these staffings and coordination.

II. Dental Services

- A. Health Plans are not permitted to prior authorize the following dental codes:
 - D7140 through D7270,
 - D3230,
 - D3240,
 - D3310 through D3330, and

- D2930, D2931, D3220, D0330 (under 6), D7111.
- B. Please see the COVID-10 Emergency Medical Coding Guidance: Teledentistry memo for more information:
<https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/COVID19EmergencyMedicalCodingTeledentistry.pdf>

III. Pharmacy Services

- A. Health plans must instruct their PBMs to remove the PBM system flag that requires the member to pay a copayment at the pharmacy.
- B. To ensure access to care, health plans must not require a prior authorization for compounded drugs for children under the age of ten years old.

IV. Physical Health Services

A. COVID-19 Testing and Treatment Services

1. Health plans are not permitted to implement prior authorization or concurrent review for services related to testing, diagnosis, and/or treatment of COVID-19.
2. Health plans must reimburse AHCCCS registered in-network and out-of-network providers for services related to testing, diagnosis, and/or treatment of COVID-19 as outlined in ACOM 203.

B. Inpatient and Post-Acute Services

1. General Requirements

- As per standard practice, services must be medically necessary, cost-effective, and federally and state reimbursable.
- Health plans must reimburse AHCCCS registered in-network and out-of-network facilities for inpatient and post-acute services during the duration of the COVID-19 emergency.
- Health plans must continue ongoing care management activities to ensure members stable for discharge to a lower level of care have safe and effective transitions of care. These care management activities may be conducted telephonically or via telehealth. Hospital notification to health plans of admission will allow health plans to assist in discharge planning.

2. Observation/Inpatient Hospital Services

- Prior Authorization
 - As per standard practice, health plans are not permitted to prior authorize emergent admissions.

- Health plans are not permitted to prior authorize COVID-19 suspected, confirmed, or related admissions. COVID-related are admissions related to COVID-19, even where the person receiving the services is not themselves suspected or confirmed to have COVID-19; this may include admissions that are necessary to create treatment capacity, prevent transmission of COVID-19 infection, or admissions that become necessary because of another individual being infected with COVID-19.
 - Health plans are permitted to prior authorize elective admissions.
 - Concurrent Review

Health plans are permitted to conduct concurrent review for elective observation/inpatient hospital services. Concurrent review for all other observation/inpatient hospital services is not permitted.
 - Home Based Supports for Hospital Discharge

Regardless of discharge diagnosis, health plans are not permitted to prior authorize medically necessary identified supports that are determined by the discharging entity for a member's discharge plan. Examples of this include but are not limited to home health nursing, oxygen, and medical equipment.
3. Post-Acute Services
- Prior Authorization

Health Plans are not permitted to prior authorize inpatient rehabilitation, long term acute care, assisted living, or skilled nursing facility admissions.
 - Concurrent Review

Health plans are permitted to conduct concurrent review for inpatient rehabilitation, long term acute care, assisted living, and skilled nursing facility stays.

C. Outpatient Services

For outpatient services requested during the COVID-19 emergency that require prior authorization, the document submission period for prior authorization will be extended to 90 days. COVID-19 testing, diagnosis and/or treatment are mandated exempt from prior authorization as per IV.A.1.

V. Medical Equipment (previously known as Durable Medical Equipment)

1. Health plans are not permitted to prior authorize medical equipment for individuals who are discharging from observation/inpatient hospital level of care.
2. While in-person evaluations may be required for DME requests, health plans must ensure their medical equipment vendors have in place contact-less evaluation and delivery procedures. Information obtained via telephonic or telehealth is strongly encouraged and accepted.

3. Physical (written or electronic) signatures must not be required to confirm medical equipment delivery. A medical equipment DME provider must provide a contactless method of confirming delivery from the member.

VI. Laboratory

1. All medically necessary testing performed in a physician's in-office lab such as newborn lead screening, hemoglobin testing, etc. must be covered without prior authorization requirements. In-network lab restrictions cannot be applied to testing services performed in a physician's office.
2. For all child, adolescent and adult outpatient services, any medically necessary lab services drawn at the physician office must be covered without prior authorization. In-network lab restrictions may be applied to testing that is drawn in a physician's office but sent to an independent laboratory for testing.