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

Original Release: March 20, 2020
Last Updated: April 2, 2021
Effective Date: April 15, 2021

Updated or added content as indicated with a date and bold type.

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

Initial prior authorization is still required for Residential Treatment Center (RTC), Behavioral Health Residential Facility (BHRF) and Therapeutic Foster Care (TFC) levels of care.

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.

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

Prior authorization extensions have been retired and are no longer required effective January 1, 2021.

Health Plans must remove prior authorization for the following dental codes:

- D7140 through D7270,
- D3230,
- D3240,
- D3310 through D3330, and
- D2930, D2931, D3220, D0330 (under 6), D7111.

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 (Revised 3/31/2021)

Effective 60 days post the date of this memo, Sections III.A and III.B will be no longer be requirements. This amount of time is being granted so the health plans have ample time to coordinate these changes with their respective Pharmacy Benefits Managers (PBMs). Agents that have been designated as preferred on the AHCCCS Drug List will be in effect and non-preferred medications that were not grandfathered during the AHCCCS Pharmacy and Therapeutics (P&T) process should be transitioned to the preferred agent(s) of the therapeutic class.

Section III.C will remain in effect until further notice.

A. Refill-too-soon edits and 90 day fills (See note at start of Section III above for reference to changes)

1. All health plans must remove the refill-too-soon edit on all non-controlled medications.
    a. Members may continue to fill prescriptions for up to a 30-day supply or they may fill a 90-day supply of maintenance medications, both of which may be done early once the edit is lifted.
    b. Specialty medications which are filled for a 30-day supply and delivered to the member's home may be filled early for the same day's supply as previously filled.
    c. When the refill-too-soon edit is lifted, Pharmacy Benefit Managers (PBMs) must check to ensure that quantity limits and duplicate therapy edits currently in place will not cause a rejection when the prescription is refilled early.
2. Controlled Substances may be refilled early when the pharmacy staff has checked with the prescribing clinician and the clinician has agreed to the early refill. The pharmacy staff or the prescribing clinician shall contact the health plan's PBM help desk for an immediate override. Please ensure that quantity limits and duplicate therapy edits will not cause a rejection when these claims are provided an override.
3. Removal of prior authorization for specific therapeutic classes

a. Health plans must remove all prior authorization requirements for the following Therapeutic Classes:
    - Antibiotics,
    - Antimalarials,
    - Antivirals,
    - Beta2 Agonist Inhalers and Inhalant Solutions,
    - Long-acting Beta2 Agonist-Corticosteroid Combination Inhalers,
    - Long-acting Beta2 Agonist-Anticholinergic Combination Inhalers,
    - Corticosteroid Inhalers and Inhalant Solutions,
    - Corticosteroid Oral Agents,
    - Nebulizers (must be available through pharmacies),
    - Cough and Cold products, such as:
        - Antihistamines,
        - Nasal Decongestants,
        - Combination products of antihistamines and nasal decongestants,
        - Cough suppression products including guaifenesin and combination products,
        - Guaifenesin oral tablets and combination products, and
        - Analgesics / Anti-febrile products (aspirin, ibuprofen, acetaminophen, acetaminophen suppositories, etc.)
    - Mast Cell Stabilizers, and
    - Methylxanthines (aminophylline and theophylline).

B. Addressing Drug Shortages (See note at start of Section III above for reference to changes)

1. The AHCCCS Drug List has preferred medications which the AHCCCS Medical Policy Manual (AMPM) 310-V requires to be utilized prior to a non-preferred agent. However, in the event of a shortage, a non-preferred medication must be approved. For example, ProAir is the preferred albuterol inhaler. Using ProAir as an example, if there is a shortage of ProAir, the health plans must allow all other branded and generic albuterol products to be reimbursed through the pharmacy claims system without prior authorization.
2. When there is a drug shortage and the health plans' network pharmacies are unable to obtain the medication in a timely manner, the health plans shall open up their pharmacy network to pharmacies that have the medication as long as they have an AHCCCS registered ID.
3. Please check the FDA web links daily for shortage updates:
    - https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm
    - https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-supply-chain-update

C. Pharmacy Copayments

1. Health plans must instruct their PBMs to remove the PBM system flag that requires the member to pay a copayment at the pharmacy.
2. 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 Services (Updated 03/31/2021)

1. **Health plans must continue the removal of any prior authorization and concurrent review requirements for observation units and acute inpatient hospitalization for:**
   - **i. Admissions where COVID-19 infection is suspected**
   - **ii. Admissions where COVID-19 infection is confirmed**
   - **iii. Admissions related to COVID-19, even where the person receiving the service is not themselves suspected or confirmed to be infected; 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 by COVID-19.**

     Services must be medically necessary, cost-effective, and federally and state reimbursable.
2. **Health plans may re-institute prior authorization and concurrent review requirements for observation units and acute inpatient hospitalization for admissions not listed in IV.B.1.i-iii.**
3. Health plans must continue the removal of prior authorization requirements and maintain concurrent review for the following levels of care:
   - Assisted Living Facilities/Centers, and
   - Skilled Nursing Facilities (SNFs)
4. **Health plans may re-institute prior authorization and concurrent review for Inpatient Rehabilitation Facilities and Long Term Acute Care Hospitals for admissions not listed in IV.B.1.i-iii.**

5. 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.
6. 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.

C. Outpatient Services (Updated 03/31/2021)

1. For outpatient services requested during the COVID-19 emergency, other than testing, diagnosis and treatment, 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. Please see IV. 1.

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

1. While in-person evaluations may be required for DME requests, MCOs 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.
2. 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.