

REVISION DATES: 10/01/2015, 08/01/2015, 08/14/2014, 08/07/2014

General Information

Many non-emergent services require prior authorization from the AHCCCS Administration, either from the DFSM Utilization Management/Care Management (UM/CM) 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 must be an AHCCCS-covered service that requires PA.

PA for specific services from the AHCCCS DFSM UM/CM Unit or the ALTCS case manager is required for all fee-for-service recipients, including fee-for-service American Indian Health Program (AIHP) 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 FESP 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.) Refer to Chapter 18 FESP.

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 meet all AHCCCS criteria including, but not limited to, clean claim and timely filing.

Prior Authorization Procedures

Prior Authorization determinations are made during regular business hours. PA requests may be submitted at any time by using the online web portal.

The on-line web portal is found at www.azweb.statemedicaid.us (Note: This web portal does not apply to ALTCS services that are authorized by the ALTCS Case Managers.)

The portal may be accessed 24 hours a day/ 7 days a week. This web portal allows the provider to not only verify eligibility, but to enter the authorization information that will subsequently be reviewed by UM/CM staff. This process assigns an immediate PA number for the pended authorization. Once the medical support is reviewed, the assigned PA number will be approved or denied.

Prior Authorization Web Portal User Manual is online at:

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

Providers may phone or fax the AHCCCS DFMS UM/CM Unit to request authorization. To obtain PA by telephone, providers must call between 9:00 AM to 11:30 AM 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) extension 74400

Providers who fax documentation to the AHCCCS DFMS UM/CM Unit must ensure that a completed Prior Authorization mandatory fax form accompanies the request.

Prior Authorization Mandatory Fax Forms:

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

AHCCCS DFMS UM/CM 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

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 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 DFSM UM/CM staff member will assign a PA number, review the information and subsequently either issue an approval, a denial, or pend the authorization for receipt of required documentation to substantiate compliance with AHCCCS criteria.

AHCCCS generates a PA confirmation letter with appropriate approval, denial, or pending 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.

If the UM/CM Unit issues a PA for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the claim payment will be adjusted accordingly. A.A.C. R9-22-703 D. 3.

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 PA files 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. Prior to submitting a claim, providers may correct any PA discrepancies online, by phone call or fax to the UM/CM Unit.

Prior Authorization of Acute Services

Pursuant to Arizona Administrative Code the following list identifies acute services requiring prior authorization. (ALTCS authorization requirements are discussed in Chapter 21, ALTCS Services.)

A.A.C. R9-22-204 B (1) advises that providers shall obtain PA from AHCCCS for the following inpatient services:

- Nonemergency and elective admission, including psychiatric hospitalization;
- Elective surgery; and
- Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.

A.A.C. R9-22-211 advises that providers shall obtain PA from AHCCCS for any medically necessary nonemergency transportation services when the distance traveled exceeds 100 miles.

A.A.C. R9-22-215 B advises that a Prior Authorization from AHCCCS is required for the following services:

- Sterilization
- Respiratory therapy
- Ambulatory and outpatient surgery facilities services
- Home health services under A.R.S. §36-2907(D)
- Private or special duty nursing services
- Rehabilitation services including physical therapy, occupational therapy, speech therapy and audiology
- Total parenteral nutrition services

A.A.C. R9-22-215 B (1 – 14) advises the following acute services do not require PA:

- 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 (up to two, 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 (effective 1/1/2014 the physical therapy limit is 30 outpatient visits per benefit year; see following section for specific details)
- 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 for 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 410-4).

The AHCCCS DFSM UM/CM Unit will review the request and the certification and shall authorize the procedure if medically necessary.

Ambulatory Surgery Center (ASC)

Ambulatory surgical facilities furnishing non-emergency surgical services must obtain a PA number for scheduled ambulatory surgery except voluntary sterilization procedures and dialysis related services including FES on Extended Services.

The facility's 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 DFSM UM/CM 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

PA is required for:

- Medically necessary dental surgery services for EPSDT recipients
- Medically necessary pre-transplant dental services for EPSDT and adults 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 age 21 years and older (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)

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, Orthotics, Prosthetics and Medical Supplies

Certain EPSDT medical supplies and prosthetic services may require PA. Refer to AMPM Chapter 400, Policy 430 EPSDT Services for required PA documentation, coverage limitations and exclusions.

DME purchases and prosthetic devices require PA when the purchase price for the item exceeds \$300.00 for acute members and \$500.00 for ALTCS members.

Consumable medical supplies (supplies which have limited potential for re-use) require PA when the cost exceeds \$100.00 per month.

PA is required for orthotics for adult members 21 years and older. Refer to FFS Chapter 13 for required PA documentation and coverage limitations and exclusions.

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 *before* all non-emergency and elective admissions including all organ and tissue transplantation services.

Notification to the UM/CM Unit *must* be provided within 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 UM/CM 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. (see AMPM Exhibit 820-1 for consent form)

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.

Non-Emergency Medical Transportation (NEMT)

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 FFS Chapter 14 Transportation Services for more information.

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 must be prior authorized for non-FES members.

Pharmacy

See Chapter 12, Pharmacy Services

Rehabilitative Services

Outpatient speech therapy and outpatient occupational therapy are not covered for non-ALTCS recipients over age 20.

Outpatient physical therapy visits are limited to 15 visits per contract year (10/1 - 9/30 of the following year) & do not require authorization.

Effective 1/1/2014 outpatient physical therapy for adults (age 21 years or older) is limited to:

- a. 15 visits per contract year to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain function once restored; and
- b. 15 visits per contract year to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

Please refer to AMPM 310-X for further information.

Surgeons

Surgeons must obtain a separate and distinct PA from that of the hospital for:

Elective or non-emergency 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 assigned an authorization number and pended until required documentation is received and reviewed.

The following documentation must be received by the AHCCCS DFSM UM/CM 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

American Indian Health Program (AIHP)

AHCCCS recipients who are enrolled with the American Indian Health Program (AIHP) may receive services from Indian Health Services (IHS), a tribally operated 638 facility or AHCCCS fee-for-service providers.

Non-IHS/638 providers must obtain authorization from the AHCCCS DFSM UM/CM Unit before they can provide certain medically necessary services to American Indian Health Program recipients; refer to the FFS prior authorization list in this chapter.

Revision History

Date	Description of changes	Page(s)
10/01/2015	Replace "ICD-9" with "ICD"	3
08/01/2015	Orthotics benefit changes effective 08/01/2015	6