

CHAPTER 800

FEE-FOR-SERVICE QUALITY AND UTILIZATION MANAGEMENT

800	<u>CHAPTER OVERVIEW</u>	<u>800-1</u>
	REFERENCES	800-1
810	<u>UTILIZATION MANAGEMENT OVERVIEW</u>	<u>810-1</u>
	A. PRIOR AUTHORIZATION	810-1
	B. CONCURRENT REVIEW FOR HOSPITAL SERVICES.....	810-3
	C. MEDICAL CLAIMS REVIEW	810-7
820	<u>PRIOR AUTHORIZATION REQUIREMENTS.....</u>	<u>820-1</u>
	A. BEHAVIORAL HEALTH	820-1
	B. BREAST RECONSTRUCTION AFTER MASTECTOMY.....	820-2
	C. COCHLEAR IMPLANTATION	820-2
	D. DENTAL SERVICES	820-3
	E. DIALYSIS	820-4
	F. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES	820-5
	G. EMERGENCY MEDICAL SERVICES	820-5
	H. EYE CARE/OPTOMETRY SERVICES.....	820-5
	I. FAMILY PLANNING SERVICES EXTENSION PROGRAM	820-6
	J. HOME HEALTH	820-6
	K. HOSPITAL INPATIENT SERVICE AUTHORIZATION	820-6
	L. HYSTERECTOMY	820-9
	M. MATERNAL AND CHILD HEALTH CARE.....	820-9
	N. MEDICAL SUPPLIES, DURABLE EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES.....	820-10
	O. NURSING FACILITY SERVICES	820-12
	P. OBSERVATION SERVICES THAT EXCEED 24 HOURS.....	820-13
	Q. PHYSICIANS AND PRIMARY CARE PROVIDERS.....	820-14

CHAPTER 800

FEE-FOR-SERVICE QUALITY AND UTILIZATION MANAGEMENT

820	<u>PRIOR AUTHORIZATION REQUIREMENTS (CONTINUED)</u>	
	R. FOOT AND ANKLE SERVICES	820-15
	S. PRESCRIPTION DRUG/PHARMACY SERVICES	820-15
	T. REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)	820-16
	U. TOTAL PARENTERAL NUTRITION	820-16
	V. TRANSPLANTATION (ORGAN AND TISSUE)	820-18
	W. TRANSPORTATION	820-19
	X. TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS	820-22
	Y. OTHER MEDICAL PROFESSIONAL SERVICES	820-23
	● EXHIBIT 820-1 AHCCCS HYSTERECTOMY CONSENT FORM	
830	<u>RESERVED</u>	<u>830-1</u>
840	<u>RESERVED</u>	<u>840-1</u>



800 CHAPTER OVERVIEW

REVISION DATES: 09/01/12, 07/01/10, 01/01/05, 10/01/01

INITIAL

EFFECTIVE DATE: 10/01/1994

This chapter defines AHCCCS Quality Management and Utilization Management (QM/UM) policies for Fee-For-Service (FFS) providers of AHCCCS covered acute care services. For purposes of this chapter, “member” is limited to FFS members with the exception of Federal Emergency Services Program (FESP) members. For information regarding FESP members, refer to [Chapter 1100](#).

The components of FFS UM discussed in this chapter include:

1. Utilization Management Overview
2. AHCCCS Division of Fee-For-Service Management (DFSM) FFS Prior Authorization (PA) Requirements and Adverse Decisions notification
3. Concurrent Review for Hospital Services
4. Quality and Utilization Management for Hospital Services, and

Refer to [Chapters 900](#) and [1000](#) for QM/UM requirements for Contractors

REFERENCES

1. Title 42, Code of Federal Regulations (42 CFR), Part 456, Subpart C
2. 42 CFR, Part 441—Services: Requirements and Limits Applicable to Specific Services
3. Arizona Revised Statutes (A.R.S.), Title 36, Chapter 29, Articles 1, 2 and 4
4. Arizona Administrative Code, Title 9, Chapter 22, Article 2 (9 A.A.C. 22, Article 2)
5. 9 A.A.C. 28, Article 2
6. 9 A.A.C. 31, Articles 2 and 16



810 UTILIZATION MANAGEMENT OVERVIEW

REVISION DATES: 10/01/15, 03/01/14, 09/01/12, 07/01/10, 03/01/09, 10/01/08, 01/01/05,
05/01/04, 10/01/01, 10/01/98, 03/14/97

INITIAL

EFFECTIVE DATE: 10/01/1994

Utilization Management (UM), often referred to as utilization review, is a methodology used by health care professionals for assessing the medical necessity, appropriateness and cost-effectiveness of professional care, services, procedures and facilities.

UM methodologies include, but are not limited to:

1. Prior authorization (does not apply to emergency services)
2. Concurrent review, and/or
3. Medical claims review (retrospective review).

A. PRIOR AUTHORIZATION

Description

Prior Authorization (PA) is a process by which the AHCCCS Division of Fee-For-Service (FFS) Management (DFSM) determines in advance whether a service that requires prior approval will be covered, based on the initial information received. PA may be granted provisionally (as a temporary authorization) pending the receipt of required documentation to substantiate compliance with AHCCCS criteria. PA does not guarantee payment. Reimbursement is based on the accuracy of the information received with the original PA, on whether or not the service is substantiated through concurrent and/or medical review, and on whether the claim meets claims submission requirements.

PA is issued for AHCCCS covered services within certain limitations, based on the following:

1. The member's AHCCCS eligibility at time of PA request, as confirmed through on-line verification
2. Provider status as an AHCCCS-registered FFS provider
3. The service requested is an AHCCCS covered service requiring PA



4. Information received by the AHCCCS/DFSM/Care Management Systems Unit (CMSU) meets the requirements for issuing a PA number, and
5. The service requested is not covered by another payer (e.g., commercial insurance, Medicare, other agency).

Amount, Duration and Scope

PA request determinations are made during regular business hours. PA requests may be submitted after regular business hours by fax or by using the online web portal.

The process for a provider submitting a PA request and obtaining a PA number prior to providing an AHCCCS covered service is as follows:

1. Providers may submit a PA request via:
 - a. On-line web portal <https://azweb.statemedicaid.us/Home.asp> or
 - b. Telephone

1-602-417-4400 (Phoenix area direct line to the PA Area)
1-800-433-0425 (In state direct line into the PA Area)
1-800-523-0231 (Out of state line to AHCCCS switchboard; dial Extension 74400 or ask for the PA Area) or
 - c. Fax

PA - (602) 256-6591
UR - (602) 254-2304
LTC - (602) 254-2426
Transport - (602) 254-2431 or
 - d. Mail

AHCCCS-Division of Fee-for-Service Management
Care Management Systems Unit (CMSU), Mail Drop 8900
701 East Jefferson
Phoenix, AZ 85034
2. Providers must be prepared to submit the following information:
 - a. Caller name, provider name and provider ID
 - b. Member/patient name and AHCCCS ID number



- c. Type of admission/service
 - d. Admission/surgery service date
 - e. ICD-10 diagnosis code(s)
 - f. CPT or CDT procedure code(s) or HCPCS code(s)
 - g. Anticipated charges (if applicable), and
 - h. Medical justification. If the PA is through the web portal, the provider will input the information using the online forms. If the provider is utilizing the fax, forms must be downloaded from the AHCCCS Website.
3. AHCCCS/DFSM/CMSU Unit staff, upon receipt and assessment of information provided, will issue to the requesting provider an approval, a provisional PA number or notify them of a denial of coverage.
 4. The AHCCCS/DFSM/CMSU Unit generates a PA confirmation letter of approval, provisional approval (awaiting additional information), or denial of coverage, which is mailed to the provider the next business day.

For all requirements related to the grievance system, refer to Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

5. PA is not required for FFS members receiving services from Indian Health Service/638 (IHS/638) providers and facilities. A non-IHS/638 provider or facility rendering AHCCCS covered services must obtain PA from the AHCCCS/DFSM/CMSU Unit for services specified in Policy 820 of this Chapter.

B. CONCURRENT REVIEW FOR HOSPITAL SERVICES

Description

Concurrent review may be performed on admission and at frequent intervals during acute inpatient hospital stays. Reviewers assess the appropriate usage of ancillary resources, Levels of Care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for continued stay and evaluates quality of care.

1. Concurrent review is provided by the AHCCCS/DFSM/CMSU Unit or an AHCCCS contracted review organization that employs licensed health care professionals to perform reviews.



2. Concurrent review begins when the AHCCCS/DFSM/CMSU Unit initiates and conducts the review or notifies the contracted review organization of the admission or need for review.
3. Concurrent review is generally initiated by the next business day and continues at intervals appropriate to the member's condition, based on the review findings. During review, the following are considered:
 - a. Necessity of admission and appropriateness of service setting
 - b. Quality of care
 - c. Length of stay
 - d. Whether services meet the coverage requirements for the eligibility type
 - e. Discharge needs, and
 - f. Utilization pattern analysis.

Concurrent Review Determinations

When the concurrent review is initiated and conducted by the AHCCCS/DFSM/CMSU Unit, the PA staff determines the appropriateness of continued services in consultation with the AHCCCS Chief Medical Officer (CMO) and/or Medical Director as needed. The AHCCCS/DFSM/CMSU Unit issues a denial notice when it is determined that the services no longer meet AHCCCS coverage criteria.

There are conditions when the concurrent review function is outsourced to a contracted review organization. These include but are not limited to:

1. Length of stay or level of care cases
2. Medical necessity cases where the medical need is in question.

If the concurrent review is outsourced to the contracted review organization, both the contracted review organization and the AHCCCS/DFSM/CMSU Unit determine the appropriateness of continued services in consultation with physician advisors, as necessary. If it is determined that service no longer meets coverage criteria, the contracted review agency will initiate a recommendation of denial.

Procedures

Procedures for the AHCCCS/DFSM/CMSU Unit and contracted review organization are as follows:



1. Continued hospital services may be denied when:
 - a. A member no longer meets intensity and severity criteria
 - b. A member is not making progress in a rehabilitative program
 - c. A member can be transferred safely to a lower LOC, or
 - d. Services do not meet the coverage criteria.
2. Consultation with the AHCCCS Medical Director or contracted review organization physician may occur to review the need for a continued stay.
3. The provider and the hospital liaison will be notified verbally or in writing regarding a potential denial of coverage and the denial date by the organization that has the concurrent review responsibility.
4. The provider has one business day to:
 - a. Agree: The provider agrees that services or stay are no longer appropriate and the denial stands, or
 - b. Disagree: The provider disagrees and provides information to the contracted review organization justifying medical necessity for continued stay.
5. When the provider disagrees, one or more of the following will occur when the concurrent review is performed by the AHCCCS/DFSM/Care Management Systems Unit, or:

AHCCCS/DFSM/CMSU UNIT ACTION	OUTCOME
<ul style="list-style-type: none">• AHCCCS/DFSM/CMSU Unit (and Medical Director, as necessary) agrees with provider.	Stay is extended.
<ul style="list-style-type: none">• AHCCCS Medical Director and/or CMO does not agree on continued stay.	Stay is denied.
<ul style="list-style-type: none">• Provider requests second review and the CMO agrees with the Medical Director to deny continued stay.	Stay is denied.
<ul style="list-style-type: none">• Provider requests second review and the CMO and Medical Director disagree.	A contracted physician advisor may be consulted and his decision to continue or deny the stay is final.



6. When the Provider disagrees, one or more of the following will occur when the concurrent review is performed by the contracted review organization:

CONTRACTED REVIEW ORGANIZATION ACTION	OUTCOME
<ul style="list-style-type: none">Contracted review organization (and their physician advisor, as necessary) agrees with attending.	Stay is extended.
<ul style="list-style-type: none">Contracted review organization physician advisor does not agree on continued stay.	Second contracted physician advisor is consulted.
<ul style="list-style-type: none">If the second contracted physician advisor agrees with the first physician advisor to deny continued stay.	Stay is denied.
<ul style="list-style-type: none">If first and second contracted agency physician advisors disagree.	A third contracted physician advisor is consulted and his decision to continue or deny the stay is final.

7. When the final determination is a denial of coverage, denial dates will be effective (as confirmed with the AHCCCS/DFSM/CMSU Unit) according to a two business-day schedule. For example:
- a. The provider is notified by the responsible concurrent review entity (AHCCCS/DFSM/CMSU Unit or contracted review organization) on October 10.
 - b. The responsible concurrent review entity allows:
 - i. One business day (October 11) for the attending physician's response period and
 - ii. One business day (October 12) for verbal notification of the denial to the attending physician and the hospital.
 - c. The denial date is effective October 13.
8. When the contracted review organization is the responsible entity, the following also applies:
- a. Immediately notifies the AHCCCS/DFSM/CMSU Unit verbally
 - b. Forwards written notification of denial of coverage to all of the following:
 - i. The attending physician



- ii. The hospital, and
- iii. AHCCCS/DFSM/CMSU (within five business days of initiation of denial).

9. For grievance system requirements, refer to 9 A.A.C. 34

C. MEDICAL CLAIMS REVIEW

Description

AHCCCS/DFSM/Claims conducts medical reviews of specified claims for each AHCCCS eligibility category to verify appropriateness and effectiveness of service utilization. Criteria for these medical claim reviews focus on factors including, but not limited to: diagnosis, utilization pattern, selected types of surgery and admissions. Focused medical reviews are conducted on a pre-payment basis, and may be applied to a sample of claims or all claims, depending on the reason for conducting the review.

Procedures

AHCCCS/DFSM/Claims Medical Review staff may review claims for physician and professional services rendered, hospital admissions, the level of care provided, and the length-of-stay in conjunction with the admission criteria. All transplant services are reviewed by the AHCCCS Transplant Coordinator, Division of Health Care Management (DHCM), Medical Management Unit.



820 PRIOR AUTHORIZATION REQUIREMENTS

REVISION DATES: 01/01/14, 03/01/12, 01/01/12, 11/01/11, 10/01/10, 07/01/10, 10/01/09, 03/01/09, 10/01/08, 10/01/07, 05/15/07, 04/01/07, 11/01/06, 08/01/06, 06/01/06, 03/03/06, 01/01/05, 07/01/04, 10/01/01, 07/01/99, 07/01/98, 06/01/98, 02/18/98, 02/12/98, 10/01/97, 05/01/97, 03/14/97, 07/22/96, 10/01/95, 08/01/95, 04/01/95

INITIAL
EFFECTIVE DATE: 10/01/1994

This section identifies AHCCCS Administration Fee-For-Service (FFS) Prior Authorization (PA) requirements for covered services for the general FFS population not in Federal Emergency Services Program (FESP) (refer to [Chapter 1100](#) for all requirements regarding services provided to FESP members). PA is not required for FFS members receiving services from Indian Health Services (IHS)/638 providers and facilities. A non-IHS/638 provider or facility rendering AHCCCS covered services must obtain PA from the AHCCCS/Division of Fee-For-Service Management Care Management Systems Unit (CMSU) for services specified in Policy 820 of this Chapter when scheduling an appointment or admission for the FFS member.

NOTE: Long Term Care services for Tribal ALTCS members are authorized by the member's ALTCS tribal case manager.

The AHCCCS/DFSM procedural requirements for submitting PA requests via web portal (preferred), fax, telephone or mail, as defined in Policy 810, apply to all services identified in this section, unless specified otherwise. For purposes of this chapter, all PA requests are submitted to the AHCCCS/DFSM CMSU Unit for approval or denial, unless specified otherwise.

A. BEHAVIORAL HEALTH

Description

AHCCCS covers behavioral health services (mental health and/or substance abuse services) within limitations depending upon the member's age and eligibility.

Outpatient behavioral health services for Tribal ALTCS members are prior authorized by the ALTCS tribal case manager. Outpatient behavioral health services for acute FFS members are prior authorized by the Integrated RBHA/RBHA/TRBHA. American Indian members may also receive behavioral health services at an Indian Health Service or Tribally owned or operated 638 facility.

Refer to Section K of this policy for behavioral health inpatient admission authorizations.



Refer to [Chapter 300](#), Policy 310 of this Manual and the [Behavioral Health Services Guide](#) for further information regarding AHCCCS covered behavioral health services and settings.

B. BREAST RECONSTRUCTION AFTER MASTECTOMY

Description

AHCCCS covers breast reconstruction for eligible Fee-For-Service (FFS) members following a medically necessary mastectomy.

Refer to [Chapter 300](#), Policy 310.

The physician performing the procedure and the facility in which the services are provided must obtain PA from the AHCCCS Medical Director, or designee, for breast reconstruction surgery provided to FFS members.

Refer to the sections of this policy addressing Hospital Inpatient Stays and Physician Services for required documentation to receive PA.

C. COCHLEAR IMPLANTATION

Description

AHCCCS covers medically necessary services for cochlear implantation for FFS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) members. Providers must obtain approval from the AHCCCS Medical Director, or designee, for all cochlear implants and related services for FFS members. Requests for PA must include documentation of the appropriate assessments and evaluations for determining suitability for a cochlear implant.

Refer to [Chapter 400](#), Policy 430, in this manual for complete information regarding covered cochlear implantation services.

Procedures

FFS provider responsibilities regarding cochlear implantation services include, but are not limited to:

1. The member's implantation specialist (otolaryngologist or otologist) must submit a written request to the AHCCCS Medical Director, or designee, for approval of the implant.
2. The following documentation must accompany the written request:



- a. The member's current history and physical examination, including information regarding previous therapy for the hearing impairment
 - b. Records documenting the member's diagnosis, current medical status and plan of treatment leading to the recommendation of implantation, and
 - c. Current psychosocial evaluation and assessment for determining the member's suitability for implant.
3. The AHCCCS Medical Director, or designee, will review the submitted documentation and provide a written response for approval or denial to the member's implant specialist. If approved, the written response will include the following information:
- a. Stipulates that the implantation center must be an AHCCCS registered provider
 - b. Instructions for obtaining PA for each implant service component, and
 - c. Coverage limitations.
4. If a cochlear implant is denied, notice will be provided in accordance with Arizona Administrative Code (A.A.C.) 9 A.A.C. 34.

Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding submission of claims and billing procedures. This manual is available online at the AHCCCS Website.

D. DENTAL SERVICES

Description

AHCCCS provides dental services for members who are under the age of 21 in both the Medicaid (EPSDT Program) and KidsCare Programs. Refer to [Chapter 400](#), Policy 430, for complete information regarding covered dental services for these members.

For members 21 years of age and older, refer to [Chapter 300](#), Policy 310D regarding services that may be provided by a dentist and under what circumstances.



Procedures

Preventive and therapeutic dental services for members who are under the age of 21 in both the Medicaid (EPSDT Program) and KidsCare Programs do not require PA. However, the following services for these members do require PA:

1. Removable dental prosthetics, including complete dentures and removable partial dentures
2. Cast crowns
3. Orthodontia services
4. Pre-transplant dental services (these services require PA by the AHCCCS transplant coordinator and review by the AHCCCS Dental Director or Designee)

PA requests for dental prosthetics, cast crowns, pre-transplant dental services, and orthodontic services may be submitted via web portal, fax, telephone, mail. PA is not necessary in emergency circumstances.

Written dental PA requests must be accompanied by:

1. Dentist substantiation of medical necessity of services through description of medical condition
2. Dentist's treatment plan and schedule, and
3. Radiographs fully depicting existing teeth and associated structures by standard illumination when appropriate.

E. DIALYSIS

Description

AHCCCS covers dialysis and related services furnished to AHCCCS FFS members by qualified providers without PA.

Refer to [Chapter 300](#), Policy 310, for covered dialysis services for members not in FESP.

Refer to [Chapter 1100](#), Policy 1120, for information regarding FESP dialysis services.



F. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Description

EPSDT services provide comprehensive health care, as defined in 9 A.A.C. 22, Article 2, through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening. Limitations and exclusion, other than the requirement for medical necessity, do not apply to EPSDT services.

PA for these services is only required as is designated in this policy and in [Chapter 400](#), Policy 430.

Refer to [Chapter 400](#), Policy 430, for complete information regarding EPSDT services (overview, definitions, screening requirements, service standards, provider requirements and exhibits).

G. EMERGENCY MEDICAL SERVICES

Description

A provider is not required to obtain PA for emergency medical services; however, a provider must comply with the notification requirements in 9 A.A.C., Article 2.

Notification of emergency admissions may be submitted via fax or telephone. A provider must notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

Refer to [Chapter 300](#), Policy 310 and Exhibit 310-1, for review of the Rule sections regarding FFS emergency services.

Refer to [Chapter 1100](#) for information regarding the Federal Emergency Services Program.

H. EYE CARE/OPTOMETRY SERVICES

Description

AHCCCS covers eye care/optometric services for members, within limitations. Coverage is provided as described in [Chapter 300](#), Policy 310.



1. Emergency eye care services do not require AHCCCS authorization.
2. Eye examinations and prescriptive lenses are covered only for EPSDT and KidsCare members. PA is not required. Prescriptive lenses for members age 21 and older are not covered unless they are the sole visual prosthetic device used by the member after cataract removal surgery.
3. Cataract removal requires PA from the AHCCCS/DFSM/CMSU Unit. Children needing cataract removal should be referred to Children's Rehabilitative Services (CRS). Refer to [Chapter 300](#), Policy 330, for CRS covered services. Other prior authorization requests for cataract removal services may be submitted via web portal, fax, telephone or mail.

I. FAMILY PLANNING SERVICES EXTENSION PROGRAM

Description

Refer to [Chapter 400](#), Policy 420 for a complete discussion of the Family Planning Services Extension Program.

J. HOME HEALTH

Description

All home health services require PA from the AHCCCS/DFSM/CMSU Unit, except for the first five visits following discharge from an acute facility.

Refer to [Chapter 300](#), Policy 310, for complete information regarding covered home health services.

Procedures

PA requests for home health services should be submitted by web portal, fax, telephone or mail prior to providing services.

K. HOSPITAL INPATIENT SERVICE AUTHORIZATION

Description

Hospital inpatient service authorization is a part of the utilization management process that may consist of both PA and continued authorization, contingent upon concurrent review findings (refer to Policy 810).



Procedures

Initial Service Authorization:

Under 9 A.A.C. 22, Article 2, the provider must notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

1. Providers must obtain PA from the AHCCCS Administration or its designee for the following inpatient hospital services:
 - a. Organ and tissue transplantations (this authorization review is performed by the AHCCCS Transplant Coordinator, AHCCCS Division of Health Care Management (DHCM), Medical Management Unit, with the exception of corneal transplants and bone grafts that are submitted to the AHCCCS/DFSM/CMSU Unit.)
 - b. Non-emergency admissions, including psychiatric hospitalizations. For psychiatric hospitalizations the following applies:
 - i. PA requests for Acute FFS members are submitted to the Integrated Regional Behavioral Health Authority (Integrated RBHA), Regional Behavioral Health Authority or the Tribal Regional Behavioral Health Authority (TRBHA).
 - ii. PA requests for Tribal ALTCS members are submitted to the AHCCCS/DFSM/CMSU Unit.
 - c. Elective surgery, with the exclusion of any surgeries listed in 2 below.
 - d. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury.
2. The following services do not require PA:
 - a. Voluntary sterilization
 - b. Dialysis shunt placement
 - c. Arteriovenous graft placement for dialysis
 - d. Angioplasties or thrombectomies of dialysis shunts
 - e. Angioplasties or thrombectomies of arteriovenous grafts for dialysis



- f. Hysteroscopies when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization.

AHCCCS covers inpatient hospital care for a normal vaginal delivery and inpatient hospital care for a cesarean delivery. Prior authorization is not required for hospitalizations that do not exceed 48 hours of inpatient hospital care for a normal vaginal delivery or do not exceed 96 hours of inpatient hospital care for a cesarean delivery.

The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother's stay in the hospital is medically necessary beyond a 48/96 hour stay.

4. For retrospectively eligible members, notification requirements are as follows:
 - a. When the member is made eligible while still in the hospital, providers must notify the Administration no later than 72 hours after the eligibility posting date for emergency hospitalizations.
 - b. When eligibility is posted after the member is discharged from the hospital, the notification requirement in 4(a) will be waived.
5. Payment for services may be denied if the hospital fails to provide timely notification or obtain the required authorization number(s) within the parameters specified in this policy. However, the issuance of an authorization number does not guarantee payment; documentation provided from the member's medical record must support the diagnosis for which the authorization was issued, and the claim must meet clean claims submission requirements.

Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding pre-payment review criteria and submission requirements. This manual is available online at the AHCCCS Website.

6. Authorization may be provisional if further review of information or documentation is needed to make a full assessment of the medical necessity for the admission, the service(s), and/or to determine the appropriate length of stay. This information may be obtained through on-site or telephonic concurrent review. Upon approval or denial, the provisional status is removed from the authorization and the provider is notified by letter of the decision.



L. HYSTERECTOMY

Description

Hysterectomy services require Prior Authorization (PA) from the AHCCCS/DFSM/CMSU Unit. AHCCCS does not cover hysterectomy procedures when performed only for the purpose of rendering an individual sterile.

Refer to [Chapter 300](#), Policy 310, for complete information regarding covered hysterectomy services.

Procedures

PA requests for hysterectomy services may be submitted via web portal, fax, telephone, or mail.

The medical record must document the medical necessity of the hysterectomy, including prior medical and surgical therapy and results. Also, the member must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children. Women who are deemed post-menopausal are not required to sign this type of consent form. PA may be granted based on these documents. Providers may use the sample AHCCCS hysterectomy consent form contained in this Chapter, Exhibit 820-1, or they may use other formats as long as the forms include the same information and signatures as the AHCCCS hysterectomy consent form.

The provider is not required to complete a consent to sterilization form prior to performing hysterectomy procedures and the 30-day waiting period required for sterilization does not apply to hysterectomy procedures.

In a life-threatening emergency, authorization is not required, but the physician must certify in writing that an emergency existed.

M. MATERNAL AND CHILD HEALTH CARE

AHCCCS covers a comprehensive set of services for pregnant women, newborns and children, including maternity care, family planning services, EPSDT services and KidsCare services.

AHCCCS requires FFS providers to request PA for pregnancy terminations.

Refer to [Chapter 400](#) for information on maternal and child health care services.



N. MEDICAL SUPPLIES, DURABLE EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES

Description

Medical supplies, durable equipment and orthotic/prosthetic devices must be prescribed by a fee-for-service physician or other appropriate practitioner. Orthotic devices are limited to EPSDT and KidsCare members.

Refer to [Chapter 300](#), Policy 310, for complete information regarding covered medical supplies, equipment and prosthetic devices.

The following requirements apply to these services:

1. Prior Authorization (PA) is required for the purchase of medical equipment and orthotic/prosthetic devices exceeding \$300.00. PA is required for all Durable Medical Equipment (DME) rentals and repairs.
2. PA is required for consumable medical supplies exceeding \$100.00 per month. (Consumable means the supplies have limited or no potential for reuse.)
3. For members age 21 and over, PA is required for medically necessary incontinence supplies. These incontinence supplies must be designated specifically to meet a medical purpose.
4. Refer to [Chapter 400](#), Policy 430, for criteria related to coverage of incontinence briefs for members under the age of 21.
5. Durable medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary equipment can be obtained at no cost. The total expense of renting the equipment must not exceed the purchase price (i.e., if AHCCCS can purchase the equipment for less than the rental fee, AHCCCS will purchase the item). All rental equipment requires PA.
6. The following items do not require PA:
 - a. Oral supplements for ALTCS members, and
 - b. Apnea management and training for premature babies up to one year of life.



AHCCCS does not cover the following:

1. Personal care items unless needed to treat a medical condition. Exception: AHCCCS covers incontinence briefs for persons over three and under age 21 as described in [Policy 430](#).
2. First aid supplies (except upon prescription by an authorized provider)
3. Hearing aids, cochlear implants or bone-anchored hearing aides for members 21 years of age or older
4. Prescriptive lenses for members 21 years of age or older (except when medically necessary following cataract removal without an implanted lens)
5. Orthotics for members 21 years of age or older
6. Penile implants or vacuum devices for members 21 years or older.

Procedures

PA for supplies/equipment may be submitted via web portal, fax, telephone, or mail.

1. In addition to information required for all PAs specified in Policy 810 of this chapter, the following information must be supplied at the time of the PA request:
 - a. Name, and dated signature
 - b. Diagnosis and diagnosis code of ordering provider
 - c. Description of medical condition necessitating the supplies/equipment, and medical justification for supplies/equipment with anticipated outcome (medical/functional)
 - d. Description of supplies/equipment requested
 - e. Duration for use of equipment
 - f. Full purchase price plus any additional costs and expected cost if rented
 - g. Provider identification number
 - h. Home evaluation, when requested by the AHCCCS/DFSM/CMSU Unit.
2. The procedure for use of the web portal for a request is:



- a. Use the web portal link as directed on line
 - b. Submit the above information via, fax or mail
 - c. Once received, a pended authorization number is given, information provided is reviewed, and a PA confirmation letter is mailed to the provider indicating a denied, approved or pended authorization status.
3. The procedure for a telephone request is:
- a. After receiving the information outlined above, the AHCCCS/DFSM/CMSU Unit issues a provisional number to the provider
 - b. The provider must then submit the information in writing via mail or fax
 - c. Upon receipt of the PA request form with all required documentation, the PA request will be reviewed, and a PA confirmation letter will be mailed to the provider indicating the PA status..
4. The procedure for written (mail or fax) request is:
- a. The provider must submit the information outlined above
 - b. Once received, information is reviewed, and PA confirmation letter is mailed to the provider indicating a denied, approved, or pended authorization status.
5. For members over the age of 21, requests for authorization of incontinence supplies must include the following information:
- a. Diagnosis of a dermatologic condition or other medical/surgical condition requiring medical management by incontinence supplies as dressings
 - b. Defined length of treatment anticipated, and
 - c. Prescription for specific incontinence supplies.

O. NURSING FACILITY SERVICES

Description

Nursing Facility (NF) services for FFS acute members are covered by AHCCCS for up to 90 days per contract year if the member's medical condition would otherwise require hospitalization. Per 9 A.A.C. 22, Article 2, in lieu of a NF, a Tribal ALTCS



member may be placed in an alternative living facility or receive home and community-based services. PA is required for these services prior to admission of the member, except in those cases for which retroactive eligibility precludes the ability to obtain PA. However, the case is subject to medical review.

Nursing Facility (NF) services for Tribal ALTCS members are authorized by the ALTCS tribal case manager.

Refer to [Chapter 300](#), Policy 310, and [Chapter 1200](#) for complete information regarding covered long term care services.

Procedures

PA requests may be submitted via web portal, fax, telephone, or mail. Initial PA will be for a period not to exceed the anticipated enrollment period of the FFS eligible member or what is determined as a medically necessary length of stay, whichever is shorter (not to exceed 90 days) and includes any day covered by Medicare.

Reauthorization for continued stay is subject to concurrent utilization review and continued eligibility.

AHCCCS/DFSM CMSU Unit staff will request hospital personnel and/or NF staff, whichever is appropriate, to initiate an ALTCS application by the 45th day for possible coverage of nursing facility services if it is believed that the member will need a NF stay lasting longer than 90 days.

P. OBSERVATION SERVICES THAT EXCEED 24 HOURS

Description

Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by hospital nursing personnel or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not Observation when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours. This is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized or whether services were rendered after midnight.

Extended stays after outpatient surgery must be billed as recovery room extensions.



Refer to [Chapter 300](#), Policy 310, for complete information regarding covered outpatient health services.

Procedures

Observation must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for observation services as long as medical necessity exists. The medical record must document the basis for observation services. Documentation must minimally include the following:

1. Physician Notes:
 - a. Condition necessitating Observation
 - b. Justification of need to continue Observation, and\or
 - c. Discharge plan.
2. Medical Records Documentation:
 - a. Orders for Observation must be written on the physician's order sheet, not the emergency room record, and must specify "Observation." Rubber stamped orders are not acceptable. Orders must be signed and dated by a physician within 24 hours if ordered by authorized non physician staff..
 - b. Follow-up orders must be written at least every 24 hours
 - c. Changes from "Observation to inpatient" or "inpatient to Observation" must be ordered by a physician or authorized individual, prior to the member's discharge from the facility.
 - d. Physician's daily progress notes

Q. PHYSICIANS AND PRIMARY CARE PROVIDERS

Description

Physicians and other Primary Care Providers (PCPs) must adhere to the PA requirements identified in this policy manual ([Chapter 300](#), [Chapter 400](#) and [Chapter 800](#)).

Refer to [Chapter 300](#), Policy 310 for complete information regarding covered PCP and physician services.



1. Fee-for-service surgeons, or the hospital employing the surgeon, must obtain a separate and distinct AHCCCS PA number from that of the hospital prior to providing the transplantation and elective/non-emergency surgeries (except voluntary sterilization). Refer to Hospital Inpatient Service Authorization. The AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, responds to all transplant requests. Assistant surgeons essential to the service and anesthesiologists do not require a PA number.
2. Effective 05/01/2010, allergic immunotherapy evaluation and treatment for members 21 years of age and over must be prior authorized by the AHCCCS/DFSM/CMSU Unit (refer to [Chapter 300](#) for limitations).

Procedures

PA requests may be submitted via mail, fax or telephone prior to providing service.

R. FOOT AND ANKLE SERVICES

Description

All foot and ankle services not covered by Medicare require PA. Refer to [Chapter 300](#), Policy 310U for complete information regarding covered foot and ankle services.

Procedures

PA requests for foot and ankle services may be submitted via web portal, fax, telephone, mail.

S. PRESCRIPTION DRUG/PHARMACY SERVICES

Description

FFS pharmacy services that exceed \$500.00 per prescription require PA. All FFS pharmacy PA is conducted through the contracted Pharmacy Benefit Manager (PBM).

All pharmacy claims are subject to post-payment review pursuant to Arizona Revised Statutes §36-2903.01.

Refer to [Chapter 300](#), Policy 310, for complete information regarding covered prescription drug/pharmacy services.

Refer to the AHCCCS Website for drug availability and authorization request form.



T. REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)

Description

Prior Authorization (PA) is required for covered occupational therapy, speech therapy and audiology services. No PA is required for covered physical therapy services. Refer to [Chapter 300](#), Policy 310 for limitations.

AHCCCS covers outpatient speech or occupational therapy only for members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs, and ALTCS-enrolled members of any age.

Refer to [Chapter 300](#), Policy 310 for complete information regarding covered rehabilitation services and [Chapter 1200](#) for complete information regarding rehabilitation services for ALTCS.

U. TOTAL PARENTERAL NUTRITION

Description

Total Parenteral Nutrition (TPN) is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition.

Amount, Duration and Scope

AHCCCS covers TPN for members 21 years of age and older when it is the only method to maintain adequate weight and strength, and for members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs when TPN is determined medically necessary. The provision of TPN does not have to meet the criterion of being the sole source of nutrition for EPSDT and KidsCare members.

1. Nursing Facilities and agencies furnishing outpatient TPN services must obtain PA at least one business day prior to initiation of service. Telephone requests are given provisional PA.
2. TPN is not a covered service if the member:
 - a. Has the ability to absorb enteral feedings, or
 - b. Has a condition where TPN cannot be expected to return the member to a functional level of health.



3. AHCCCS follows Medicare guidelines regarding the provision of TPN services.

Refer to [Chapter 300](#), Policy 310 for complete information regarding covered TPN services.

Procedures

Written medical documentation substantiating compliance with criteria must be received by the AHCCCS/DFSM/CMSU Unit within five business days of initial authorization request. Medical documentation must include:

1. History and physical which describes member's condition and diagnosis
2. Physician's orders
3. Dietary assessment, including member's weight
4. Any pertinent progress notes (nursing/physician), which currently reflect the member's dietary, eating and functional status
5. Physician progress notes indicating expected outcome of treatment
6. Nursing facility records documenting percentage of each meal's consumption by member, and
7. Current laboratory data.

AHCCCS/DFSM/CMSU, upon receipt of documentation, will:

1. Approve, if in compliance with nutritional therapy criteria
2. Review with the AHCCCS Medical Director, or designee, for determination of coverage, if not in compliance with standard criteria
3. Return the referral form to provider with findings of:
 - a. Approval, date, and note of any limitations; or
 - b. Denial of coverage reason.



V. TRANSPLANTATION (ORGAN AND TISSUE)

Description

Providers must obtain PA from the AHCCCS Transplant Coordinator for all organ and tissue transplantation services to be provided to FFS members. Pursuant to §1903(v) of the Social Security Act and 9 A.A.C. 22, Article 2, FESP members are not eligible for transplantation services.

Refer to [Chapter 300](#) (Policy 310 and Attachment A) in this Policy for complete information regarding covered transplantation or related services.

AHCCCS also requires providers to obtain PA for transplant related services provided to AHCCCS members who have undergone transplantations not covered by AHCCCS.

AHCCCS utilization management requirements, including PA, are identified below.

Procedures

FFS provider responsibilities regarding medically necessary organ and tissue transplantation services for eligible members include, but are not limited to:

1. The member's transplantation specialist (hematologist/oncologist, cardiologist, gastroenterologist, nephrologist, etc.) must submit a written request to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, for approval of the transplantation.
2. The following documentation must accompany the written request:
 - a. Current history and physical, including information regarding previous therapy for the disease requiring covered organ and tissue transplantations
 - b. Records of diagnostic studies documenting the diagnosis, member's current medical status and plan of treatment leading to the recommendation of transplantation
 - c. Summary of anticipated outcome for the member.
3. The AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, will verify the member's eligibility. If approval is requested at the end of a month, eligibility will be verified for the following month.
4. The AHCCCS Medical Director, or designee, will review the submitted documentation, consult with appropriate specialists when necessary, and inform



the member's transplantation specialist whether or not transplantation is approved. Written approval will include the following information:

- a. Designation of the appropriate transplant centers with which AHCCCS maintains a contract, and
 - b. Instructions for obtaining PA for each transplantation service component.
5. AHCCCS will monitor convalescence via progress reports submitted to the Transplant Coordinator, DHCM, Medical Management Unit.
 6. Providers must submit claims in accordance with AHCCCS policies and procedures.

Refer to the AHCCCS FFS Provider Manual for additional information. This manual is available on the AHCCCS Website.

In addition to the PA requirements, providers:

1. Submit to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, utilization abstracts that include new treatments, medical progress and/or complications, and laboratory results. Weekly submissions begin with the member's approval for transplantation and end with discharge from convalescent care.
2. Offer recommendations for the ongoing treatment and monitoring of the member after discharge.
3. Cooperate with requests from the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, to supply summary data for outcomes studies.

PA requests for transplant-related services provided to AHCCCS members who have undergone transplantations not covered by AHCCCS may be submitted via web portal, fax, telephone, or mail.

W. TRANSPORTATION

Description

AHCCCS covers the following transportation services:

1. Emergency transportation - emergency transportation does not require PA from the AHCCCS/DFSM/CMSU Unit, although such services are only covered to the nearest medical facility, which is medically equipped and staffed to provide appropriate medical care.



Emergency transport to out-of-state facilities is covered only when the out-of-state facility is the nearest appropriate facility.

2. Medically necessary non-emergency transportation – PA is required for medically necessary (non-emergency) ground transportation when the mileage is greater than 100 miles round trip. Medically necessary transportation of 100 miles or less, round trip, does not require PA.

PA is always required for medically necessary (non-emergency) air transportation regardless of the number of miles.

Transportation is limited to the cost of transporting the member to the nearest appropriate AHCCCS registered provider capable of meeting the member's medical needs. Transportation must only be provided to transport the member to and from the required covered medical service.

3. Medically necessary maternal and newborn transportation - medically necessary maternal and newborn transportation, as specified in Chapter 300, does not require PA.

Refer to [Chapter 300](#), Policy 310 for a complete description and discussion of covered transportation services.

Procedures

In addition to requirements for all PAs (specified in Policy 810 of this chapter) the following conditions must also be met when PA is requested for non-emergency medically necessary transportation.

The following information may be requested when requesting PA via web portal, telephone or fax:

1. Physician's order, including medical justification for travel outside the member's area of residence when applicable.
2. Descriptions of disability requiring special transport and/or special circumstances
3. Type of transportation and need for attendant services, as appropriate
4. Estimated cost of transportation, attendant services, meals or lodging, as appropriate.



PA for non-emergency medically necessary transportation provided to AHCCCS FFS members or American Indian Health Plan (AIHP)-enrolled members through the use of a private vehicle must be requested by the member's medical service provider. PA for transportation will not be issued unless the transportation provider is an AHCCCS registered provider prior to seeking PA.

Authorization Requirements to Receive Medically Necessary Non-Emergency Transportation Services to Obtain AHCCCS Covered Medical Services.

1. For AHCCCS American Indian members who reside either on-reservation or off-reservation and are enrolled with AIHP (Contractor ID number 999998) transportation services are covered on an FFS basis under the following conditions:
 - a. The request for transportation services is prior authorized through the AHCCCS/DFSM/CMSU Unit when mileage is greater than 100 miles. PA is not required for IHS/638 providers.
 - b. The member is not able to provide, secure or pay for their own transportation, and free transportation is not available; and
 - c. The transportation is provided to and from either of the following locations:
 - i. The nearest appropriate IHS/Tribal 638 medical facility located either on-reservation or off-reservation (facilities that are located out-of-state services, or
 - ii. The nearest appropriate AHCCCS registered provider located off-reservation.
2. For American Indian members enrolled in either an acute or ALTCS managed care organization, please check with the managed care organization for prior authorization requirements.
3. Members who are enrolled with AIHP and live either on-reservation or off-reservation, and are receiving behavioral health services as specified in [Chapter 300](#) under Policy 310, Behavioral Health Services, may receive non-emergency medically necessary on-reservation transportation services as follows:
 - a. Non-emergency medically necessary transportation may be provided as outlined above (#1 above) on an FFS basis for the following members:
 - i. An AIHP enrolled member, residing either on-reservation or off-reservation who is receiving behavioral health services but is not enrolled with an ADHS designated Integrated Regional Behavioral



- Health Authority (Integrated RBHA or Regional Behavioral Health Authority (RBHA).
- ii. An AIHP enrolled member who lives on-reservation but is a member of a tribe that is not designated as a Tribal Behavioral Health Authority (TRBHA) through an agreement with the ADHS, and who receives services at an IHS/Tribal 638 facility or through an off-reservation provider; or
- b. If the AIHP member is enrolled with, and receiving behavioral health services through, an Integrated RBHA, RBHA, or TRBHA, non-emergency medically necessary on-reservation transportation is coordinated, authorized and provided by the Integrated RBHA, RBHA or TRBHA.

For Tribal ALTCS members, transportation services are authorized by the tribal case manager.

Refer to Chapter 800 for complete information regarding prior authorization for Acute FFS members.

Refer to AHCCCS Contractors Operation Manual (ACOM) Policy 205, Ground Ambulance Transportation Reimbursement Guidelines for Non-Contracted Providers, for information regarding reimbursement.

Refer to the AHCCCS FFS Provider Manual or AHCCCS Billing Manual for IHS/Tribal providers for provider registration and billing information. Both of these manuals are available on the AHCCCS Website.

X. TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS

Description

Triage/emergency medical screening and evaluation services are the medically necessary screening and assessment services provided to FFS, acute care and ALTCS members in order to determine whether or not an emergency medical condition exists, the severity of the condition, and those services necessary to alleviate or stabilize the emergent condition. These services are covered services if they are delivered in an acute care hospital emergency room.

Amount, Duration, and Scope

Medically necessary screening and evaluation services to rule out an emergency condition, or to determine the severity of an emergency medical condition and necessary treatment services required for the emergency medical condition, do not require Prior Authorization (PA) from the AHCCCS/DFSM/CMSU Unit.



If the presenting condition assessed during triage/emergency medical screening and evaluation is determined not to be an emergency condition, any further assessment, care and treatment is subject to AHCCCS FFS PA and utilization management requirements.

Providers responsible for triage, screening and/or evaluation of emergency medical conditions must submit supporting medical documentation for services rendered. At a minimum, the emergency room record of care and itemized statement must be submitted when reporting or billing services to the AHCCCS Administration for services provided to FFS members.

Medical review of emergency room records must consider each case on an individual basis to determine if:

1. The triage/screening services were reasonable, cost-effective and medically necessary to rule out an emergency condition and evaluate the member's medical status, and
2. The evaluation of the member's medical status meets criteria for severity of illness and intensity of service.

If the provider fails to submit medical records necessary for review, or if the medical records fail to meet the criteria specified in this policy, the claim may be denied.

Refer to Policy 810 of this Chapter for a description of notification and PA procedures for inpatient admission or post-assessment therapy.

Refer to the AHCCCS FFS Provider Manual for information regarding service reporting and billing requirements. This manual is available on the AHCCCS Website.

Y. OTHER MEDICAL PROFESSIONAL SERVICES

Under 9 A.A.C. 22, Article 2, the following medical professional services do not require prior authorization if a member receives these services in an inpatient, outpatient or office setting.

1. Voluntary sterilization
2. Dialysis shunt placement
3. Arteriovenous graft placement for dialysis
4. Angioplasties or thrombectomies of dialysis shunts



5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis
6. Eye surgery for the treatment of diabetic retinopathy
7. Eye surgery for the treatment of glaucoma
8. Eye surgery for the treatment of macular degeneration
9. Home health visits following an acute hospitalization (limit up to five visits).
10. Hysteroscopies when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization.
11. Physical therapy for persons age 21 years or older; limited to 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 that function once restored, and 15 visits per contract year to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.
12. Facility services related to wound debridement.
13. Apnea management and training for premature babies up to one year of life.

EXHIBIT 820-1

**AHCCCS
HYSTERECTOMY CONSENT FORM**

EXHIBIT 820-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS)
HYSTERECTOMY CONSENT FORM**

A hysterectomy is the removal of the whole uterus (womb). A hysterectomy cannot be reversed and it will permanently prevent you from having children. A hysterectomy should only be performed when there is a disease of the woman's uterus or some other problem that can only be treated by removing the uterus. It is a serious operation and there are discomforts and a chance of serious health problems.

AHCCCS does not cover hysterectomy procedures when performed only for the purpose of rendering an individual sterile.

By signing below, I hereby consent of my own free will to undergo a hysterectomy, which will render me permanently incapable of reproducing. My signature also acknowledges that I have read and understood the above information.

MEMBER SIGNATURE

DATE

MEMBER AHCCCS IDENTIFICATION
NUMBER

MEMBER SOCIAL SECURITY NUMBER

In accordance with Federal Regulation 42 C.F.R. §441.255, the signature and date below are required in order for reimbursement to be made.

PERSON WHO OBTAINED THE MEMBER'S
CONSENT TO THE HYSTERECTOMY

DATE



830 RESERVED



840 RESERVED