820 - FEE-FOR-SERVICE PRIOR AUTHORIZATION REQUIREMENTS

EFFECTIVE DATES: 10/01/94, 07/01/17, 03/01/19, 04/01/22, 01/26/24, 09/27/2024

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I. PURPOSE

This Policy applies to Fee-For-Service (FFS) populations as specified within this Policy including: Tribal ALTCS, TRBHA, the American Indian Health Program (AIHP), and DES DDD Tribal Health Program (DDD THP); excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100). This Policy establishes the process by which AHCCCS/DFSM applies FFS Prior Authorization (PA) requirements for covered services.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this policy.

III. POLICY

For purposes of this Policy, all PA requests shall be submitted to AHCCCS/DFSM for approval or denial, unless specified otherwise. In the case of a service denial, termination, suspension, or reduction, a notice will be provided in accordance with AAC Title 9, Chapter 34 For information on requesting Provider Resubmission and Reconsideration or filing an Appeal refer to the Rights and Responsibilities page under the Member/Applicants section of the AHCCCS website.

Verify PA requirements per billing code by viewing the FFS Prior Authorization Guidelines under Reference Extracts on the AHCCCS Medical Coding Resources web page under the Plans/Providers section of the AHCCCS website.

Requests submitted without the required minimum information may be denied for insufficient documentation. To review clinical documentation requirements, refer to AMPM Policy 940.

1. The required minimum information includes but is not limited to:
   a. Service dates,
   b. Diagnosis,
   c. Billing codes,
   d. Valid Signatures,
   e. Medical necessity documentation, and
   f. Member name and Date of Birth or AHCCCS ID on each page of the medical record. AHCCCS/DFSM requirements for submitting PA requests via the AHCCCS online web portal (preferred), fax, or mail, as specified in AMPM Policy 810, apply to all services identified in this Policy, unless specified otherwise.

2. A PA is not required:
   a. For emergency services,
   b. When AHCCCS is not the primary payer,
   c. For services rendered to FFS members when provided by Indian Health Service (IHS)/638 providers and facilities, or
   d. For periods of member retroactive eligibility including Prior Quarter Coverage and Prior Period Coverage.

3. AHCCCS has the discretionary authority to terminate an approved PA based on what is in the best interest of the member and/or medically necessary for the member.

4. AHCCCS reserves the right to require PA of providers with advance notice.

5. Title XXI members receiving pharmacy services from an IHS/638 provider may be subject to medication PA requirements as required by the FFS Pharmacy Benefits Manager (PBM). Refer to Chapter 10 of the AHCCCS IHS/638 Provider Billing manual for IHS/638 pharmacy billing information.

A. PRIOR AUTHORIZATION REQUEST SUBMISSION PROCESS

For additional information related to FFS PA submission requirements and procedures, visit the AHCCCS website Plans/Providers/Fee-For-Service Health Plans/Prior Authorization section of the AHCCCS website.

Refer to the AHCCCS FFS Provider Billing Manual for information regarding submission of claims and billing procedures. This manual is available online under the Resources section of the AHCCCS website.

The documentation of care coordination is required to be included in the medical record submitted for PA in accordance with other Medical Documentation requirements.

1. Care Coordination Requirements
   The Fee-For-Service (FFS) providers are required to coordinate service delivery across all levels of care to include applicable treating providers or entities including but not limited to:
   a. The assigned TRBHA,
   b. Assigned Tribal ALTCS case manager,
   c. The DDD Case Manager or DDD District Nurse,
   d. American Indian Medical Home (AIMH),
   e. Primary Care Provider (PCP),
   f. American Indian Health Facilities,
   g. The inpatient and/or outpatient treatment team, to include the Behavioral Health Professional (BHP) whom shall be responsible for the member's comprehensive Behavioral Health (BH) treatment plan, and
   h. Other individuals on the treatment team, including physical health and BH providers, as applicable.

B. BEHAVIORAL HEALTH

AHCCCS covers BH and/or Substance Use Disorder (SUD) services within limitations depending upon the member's age and eligibility.

1. Prior Authorization (PA) is required for admission to the following behavioral health settings to include:
   a. BHIFs:
      i. Residential Treatment Centers (RTC)s,
      ii. Psychiatric hospitals,
      iii. Psychiatric units of acute hospitals, and
      iv. Subacute and detox facilities.
   b. Behavioral Health Residential Facilities (BHRF)s.

2. The Behavioral Health (BH) authorization requests submitted to AHCCCS/DFSM include:
   a. All acute inpatient hospital admissions for Tribal ALTCS members,
   b. The BH admissions for members assigned to the AIHP for BH services,
   c. The BH admissions for members assigned to a TRBHA, and
   d. The BH admissions for DDD THP members who are not assigned to a DDD Subcontracted Health Plan.

3. The Behavioral Health Inpatient Facility Initial PA documentation shall include:
   a. A Certification Of Necessity ed (CON) due to AHCCCS/DFSM:
      i. Prior to admission or on the day of admission,
      ii. For an emergency admission within 72 hours, not applicable to RTCs,
      iii. Shall be signed by a healthcare provider with Doctor of Medicine (MD) or DO) credentials, and
      iv. The CONs cover the first 72 hours (or first three days) of the eligible authorization period.

b. A psychiatric evaluation or documentation sufficient to clearly address the required documentation elements as specified in the CON, and that would normally be provided as part of a psychiatric evaluation, including the initial treatment plan, except that:
   i. For detoxification admissions, a history and physical may be submitted if a psychiatric evaluation cannot be completed and shall include the initial treatment plan.

4. The BHIF Continued Authorization shall be requested prior to the end date of the previously authorized date range, and shall include:
   a. A Recertification of Need (RON):
      i. A completed RON is required upon the expiration of the CON,
      ii. The RON may be signed by the MD, DO, Physician's Assistant (PA), and/or Nurse Practitioner (NP),
      iii. The RONs are valid for seven days in the acute hospital setting,
      iv. The RON valid seven days, with RON to be submitted every seven days during the stay till discharge and,
      v. The RON for RTC is valid for 30 days, RON to be submitted every 30 days until discharge for 30 days in the inpatient residential setting.
   b. A Psychiatric evaluation, if not submitted within the initial authorization request, and
   c. The subsequent authorization requests for acute settings are due every seven days until discharge.

5. The following documentation in a BHIF setting shall be signed by the BHMP. Refer to AMPM Policy 940.
   a. A treatment plan which shall include:
      i. The documentation of care coordination with the member's TRBHA, Tribal case manager, or other outpatient providers and discharge planning team,
      ii. The BHMP attending provider progress notes, and
      iii. The discharge and aftercare documentation:
         1) A discharge summary signed by the attending BHMP shall include disposition, discharge medication(s), diagnosis, aftercare plan, appointments for medication management, counseling, and/or case management.

6. The Behavioral Health Residential Facility (BHRF) Authorization:
   a. The providers shall adhere to all criteria for medical necessity of admission, continuation, and exclusionary criteria as described in AMPM Policy 320-V and refer to the FFS PA Website for PA requirements. All BHRF providers shall request PA from AHCCCS/DFSM before admitting the member and prior to expiration of the current authorization for continued stays,

b. The treatment plans must be submitted as part of a PA request:
   i. The member's outpatient treatment team shall initiate the BHRF referral prior to admission and share pre-admission comprehensive assessment and treatment plan or be part of the pre-admission assessment and treatment plan formulation when the documentation is created by another qualified provider. Exception to this requirement exists when the member is evaluated by the Crisis provider, Emergency Department (ED), or Behavioral Health Inpatient Facility (BHIP), In the case of an exception, the BHRF shall notify the member's outpatient treatment team of admission prior to creation of the BHRF treatment plan, and
   ii. The documentation at a minimum should support medical necessity for BHRF as the least restrictive environment to meet member's needs.

c. A Continued Stay requests shall include continued medical necessity criteria which includes at a minimum the following:
   i. All BHRFs providing services to FFS members are required to submit to AHCCCS/DFSM documentation of all participants in the treatment planning meetings during the continued stay review process and to adhere to the below elements:
      1) The continued stay shall be assessed by the BHRF staff in coordination with the applicable outpatient treatment team during treatment plan review and updates. Progress towards the treatment goals and continued display of risk and functional impairment shall also be assessed. Treatment interventions, frequency, crisis/safety planning, and targeted discharge shall be adjusted accordingly to support the need for continued stay. The following criteria shall be considered when determining continued stay:
         a) The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition, and
         b) The providers and/or supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.
   ii. At a minimum, treatment planning shall occur between key members of the treatment team including but not limited to BHRF providers, TRBHA, outpatient treatment team, Health Care Decision Maker (HCDM), and Special Assistance/Advocate as applicable on a monthly basis,
   iii. Documentation of care coordination is required and shall include evidence of treatment planning meetings, discharge planning with the TRBHA and/or Tribal ALTCS case manager, outpatient provider, and identification of treatment team members' roles,
   iv. Frequency, type, and duration of each treatment service or session, and
   v. Documentation of each treatment session or therapeutic activity as an individual entry in the medical record, including:
      1) The date of service,
      2) Start and end time,
      3) Topic as related to the treatment plan,
      4) Patient response, and
      5) Signature and credentials of the individual conducting the treatment activity including the date signed.

d. All BHRF providers shall notify AHCCCS/DFSM upon discharge. The discharge notification shall include provision of the member's discharge date and a written discharge summary, within 10 working days of the discharge date and shall also include the following:
   i. The aftercare plans,
   ii. Referrals for ongoing care needs as the BHRF is responsible for making referrals for member's post discharge care,
   iii. Documentation of follow up appointments with care team(s),
   iv. Information regarding where the member was discharged to, including mode of transportation and who accompanied the member (if applicable),
   v. Name and credentials of outpatient treatment team members the provider has contacted, including the TRBHA or Tribal ALTCS case manager (when enrolled),
   vi. Detailed notes of coordination with outpatient treatment team and the TRBHA or Tribal case manager (when applicable) documenting participation in treatment and discharge planning activities,
   vii. Documentation during the stay of coordination of care with the member's outpatient treatment team and the TRBHA or Tribal case manager (when applicable) for ongoing BH needs after discharge from BHRF,
   viii. All treatment services provided to the member,
   ix. Current treatment plan goals, and
   x. Status of progress towards each treatment plan goal.

7. The following documentation in a BHIF setting shall be signed by the BHMP. Refer to AMPM Policy 940. A treatment plan which shall include:
   a. The documentation of care coordination with the member's TRBHA, Tribal case manager, or other outpatient providers and discharge planning team,
   b. The BHMP attending provider progress notes, and
   c. The discharge and aftercare documentation including:
      i. A discharge summary signed by the attending BHMP shall include disposition, discharge medication(s), diagnosis, aftercare plan, appointments for medication management, counseling, and/or case management.

Fee-for-Service (FFS) providers and stakeholders may contact AHCCCS/ DFSM for assistance as needed.

The Behavioral Health services are also available to FFS members at an IHS/638 facility.

The outpatient BH services for Tribal ALTCS members are coordinated through the Tribal ALTCS case manager.

Refer to AMPM Policy 310-B for further information regarding AHCCCS covered BH services and settings.

C. BREAST RECONSTRUCTION AFTER MASTECTOMY

AHCCCS covers breast reconstruction for eligible FFS members following a medically necessary mastectomy as specified in AMPM Policy 310-C. A PA is required for breast reconstruction surgery provided to FFS members.

D. CHIROPRACTIC SERVICES

AHCCCS will cover up to 20 medically necessary chiropractic visits for members 21 years of age and older each contract year, without PA. Additional chiropractic services in the same year must receive PA and may be authorized if determined to be medically necessary. Services must be ordered by a Primary Care Physician/Practitioner (PCP) and be within the scope of chiropractic practice as defined by State law.

The following documentation shall accompany the PA request:

1. The prescription from the PCP.

2. The clinical documentation to support medical necessity and length of need.

3. The documentation of patient response to treatment.

E. COCHLEAR IMPLANT

AHCCCS covers medically necessary services for cochlear implantation for FFS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) members at an AHCCCS registered implantation center. PA is required for all cochlear implants and related services for FFS members. Requests for PA shall include documentation of the appropriate assessments and evaluations for determining suitability for a cochlear implant. Refer to AMPM Policy 430 for complete information regarding covered cochlear implant services.

The following documentation shall accompany the PA request:

1. The member's current history and physical examination, including information regarding previous therapy for the hearing impairment.

2. The records documenting the member's diagnosis, current medical status and plan of treatment leading to the recommendation of cochlear implant.

3. The current psychosocial evaluation and assessment for determining the member's suitability for cochlear implant.

F. DENTAL SERVICES

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

AHCCCS provides coverage of dental services for members 21 years of age and older within the limitations as specified in AMPM Policy 310-D1 and AMPM Policy 310-D2. The dental limits specified in AMPM Policy 310-D1 and AMPM Policy 310 D-2 do not apply when an AI/AN member 21 years of age and older is receiving medically necessary, AHCCCS covered dental services at an IHS or Tribal 638 facility.

Dental services for DDD THP members 21 years of age and older are coordinated by AHCCCS/DFSM ALTCS unit and dental services for Tribal ALTCS members 21 years of age and older are coordinated by the member's Tribal Case Manager.

1. The preventive and therapeutic dental services for members who are under the age of 21 in both the AHCCCS (EPSDT Program) and KidsCare Programs do not require PA. However, the following services for these members shall require PA:
   a. Removable dental prosthetics, including complete dentures and removable partial dentures,
   b. Cast crowns,
   c. Orthodontia services, and
   d. Pre-transplant dental services (these services also require approval by AHCCCS, Medical Management Transplant Coordinator and review by the AHCCCS Dental Director or Designee).

2. Dental PA requests shall be accompanied by:
   a. Dentist substantiation of medical necessity of services through description of medical condition,
   b. Dentist's treatment plan and schedule, and
   c. Radiographs fully depicting existing teeth and associated structures by standard illumination when appropriate.

G. DIALYSIS

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

Refer to AMPM Exhibit 300-1, for covered dialysis services for members not in FES Program.

Refer to AMPM Policy 1100, for information regarding FES Program dialysis services.

H. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) services provide comprehensive health care, as defined in AAC R9-22-213 through primary prevention, early intervention, diagnosis, and medically necessary treatment of physical and BH conditions for AHCCCS members who are under 21 years of age. EPSDT covers all medically necessary services to treat or ameliorate physical and BH disorders, and defects, to include conditions identified in an EPSDT screening. Limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

A PA for these services is only required as designated in this Policy and in AMPM Policy 430.

Refer to AMPM Policy 430 for information regarding EPSDT services.

I. EMERGENCY MEDICAL SERVICES

A provider is not required to obtain PA for emergency medical services however, a provider shall comply with the notification requirements AACR9-22-210 which require that the provider notify AHCCCS no later than 72 hours after an FFS member's emergent inpatient admission. Notification of emergency admissions may be submitted via AHCCCS online web portal or via fax. AHCCCS/DFSM may deny payment for failure to provide timely notice.

Prior Authorization (PA) is required when an FFS member remains inpatient 72 hours or more following an emergent medical admission.

Refer to AAC R9-22-210, for review of the Rule sections regarding FFS emergency services.

Refer to AMPM Policy 1100 for information regarding the FES Program.

J. EYE CARE/OPTOMETRY SERVICES

AHCCCS covers eye care/optometric services for members, within limitations. Coverage is provided as specified in AMPM Exhibit 300-1.

Prior Authorization is not required for routine eye examinations and prescriptive lenses are covered for EPSDT and KidsCare members.

Prescriptive lenses for members 21 years of age and older requires PA and are only covered when the lenses are the sole visual prosthetic device used by the member after cataract extraction.

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) and KidsCare members needing cataract removal should have a Children's Rehabilitative Services (CRS) application submitted. See the CRS Referrals webpage on the AHCCCS website for application instructions. For general information on CRS services, visit the CRS webpage on the AHCCCS website.

Cataract removal requires PA.

K. HOME HEALTH NURSING AND HOME HEALTH AIDE SERVICES

A PA is required for all home health nursing and home health aide services except for the first five home health visits following discharge from an acute facility. All PA requests for home health nursing and home health aide services shall be submitted prior to providing services not associated with an acute facility discharge or beyond the first five home health visits following discharge from an acute facility. All PA requests shall be accompanied by supporting medical documentation including documentation of the face-to-face encounter requirements as specified in AMPM Policy 310-I.

Refer to AMPM Policy 310-I for information regarding covered home health services.

L. HOSPITAL INPATIENT SERVICE AUTHORIZATION

Hospital inpatient service authorization is a part of the utilization management process that may consist of both PA and continued authorization, contingent upon review findings as specified in AMPM Policy 810.

1. Fee-for-Service (FFA) Inpatient Admission requires the following criteria to be met:
   a. The physician or other practitioner responsible for a member's care at the hospital has determined the member should be admitted as an inpatient,
   b. The member demonstrates signs and/or symptoms severe enough to warrant the need for medical care, and
   c. Any one of the following:
      i. The member requires receipt of services of such intensity that the services can be furnished safely and effectively only on an inpatient basis,
      ii. The member's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting, or
      iii. The medical predictability of something adverse happening to the patient is uncertain.

2. The Initial Authorization:
   As specified in AAC R9-22-204 the provider shall notify AHCCCS/DFSM no later than 72 hours after an FFS member receiving emergency medical or BH services is emergently admitted for inpatient treatment. AHCCCS/DFSM may deny payment for failure to provide timely notice and for missing documentation.

   At a minimum, initial inpatient notifications for physical health admissions shall specify the FFS member's admission status at the time of notification and be accompanied by the facility's face sheet and history and physical documentation. Refer to above BH section for BH inpatient admission documentation requirements.

3. The providers shall obtain PA for the following inpatient hospital services for all FFS and DDD THP members:
   a. Organ and tissue transplant requests are submitted to AHCCCS/DFSM including corneal transplants and bone grafts,
   b. Elective and non-emergency inpatient admissions,
   c. Emergent physical health inpatient admissions that exceed 72 hours in duration,
   d. Psychiatric hospitalizations and other BH services, refer to the above BH section in this Policy,
   e. Prior Authorization (PA) requests for all acute inpatient hospital admissions for Tribal ALTCS and DDD THP members are submitted to AHCCCS/DFSM,
   f. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury, and
   g. Elective surgery, with the exclusion of any of the surgeries listed below.

   AHCCCS covers inpatient hospital care after a routine vaginal delivery and inpatient hospital care after a cesarean delivery. Prior Authorization (PA) is not required for hospitalizations that do not exceed 72 hours of inpatient hospital care for a routine vaginal delivery or do not exceed 96 hours of inpatient hospital care for a cesarean delivery.

   The attending health care provider, in consultation with an agreement by the member, may discharge the member or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the parent's continued stay in the hospital is medically necessary beyond the minimum 48 or 96 hours stay.

4. For retrospectively eligible members, notification requirements are as follows:
   a. When the member becomes AHCCCS-eligible while still in the hospital, providers shall notify AHCCCS/DFSM no later than 72 hours after the eligibility posting date for emergency hospitalizations, and
   b. When eligibility is posted after the member is discharged from the hospital, the notification requirement noted above in(a) will be waived.

5. Payment for services may be denied if the hospital fails to provide timely notification or obtain PA when required, specified in the Hospital Inpatient Service Authorization section of this Policy. The issuance of an authorization number does not guarantee payment. Documentation provided from the member's medical record shall support the diagnosis and treatment for which the authorization was issued, and the claim shall meet clean claims submission requirements.

6. Prior Authorization (PA) 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. Upon approval or denial, the provisional status is removed from the authorization and the provider is notified by letter of the decision.

M. HYSTERECTOMY

1. The Hysterectomy services require PA. As specified in 42 CFR 441.255, Hysterectomies are not covered when:
   a. Performed solely for the purpose of rendering an individual permanently incapable of reproducing, or
   b. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

2. The PA request shall include:
   a. The medical documentation supporting the medical necessity of the hysterectomy, including prior medical and surgical therapy and results,
   b. The diagnostic test results, and
   c. The copy of the member's consent and acknowledgment form, refer to Attachment A of this policy.

The member shall sign consent and acknowledgment of receipt of information that the hysterectomy will render her incapable of reproducing as specified in 42 CFR 441.255.

Pursuant to 42 CFR 441.255(d), the physician performing the hysterectomy shall sign a written certification if the individual was already sterile before the hysterectomy or required the hysterectomy due to a life-threatening emergency and prior acknowledgement by the individual was not possible.

The PA may be granted based on these documents. Providers may use the sample AHCCCS Hysterectomy Consent and Acknowledgement Form (Attachment A), or they may use other formats if the forms include the same information and required signatures as specified in the AHCCCS hysterectomy acknowledgement form.

Refer to AMPM Policy 310-L for information regarding coverage of medically necessary Hysterectomies.

The provider is not required to complete 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 shall certify in writing that an emergency existed. The physician shall also include a description of the nature of the emergency.

N. LABORATORY SERVICES

AHCCCS covers medically necessary laboratory testing that is performed by an AHCCCS registered laboratory provider with current Centers for Laboratory Improvement Act (CLIA) certification provided by an organization that is approved by Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR 493.61.

A routine laboratory testing does not require PA for FFS members. Refer to AMPM Policy 310-N for information regarding coverage of medically necessary laboratory services.

A genetic testing and a biomarker testing require FFS PA. Refer to AMPM Policy 310-II for information and criteria on coverage of Genetic testing. Refer to AMPM policy 310-KK for information on coverage of Biomarker testing. The FFS PA requests for genetic and biomarker testing, at minimum shall include the following:

1. Documentation specifying how the testing is consistent with the coverage criteria.
2. Recommendations from a licensed genetic counselor or ordering provider.
3. Clinical findings including family history and any previous test results.
4. A description of how the biomarker test results will guide treatment options for the member.
5. The rationale for choosing the particular biomarker test requested.
6. Medical literature citations as applicable.

O. 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.

A PA is required for medically necessary pregnancy terminations, with the exception of medically necessary pregnancy terminations that are billed by an IHS or 638 provider.

All PA requests for medically necessary pregnancy terminations require submission of a completed CON for Pregnancy Termination (refer to AMPM Policy 410, Attachment C) and all other required documentation. All claims submitted by an IHS /638 provider require submission of the CON, or submission of documentation that includes all required certifications and documentation.

Refer to AMPM Policy 410 for information regarding coverage of medically necessary pregnancy terminations and other documentation requirements.

Refer to AMPM Chapter 400 for information on maternal and child health care services.

P. MEDICAL EQUIPMENT, MEDICAL APPLIANCES, AND MEDICAL SUPPLIES, AND ORTHOTIC/ PROSTHETIC DEVICES

Medical equipment and supplies shall be prescribed by a physician or other approved ordering practitioner. For complete information regarding coverage of medical equipment and supplies including face-to-face requirements, as specified in AMPM Policy 310-P.

Orthotic and prosthetic devices shall be prescribed by a physician or other appropriate practitioner. Prior Authorization (PA) is required for the purchase of orthotic and prosthetic devices exceeding $300.00. Refer to AMPM Policy 310-JJ for complete information regarding coverage of orthotic and prosthetic devices.

1. The following requirements apply to medical equipment and supplies services:
   a. Prior Authorization (PA) is required for the purchase of medical equipment exceeding $300.00. PA is required for all medical equipment rentals and repairs,
   b. Prior Authorization is required for consumable medical supplies (as defined in AMPM Policy 310-P) exceeding $100.00,
   c. For members 21 years of age and older, PA is required for medically necessary incontinence supplies. These incontinence supplies are covered when necessary to treat a condition. In addition, PA requirements for incontinence briefs for ALTCS members 21 years of age and older as specified AMPM Policy 310-P,
   d. Refer to AMPM Policy 430 for PA requirements and criteria for coverage of incontinence briefs for members under the age of 21, and
   e. All rental equipment requires PA. 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 shall not exceed the purchase price (i.e. if AHCCCS can purchase the equipment for less than the rental fee, AHCCCS will purchase the item).

2. Apnea management and training for premature babies up to one year of life does not require PA.

3. In addition to information required for all PAs specified in AMPM Policy 810, the following information shall be supplied at the time of the PA request:
   a. Prescription or order with ordering provider's name, and dated signature with credentials listed,
   b. Diagnosis indicated by ordering provider,
   c. Description of medical condition necessitating the supplies/equipment, and medical justification for medical supplies/equipment with anticipated outcome (medical/ functional),
   d. Clinical documentation, including documentation that meets face-to face encounter requirements as specified in AMPM Policy 310-P,
   e. Description of medical supplies /equipment requested,
   f. Duration for use of medical equipment,
   g. Item price plus any additional costs and expected cost if rented,
   h. Provider identification number, and
   i. Home evaluation, when requested by AHCCCS/DFSM.

4. For members 21 years of age and older, requests for authorization of incontinence supplies shall 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.

5. For ALTCS members 21 years of age and older, refer to AMPM Policy 310-P for complete information on coverage requirements. Incontinence supplies for Tribal ALTCS members are authorized by the Tribal ALTCS case manager. Refer to AMPM Policy 1620-F for additional information on the Tribal ALTCS case manager role.

Q. AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE

1. Coverage:
   a. The provision of Augmentative and Alternative Communication device systems includes coverage for eligible members of all ages when the services, supplies, and accessories are considered medically necessary as defined in AAC R9-28-101 and R9-28-201,
   b. Prior Authorization (PA) is required for all Augmentative and Alternative Communication device systems and services. For services to be considered medically necessary, the services must be reasonable and necessary to treat illness, injury, disease, disability, or developmental condition. Medical necessity is a critical factor for determining eligibility for reimbursable therapy and treatment services, and
   c. Requests for PA shall be reviewed by AHCCCS/DFSM based on medical necessity. If AHCCCS/DFSM approves the request, payment is still subject to all general conditions of AHCCCS/DFSM, including member eligibility, other insurance, clean claim, and satisfaction of any other program requirements.
2. Items that are included in the AHCCCS/DFSM covered benefits for an Augmentative and Alternative Communication device system and are not reimbursed separately include, but are not limited to, the following:
   a. Applicable software [except for software purchased specifically to enable a member-owned computer or a Personal Digital Assistant (PDA) to function as an Augmentative and Alternative Communication device system],
   b. Batteries,
   c. Battery charger,
   d. Power supplies,
   e. Interface cables,
   f. Interconnects,
   g. Sensors,
   h. Alternating Current (AC) or other electrical adapters,
   i. Adequate memory to allow for system expansion within a three-year time frame,
   j. Device Access (refers to the tools or technology that a person uses to access or interact with their Augmentative and Alternative Communication system) when necessary,
   k. Mounting device when medically necessary,
   l. Any extended warranty,
   m. Carrying case, and
   n. Any medically necessary treatment services for the programming and modification or adaptation of purchased devices by AHCCCS/DFSM, or the primary payor.

3. Non-covered items that are not necessary to operate the device and are unrelated to the Augmentative and Alternative Communication system or software components are not covered. These items include, but are not limited to:
   a. Printer, and
   b. Wireless internet access devices.

4. Prior Authorization (PA) Requirements
   A Prior Authorization (PA) is required for Augmentative and Alternative Communication device systems and services provided through AHCCCS/DFSM for the following services:
   a. All Augmentative and Alternative Communication device system purchases,
   b. All Augmentative and Alternative Communication device system modifications,
   c. All Augmentative and Alternative Communication device system accessories,
   d. Replacement of Augmentative and Alternative Communication device system or components,
   e. All Augmentative and Alternative Communication device system repairs,
   f. Treatment services for the programming and modification or adaptation of an Augmentative and Alternative Communication device system, and
   g. The Augmentative and Alternative Communication device evaluation.

5. All relevant clinical documentation that supports and/or demonstrates that the coverage criteria is medically necessary and that other requirements have been met shall be submitted to AHCCCS DFSM. Supporting documentation including but not limited to the following:
   a. The member's medical records,
   b. Therapy service records,
   c. Other records from healthcare professionals, and
   d. Test reports as requested by AHCCCS/DFSM relevant to the request.

6. Augmentative and Alternative Communication Device Evaluation
   The Prior Authorization (PA) Evaluation requests must include the following information or documentation:
   a. A detailed written order or prescription by the member's provider. The detailed written order shall:
      i. Be signed and dated by the provider, familiar with the member dated within 365 days of the PA request,
      ii. Include the National Provider Identifier (NPI) numbers of the prescribing qualified health professional, and
      iii. Indicate the prescription is for an Augmentative and Alternative Communication evaluation.

7. Augmentative and Alternative Communication Device System Purchase Documentation Requirement
   The Prior Authorization (PA) requests must include the following information and documentation:
   a. A detailed written order or prescription for the purchase by the member's practitioner,
   b. A plan of care established by an appropriately credentialed and trained speech-language pathologist and prescribed by the member's practitioner for the treatment services to use the Augmentative and Alternative Communication device system,
   c. Documentation of the appropriate ICD-10-CM medical and treating diagnoses (if applicable) and a description of how the diagnoses relate to the member's communication needs and any significant medical information pertinent to the use of the Augmentative and Alternative Communication device system,
   d. A written report of the member's current communication abilities and levels of function, including the results as reported on the member's most recent formal, face-to-face comprehensive speech-language assessment administered according to the generally accepted standards of practice by an appropriately credentialed and trained speech-language pathologist, within one calendar year before the date of the written PA request, and
   e. Documentation to demonstrate how the prescribed Augmentative and Alternative Communication device system is medically necessary.

8. Augmentative and Alternative Communication Device System Repair Documentation Requirements
   The PA requests must include the following:
   a. A prescription from the treating Practitioner,
   b. A statement that describes the needed repair,
   c. Justification of medical necessity, and
   d. The estimated cost of repairs is determined by the Durable Medical Equipment (DME) supplier.

9. Augmentative and Alternative Communication Device System Replacement Documentation Requirements
   The PA requests must include the following:
   a. A joint statement from the prescribing practitioner's and a licensed speech-language pathologist.

10. Augmentative and Alternative Communication Device System Treatment (Training)
    The PA requests must include the following:
    a. A prescription from the treating Practitioner (Certificate of Medical Necessity [COMN]).

    If the family refuses training sessions, the treating speech-language pathologist shall provide written notification to AHCCCS/DFSM.

    Refer to the AHCCCS Fee-for-Service Provider Billing Manual for detailed description and assessment requirements.

R. NURSING FACILITY SERVICES

The Nursing Facility (NF) services for AIHP members 21 years of age and older are covered by AHCCCS for up to 90 days per benefit year if the member's medical condition would otherwise require hospitalization.

Short-term NF admission of 90 days or less that follow a DDD THP member's hospital discharge is authorized by AHCCCS/DFSM.

The Nursing Facility (NF) admissions for DDD THP members following hospital discharge that exceed 90 days, or which are not preceded by discharge from a hospital, are authorized by DDD.

A PA is required for all bed hold days.

The swing bed days in an acute hospital are subject to the same limitations and authorization criteria as services rendered in an NF setting.

Per AAC R9-28, Article 2, in lieu of a NF, an ALTCS or DDD THP member may be placed in an alternative living facility or receive home and community-based services. Prior Authorization from the member's ALTCS case manager 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.

The Nursing Facility (NF) services for Tribal ALTCS members are authorized by the member's Tribal ALTCS case manager.

Refer to AMPM Policy 310-R and AMPM Chapter 1200 for complete information regarding coverage and limitations related to long term care services.

The initial PA will be for a period not to exceed the anticipated enrollment period of the FFS acute 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.

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

AHCCCS/DFSM 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 NF services if it is believed that a member will need an NF stay lasting longer than 90 days.

S. OBSERVATION SERVICES

The 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.

The 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.

The Extended stays after outpatient surgery shall be billed as recovery room extensions. Dates authorized for recovery room extensions shall match the dates billed on the claim. Authorization of extended recovery room services requires submission of supporting documentation.

Refer to AMPM Policy 310-S, for complete information regarding covered outpatient health services.

The Observation shall 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. Medical necessity shall exist for all observation stays.

The medical record shall document the basis for observation services. Documentation shall 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 shall be written as a physician's order, and shall specify "observation”,
   b. Orders for observation shall be signed and dated by a physician within 24 hours of the order,
   c. Follow-up orders shall be written at least every 24 hours,
   d. Changes from "observation to inpatient" or "inpatient to observation" shall be ordered prior to the member’s discharge from the facility, and
   e. The physician’s daily progress notes shall accompany documentation.

3. Observation services do not require PA. All claims for observation services shall be submitted with the above documentation.

T. OUTPATIENT SURGERY CENTERS

The Ambulatory Surgery Centers (ASC) shall obtain PA from AHCCCS/DFSM for all outpatient surgeries performed in this setting. The ASC shall obtain a separate and distinct AHCCCS PA number from that of the surgeon. The PA requirements for the surgeon may differ from the ASC's PA requirement. The ASC shall only request PA for the codes that are billable by the ASC. Billable codes for the ASC may differ from those billable by the surgeon.

The Documentation supporting medical necessity shall be submitted prior to providing the elective/non-emergency service. Documentation from the surgeon that establishes medical necessity for the service(s) the ASC intends to bill may be used to satisfy medical necessity documentation requirements.

U. PHYSICIANS AND PRIMARY CARE PROVIDERS

The Physicians and other PCPs shall adhere to the FFS PA requirements. PA is not required for evaluation and management services.

Refer to AMPM Policy 510 for information regarding covered PCP and physician services.

1. The FFS surgeons, or the facility employing the surgeon, shall obtain a separate and distinct AHCCCS PA number from that of the facility PA number prior to providing elective/non-emergency surgeries (except voluntary sterilization). Refer to Hospital Inpatient Service Authorization. The AHCCCS/DFSM, responds to all FFS transplant requests. Assistant surgeons essential to the service and anesthesiologists do not require a separate PA number.

2. Allergic immunotherapy is not covered for members 21 years of age and older. Allergy testing for members 21 years of age and older is not covered unless the member has sustained an anaphylactic reaction or severe allergic reaction, where further exposure may result in a life-threatening situation. Refer to AMPM Exhibit 300-1 for additional information. These services shall be prior authorized by AHCCCS/DFSM for members 21 years of age and older. Allergy testing and allergic immunotherapy services for members under 21 years of age does not require authorization.

V. FOOT AND ANKLE SERVICES

The Medically necessary foot and ankle care services provided by a podiatrist or podiatric surgeon, shall be ordered by the PCP, attending physician or practitioner. The ordering information shall be documented in the member's medical record. Elective surgical services are subject to PA requirements. A PA is not required for evaluation and management services.

Refer to AHCCCS FFS Provider Manual for billing requirements.

W. PRESCRIPTION DRUG/PHARMACY SERVICES

The FFS pharmacy PA is conducted through AHCCCS' contracted Pharmacy Benefit Manager (PBM).

All pharmacy claims are subject to post-payment review pursuant to ARS 36-2903.01 (L).

Refer to AMPM Policy 310-V for complete information regarding covered prescription drug/pharmacy services.

Refer to the AHCCCS Website for the AHCCCS AIHP drug list and the Pharmacy/Drug PA form.

X. OCCUPATIONAL, PHYSICAL AND SPEECH THERAPIES

1. Inpatient Services

   For members who receive occupational, physical, and speech therapies in an inpatient setting, coverage for these therapies is included in the facility authorization.

   For DDD THP members who receive services in an inpatient setting, contact the DDD Case Manager for discharge planning.

   For Tribal ALTCS members who receive services in an inpatient setting, contact the Tribal Case Manager for discharge planning. Refer to AMPM Policy 1620-Efor information.

2. Outpatient Services

   No PA is required for covered outpatient occupational and physical therapy services. For members who receive occupational, physical, and speech therapies in an inpatient setting, coverage for these therapies is included in the facility authorization.

   For Tribal ALTCS or DDD THP members who receive therapies in an outpatient setting, contact the Tribal Case Manager or DDD Case Manager, as applicable, for care coordination.

   AHCCCS covers outpatient speech therapy only for members who are under the age of 21 in both the AHCCCS (EPSDT program) and KidsCare programs, and ALTCS-enrolled members of any age. Authorization is not required.

   Refer to AMPM Policy 310-X for information and limitations regarding covered services regarding rehabilitation services for members.

Y. TOTAL PARENTERAL NUTRITION

AHCCCS covers Total Parenteral Nutrition (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. Refer to AMPM Policy 430 for complete information regarding parenteral nutrition therapy for EPSDT and KidsCare members.

A PA is required for coverage of TPN. All NFs and agencies furnishing outpatient TPN services shall obtain PA prior to initiation of service.

1. Written medical documentation substantiating compliance with AMPM Policy 310-GG requirements shall be submitted to AHCCCS/DFSM to support the authorization request. Medical documentation shall include:
   a. History and physical which describes member's condition and diagnosis,
   b. Physician's orders,
   c. Dietary assessment, including member's weight,
   d. Any pertinent progress notes (nursing/physician), which currently reflect the member's dietary, eating and functional status,
   e. Physician progress notes indicating expected outcome of treatment,
   f. The NF records documenting percentage of each meal's consumption by member, and
   g. Current laboratory data.

Z. TRANSPLANTS (ORGAN AND TISSUE)

The Providers shall obtain PA from AHCCCS for all organ and tissue transplant services to be provided to FFS member. Refer to AMPM Policy 310-DD for complete information regarding covered transplants, transplant components, related services, and submission requirements.

Pursuant to Section 1903(v)(2)(C) of the Social Security Act and AAC R9-22-206, FES Program enrolled individuals are not eligible for transplantation services.

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

1. Responsibilities for the FFS provider regarding medically necessary organ and tissue transplant services for eligible members include, but are not limited to:
   a. The faxed submission of PA requests to the AHCCCS/DFSM PA Unit, for approval of the transplantation and all related transplant components, and
   b. The online submission of PA requests to AHCCCS/DFSM, for approval of the medically necessary transplant related services that are not included in the transplant components.

   Refer to the AHCCCS Reinsurance Policy Manual for additional information. This manual is available on the AHCCCS Website.

2. Per the AHCCCS Transplant Contracts, the transplant facilities are expected to assist with coordinating the following transportation services:
   a. Room, and board (lodging) for:
      i. The transplant candidate to and from medical treatment during the time it is necessary for the member to remain in close proximity to the transplant center, and if needed,
      ii. The designated caregiver or escort as identified by the transplant facility.

   This includes pre- and post-transplant care by the transplant center. If determined to be medically necessary by the transplant specialist, members post allogeneic transplant may be required to be within one hour travel time of the transplant facility.

3. The Requests for transportation to and from transplant services shall be submitted separately from requests for meals and lodging as specified in the transportation section of this policy.

4. The Meal Cards for transplant-related travel outside the member's service area shall be requested for the member's designated caregiver/escort via the AHCCCS/DFSM authorization process.

5. The Meal cards for the member's designated caregiver/escort when the member is 18 years or age or older or when the service is not transplant-related, shall be authorized when an escort is determined to be medically necessary.

6. A Transplant-related medical services provided to FFS members who have undergone transplants not covered by AHCCCS require PA.

AA. TRANSPORTATION

A Prior Authorization (PA) is required for medically necessary Non-Emergency Transportation (NEMT) that does not originate through a 911 call or other emergency response system when the distance traveled exceeds 100 miles one way or roundtrip, and all air NEMT regardless of the number of miles.

1. AHCCCS covers the following transportation services as specified in AMPM Policy 310-BB:
   a. Emergency transportation:
      i. Emergency transportation does not require PA from AHCCCS/DFSM, although such services are only covered to the nearest medical facility, which is medically equipped and staffed to provide appropriate medical or BH care, and
      ii. Emergency transportation to out-of-State facilities is covered only when the out-of-State facility is the nearest appropriate facility.
   b. Medically necessary NEMT to and from covered medical or BH services that are rendered by an AHCCCS registered provider, to include IHS/638 providers, and
   c. Medically necessary maternal and newborn transportation is covered and does not require authorization.

2. Lodging and meals are covered when the member is unable to arrange and pay for these services on their own, and charitable lodging and/or charitable meals are not available to a member, and the member requires a medically necessary overnight stay near a treating facility located outside the Geographic Service Area (GSA) where the member resides.

   A single caregiver/escort may be determined to be medically necessary as ordered by the treating provider. An escort may be required if a member has a functional or cognitive deficit that impairs the member's ability to safely function independently.

3. An escort order is not required for a minor or for a designated transplant recipient's escort.

4. For transportation requests, including but not limited to, specialty transportation needs and travel outside the member's GSA /county of residence the following documentation shall accompany the written request as applicable.
   a. Provider's order, including medical justification for travel outside the member's GSA /county of residence, and need for escort when applicable,
   b. Case plan notes from an AHCCCS registered BH provider indicating the length, duration, and frequency of service or other supporting documentation as needed to make a coverage determination,
   c. Descriptions of disability requiring special transport and/or special circumstances,
   d. Type of transportation and need for escort services, as appropriate,
   e. Estimated cost of transportation, escort services, meals or lodging, as appropriate, and/or
   f. Non-Emergency Medical Transportation (NEMT) authorization requests shall contain a valid BH or physical health diagnosis to be authorized by AHCCCS/DFSM staff.

   A PA for transportation will not be issued unless the transportation provider is an actively registered AHCCCS transportation provider on the date of service requested.

   Non-Emergency Transportation (NEMT) providers shall not view or be in possession of clinical documentation containing member Protected Health Information (PHI). For the protection of member's PHI, NEMT providers are encouraged to request that the service provider submit the required documentation supporting medical necessity to AHCCCS/DFSM via fax with the completed FFS Medical Documentation form as the coversheet.

5. Prior Authorization for NEMT services:
   a. Non-Emergency Transportation (NEMT) services for FFS members enrolled with AIHP, DDD THP, and/or assigned to a TRBHA, are authorized on an FFS basis by AHCCCS/DFSM,
   b. For Tribal ALTCS members, all physical health and BH transportation services are authorized by the Tribal ALTCS case manager, and
   c. For ACC, or ALTCS EPD, and ACC-RBHA Contractor enrolled members, contact the Contractor of enrollment for PA requirements.

6. The NEMT providers shall coordinate directly with each tribe to obtain tribal business license and maintain good standing.

7. Prior Authorization (PA) will be denied for transport services on reservation if the NEMT provider does not have the corresponding Tribal business license on file with AHCCCS Provider Registration

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

BB. TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS

The Triage/emergency medical screening and evaluation services are the medically necessary screening and assessment services provided to FFS 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 or Free-Standing Emergency Department (FRED).

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 PA from AHCCCS/DFSM.

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 utilization management requirements.

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

A Medical review of emergency room records shall 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.

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 is subject to denial.

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

   Refer to the AHCCCS FFS Provider Billing Manual for information regarding billing requirements.

CC. OTHER MEDICAL PROFESSIONAL SERVICES

Under 9 AAC 22, Article 2, the following medical professional services do not require PA:

1. Voluntary sterilization (No PA required for AIHP and Tribal ALTCS members aged 21 years and older. PA is required for DDD THP members.
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. A PA is not required for the first five visits following an acute hospitalization.
10. Hysteroscopies for AIHP and Tribal ALTCS members aged 21 years and older when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization. A PA is required for DDD THP members.
11. Outpatient physical and occupational therapy for Acute members 21 years of age or older are described in detail in AMPM Policy 310-X.
12. Facility services related to wound debridement.
13. Apnea management and training for premature babies up to one year of life.

DD. CHEMOTHERAPY AND RADIATION ONCOLOGY SERVICES

Chemotherapy and radiation oncology services do not require PA, except for Intensity Modulated Radiation Therapy (IMRT). IMRT requires PA. Clinical documentation for IMRT shall establish medical necessity for treatment of radiosensitive tumors where critical structures cannot be adequately protected with standard 3D conformal radiotherapy.