820 - FEE-FOR-SERVICE AUTHORIZATION REQUIREMENTS

EFFECTIVE DATES: 10/01/94, 07/01/17, 03/01/19, 04/01/22, 01/26/24, 09/27/24, 07/01/25, 10/01/25, 07/16/26

APPROVAL DATES: 04/01/95, 08/01/95, 10/01/95, 07/22/96, 03/14/97, 05/01/97, 10/01/97, 02/12/98, 02/18/98, 06/01/98, 07/01/98, 07/01/99, 10/01/01, 07/01/04, 01/01/05, 03/03/06, 06/01/06, 08/01/06, 11/01/06, 04/01/07, 05/15/07, 10/01/07, 10/01/08, 03/01/09, 10/01/09, 07/01/10, 10/01/10, 11/01/11, 01/01/12, 03/01/12, 01/01/14, 01/01/17, 05/03/18, 12/20/18, 01/13/22, 01/24/24, 07/10/24, 03/25/25, 09/25/25, 07/05/26

I. PURPOSE

This Policy applies to Fee-For-Service (FFS) populations as specified within this Policy including: American Indian Health Program (AIHP), Tribal ALTCS, TRBHA, the, 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 ACOM and AMPM 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. Refer to AMPM Policy 810 for more information on service denial, termination, suspension, or reduction and review timeframes. 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 the PA requirements per billing code by viewing the FFS PA Guidelines under Reference Extracts on the AHCCCS Medical Coding Resources web page under the Plans/Providers section of the AHCCCS website.

The FFS payments are subject to audits and investigations by AHCCCS Office of Inspector General (OIG).

The issuance of an authorization number does not guarantee payment.

The 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. Refer to the Fee-for-Service Billing Manual for more information on claim and billing requirements.

The PA may be provisional if further review of information or documentation is needed to make a full assessment of the medical necessity for an admission, service(s), and/or 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. AHCCCS Division of Fee-For-Service Management (DFSM) may request additional documentation, and an extension may be granted if it is determined that more information is needed to establish medical necessity. See AMPM Policy 810 for more information on PA extensions.

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

1. 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,
   d. For periods of member retroactive eligibility including Prior Quarter Coverage and Prior Period Coverage, or
   e. For non-emergency ambulance transports when the service call originated through the 911 or Emergency Response System.

2. 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. The member's 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.

3. It is in the sole discretion of AHCCCS to terminate an approved PA based on additional information after the date of PA approval.

4. If AHCCCS in its sole discretion determines that PA shall be required for additional provider types, AHCCCS will provide 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 the AHCCCS Pharmacy Information page under the Plans/Providers section of the AHCCCS website for PBM PA requirements and 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 via the Guides/Manuals/Policies link.

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

Care Coordination Requirements - the Providers serving FFS members are required to coordinate service delivery across all levels of care to include applicable treating providers or entities including but not limited to:

1. The assigned TRBHA.
2. Assigned Tribal ALTCS case manager.
3. The DDD Case Manager or DDD District Nurse.
4. American Indian Medical Home (AIMH).
5. Primary Care Provider (PCP).
6. Indian Health Services (IHS) and Tribally operated 638 facilities.
7. 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.
8. 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. A PA is required for BH treatment rendered by the following behavioral health service providers:
   a. Psychiatric units of acute hospitals,
   b. Psychiatric specialty hospitals,
   c. Residential Treatment Centers (RTCs),
   d. Subacute detox facilities,
   e. Behavioral Health Residential Facilities (BHRFs), and
   f. Intensive Outpatient Treatment Program (IOP) providers.

2. The Care provided in each of these service settings shall include documentation of care coordination with the appropriate individuals and entities comprised of the member's outpatient treatment team. The initial and continued stay PA requests shall include documented evidence of care coordination with the member's:
   a. Health Care Decision Maker (HCDM) (when applicable),
   b. TRBHA (if TRBHA enrolled),
   c. Tribal ALTCS Case Manager (if ALTCS enrolled), and
   d. Special Assistance Advocate (when applicable).

   Refer to Section L for Hospital Service Authorizations and AAC Title 9, Chapter 10, Article 3 for inpatient BH hospital admissions.

3. The Behavioral Health (BH) PA requests submitted to AHCCCS DFSM shall 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.

4. The Behavioral Health Inpatient Facilities (BHIFs) Authorizations. The Behavioral Health Inpatient Facilities (BHIFs) include RTCs and sub-acute detox facilities:
   a. The BHIF initial PA documentation shall include:
      i. A Certification of Necessity (CON) that shall be signed by a healthcare provider with Doctor of Medicine (MD) or Doctor of Osteopathy (DO) credentials. The CON covers the first 72 hours of the initial authorization period for a sub-acute detox facility admission, or the first 30 days of an RTC admission and shall be submitted to AHCCCS DFSM:
         1) Prior to admission or on the day of admission, or
         2) Within 72 hours of an emergency admission.
      ii. A current psychiatric evaluation or documentation sufficient to clearly address the required documentation elements as specified in the CON are due by the date of admission. When a current psychiatric evaluation is not available on the date of admission, the following applies:
         1) When a current psychiatric evaluation is not available on the date of admission, clinical documentation that would normally be documented as part of a psychiatric evaluation, including the initial treatment plan shall be submitted, or
         2) For detoxification admissions, a history and physical may be submitted if a psychiatric evaluation cannot be completed and shall include the initial treatment plan.
   b. A continued Authorization shall be requested prior to the end date of the previously authorized date range, and shall include:
      i. A Recertification of Need (RON). A RON shall be signed by a healthcare provider with MD, DO, Physician Assistant or Nurse Practitioner (NP) credentials, and is required upon the expiration of the CON. The RON must be renewed and submitted:
         1) By the fourth calendar day following CON submission, and then every seven days for detox facility admissions, for the duration of the admission, or
         2) Every 30 days for RTC admissions for the duration of the admission.

ii. A Psychiatric evaluation, if not submitted with the initial authorization request,
iii. The treatment plan. The treatment plan shall be signed by a Behavioral Health Medical Professional (BHMP). Documentation of coordination with the member's TRBHA, Tribal ALTCS case manager, or other outpatient treatment team providers shall be evident in the member's treatment plan,
iv. The BHMP attending provider progress notes, and
v. The Discharge and aftercare plan documentation which shall include:
    1) A discharge summary signed by the attending BHMP which shall include:
        a) The Member disposition,
        b) Discharge medication(s), and
        c) Diagnosis.
    2) An aftercare plan specifying appointments for:
        a) Medication management,
        b) Counseling, and/or
        c) Case management services.

5. Behavioral Health Residential Facility (BHRF) Authorizations

Unless an exception noted in this policy applies, the BHRF admission referral shall be initiated by the member's outpatient treatment team. The BHP that is part of the member's outpatient treatment team shall formulate the member's pre-admission treatment plan, and comprehensive pre-admission BH assessment. In cases where the referral documentation is created by another qualified provider, the member's outpatient treatment team shall be part of the pre-admission assessment and treatment plan formulation.

An exception will be made for FFS members transitioning from jails, prisons, detention facilities or other justice settings. Providers are expected to coordinate with justice system stakeholders consistent with FFS requirements in AMPM Policy 1022. When a referral to a higher level of care, including Behavioral Health Residential Facility (BHRF) services, is required prior to or immediately following release, the referral is typically completed by an outpatient behavioral health provider in conjunction with an assessment.

In circumstances where an outpatient provider referral has not occurred prior to release, a pre-release behavioral health assessment completed by a justice system, medical or behavioral health provider may be accepted for PA review when the following conditions are met:

a. The member otherwise meets AHCCCS medical necessity and program criteria for the requested service, and
b. All other PA documentation and other PA requirements are satisfied.

Acceptance of justice system assessment documentation under this provision does not establish justice system entities as AHCCCS-registered referring providers and does not waive or supersede any additional authorization, coverage, or program requirements.

See AMPM Policy 320-V for BHRF policy coverage and exclusionary criteria. Refer to the FFS PA Website for additional BHRF PA information.

With the exception of members transitioning from carceral settings mentioned above, BHRF providers are required to submit a completed copy of the Fee For Services (FFS) Intensive Outpatient Program (IOP)/BHRF CON with all initial BHRF PA requests. The CON is mandatory and shall be submitted to AHCCCS DFSM on or prior to the date of BHRF admission. The CON is effective for the initial 30 days of the BHRF admission. The submission of the CON and the pre-admission comprehensive behavioral health assessment satisfies documentation submission requirements for initial BHRF PA requests.

6. The BHRF providers shall request PA from AHCCCS DFSM prior to admitting an FFS member and prior to the expiration of previously authorized dates for continued stays: For dates of service prior to the 2025 effective date, BHRF initial PA documentation shall include all of the following:
   a. The pre-admission treatment plan:
      i. Exception to this requirement exists when the member is evaluated by the Crisis provider, Emergency Department (ED), or inpatient hospital, and
      ii. 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 documentation at a minimum must support medical necessity for BHRF as the least restrictive environment to safely meet the member's needs.
   b. Comprehensive pre-admission BH assessment:
      i. Exception to this requirement exists when the member is evaluated by the Crisis provider, Emergency Department (ED), or inpatient hospital, and
      ii. 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 documentation at a minimum must support medical necessity for BHRF as the least restrictive environment to safely meet the member's needs.

7. The Continued Stay requests shall document medical necessity for BHRF service continuation. The BHRF providers are required to submit a completed copy of the FFS IOP/BHRF RON with all continued stay BHRF PA requests. The RON is mandatory and shall be submitted to AHCCCS DFSM upon expiration of the CON or previous RON. In the case of continued stay, PAs that were requested prior to the 2025 effective date, the RON is required with the submission of the next continued stay request. The RON is effective for 60 calendar days and shall accompany other required continued stay documentation. The following criteria shall be considered when determining continued stay:
   a. The member continues to demonstrate significant risks of harm and/or functional impairment as a result of a behavioral health condition, and/or
   b. The providers and/or support are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

8. The following BHRF continued stay documentation is required for dates of service prior to and after the 2025 effective date: The current treatment plan formulated by the BHRF and signed by the BHRF BHP. 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, HCDM, and Special Assistance/Advocate as applicable on a monthly basis:
    a. Documentation of BHRF staff coordination with the key individuals of the member's outpatient treatment team is required. Treatment team members shall be identified by entity, name, and role,
    b. Documentation of all treatment plan updates,
    c. Documented progress towards the treatment goals,
    d. Documented status of continued risk and/or functional impairment,
    e. Documented treatment interventions specifying frequency, including crisis/safety planning,
    f. Documentation of a targeted discharge date which shall be adjusted accordingly in response to changes in the member's treatment plan,
    g. Progress notes documenting the frequency, type, and duration of the BHRF treatment sessions and therapeutic activities occurring during the authorization period to include:
        i. Identifying member information to include member name, date of birth, and AHCCCS ID number,
        ii. The date of service,
        iii. Start and end time,
        iv. Topic as it relates to the treatment plan,
        v. Patient response, and
        vi. Signature and credentials of the individual conducting the treatment activity including the date signed.
    h. Documentation of the frequency, type, and duration of any treatment conducted by providers outside of the BHRF, during the time the member is receiving treatment in the BHRF setting to include:
        i. The date of service,
        ii. Treatment start and end times,
        iii. The topic as it relates to the member's treatment plan,
        iv. The Patient response, and
        v. The name and credentials of the provider conducting the treatment activity.
    i. The discharge notification shall be provided to AHCCCS DFSM upon the member's discharge from the BHRF. The discharge notification shall include:
        i. The provision of the actual date of discharge from the BHRF, and
        ii. Where member was discharged to.
    j. The written discharge summary shall be submitted to AHCCCS DFSM within 10 working days of the discharge date and shall include the following:
        i. The aftercare plans,
        ii. The name and credentials of the outpatient treatment team members the provider has contacted,
        iii. Referrals for post-discharge care to meet the member's ongoing care needs,
        iv. Documentation of follow up appointment dates with care team(s),
        v. The level of care the member was discharged to,
        vi. The mode of discharge transportation and who accompanied the member (if applicable), and
        vii. The level of progress made towards each treatment plan goal.

9. Intensive Outpatient Programs (IOPs)

The IOPs are structured non-residential treatment programs which address mental health and Substance Use Disorders (SUDs), that do not require detoxification, through a combination of individual, group, and family counseling and therapy and educational groups. Refer to AMPM Policy 310-B and the AHCCCS Covered Behavioral Health Services Guide for information on IOP services. IOP services require authorization. Submission of the completed FFS IOP/BHRF CON with initial IOP authorization requests or the RON with all IOP service continuation authorization requests is mandatory for dates of service that occur on or after the 2025 effective date:

a. The initial authorization request documentation shall be submitted to AHCCCS DFSM within 72 hours of the initiation of IOP services. The initial authorization documentation shall include:
    i. Certification of Necessity (CON) for IOP treatment which:
        1) Must be signed by the BHP overseeing the member's treatment,
        2) Any independently licensed Behavioral Health Professional (BHP) must be actively enrolled with AHCCCS. Associate-level BHPs are not required to enroll directly with AHCCCS but must provide services under appropriate supervision and in accordance with AHCCCS and state regulatory requirements,
        3) The BHP signature must include credentials and comply with AMPM Policy 940, and
        4) Is valid for the initial 30 calendar days of treatment.
    ii. Comprehensive BH Assessment.
b. The Service continuation documentation is required for the continuation of IOP services and shall be submitted to AHCCCS DFSM upon expiration of the CON or the previous RON. The Service continuation documentation shall include the Recertification of Need (RON). The RON is due as follows:
    i. Every 12 weeks for IOP SUD treatment, or
    ii. Every 30 calendar days for IOP psychiatric treatment.

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

Behavioral Health services are also available to FFS enrolled American Indian/Alaska Native (AI/AN) members at an IHS/638 facility.

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. The services must be ordered by a Primary Care Physician (PCP)/Practitioner and be within the scope of chiropractic practice as defined by State law.

The following documentation shall accompany the PA request:

1. A prescription and/or order from the PCP/Practitioner.

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 members at an AHCCCS registered implantation center. A PA is required for all cochlear implants and related services for FFS. The requests for PA shall include documentation of the appropriate assessments and evaluations for determining suitability for a cochlear implant. Refer to AMPM Policy 430 and AMPM Policy 310-JJ 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 [Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program] and KidsCare Programs. Refer to AMPM Policy 430 and AMPM Policy 431, 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.

The 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 ALTCS 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 require approval by AHCCCS DFSM, and the AHCCCS Dental Director or Designee).

2. The 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 providers serving FFS members without PA.

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

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

H. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

The 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. The 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 AAC R9-22-210 which require that the provider notify AHCCCS no later than 72 hours after an FFS member's emergent inpatient admission. The notification of emergency admissions may be submitted via AHCCCS online web portal or via fax for services that meet fax criteria. Refer to AMPM Policy 810 for more information on fax submissions. AHCCCS DFSM may deny payment for failure to provide timely notice.

A PA is required when a non-FESP FFS member remains inpatient 72 hours or more following an emergent medical admission. Consecutive service dates that occur prior to an emergent inpatient hospital admission (i.e. emergency room days and observation days) must be included in the date span of the inpatient authorization request. Refer to the Hospital section of this policy for more information related to PA for hospital admissions.

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 FESP.

J. EYE CARE/OPTOMETRY SERVICES

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

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

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

The 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 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 that are not associated with an acute facility discharge or that are beyond the first five home health visits following discharge from an acute facility.

The Rehabilitative therapies delivered by home health agencies do not require PA but may be subject to Electronic Visit Verification (EVV) requirements. Please refer to the EVV Services web page for a list of services that are subject to EVV. The PA satisfies the EVV requirement for home health services that are subject to PA. All PA requests shall be accompanied by the following supporting medical documentation:

1. Initial Authorization:
    a. Documentation of the face-to-face encounter requirements as specified in AMPM Policy 310-I, and
    b. Prescription from ordering prescribers indicating specific home health nursing duties and duration of need for home health services.

2. Subsequent Authorization:
    a. New order from prescriber for any changes to the member's plan of care,
    b. Clinical documentation to include:
        i. Home Health Certification/Plan of Care,
        ii. Skilled Nursing notes to include:
            1) Date and time of visit to include in and out times,
            2) Reason for visit,
            3) Assessment findings to include wounds status and measurements as applicable,
            4) Skilled nursing care delivered,
            5) Plan for next visit, and
            6) Nursing signatures with credentials.

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

L. HOSPITAL SERVICE AUTHORIZATION

The hospital inpatient service authorization is a utilization management function that may consist of both PA and continued stay review, contingent upon review findings as specified in AMPM Policy 810.

1. All FFS Inpatient Hospital Admissions require the following criteria to be met:
   a. An order for inpatient admission written by a physician with MD or DO credentials certifying the member requires inpatient treatment,
   b. The member demonstrates signs and/or symptoms severe enough to warrant the need for treatment, and
   c. Any 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 were provided in a less intensive setting, or
      iii. The medical predictability of something adverse happening to the patient is uncertain.

2. Initial Inpatient Authorization

   As specified in AAC R9-22-204 the provider shall notify AHCCCS DFSM no later than 72 hours after the emergent inpatient admission of an FFS member. AHCCCS DFSM may deny payment for failure to provide timely notice and for missing documentation.

   At a minimum, initial inpatient admission notifications shall specify the FFS member's admission status at the time of notification and be accompanied by:
   a. The facility's hospital face sheet,
   b. History and physical documentation,
   c. An order for inpatient admission that is written and signed by a physician with MD or DO credentials, or
   d. In the case of behavioral health admissions to an acute general hospital or psychiatric specialty hospital the following documents are required:
      i. A CON that has been signed by a physician with MD or DO credentials is required. The CON satisfies the FFS physician inpatient order and/or certification requirement,
      ii. A Psychiatric Evaluation (behavioral health admissions), or documentation sufficient to clearly address the required documentation elements that would typically be provided as part of a psychiatric evaluation, and
      iii. The initial behavioral health treatment plan.

3. An Authorization is required for the following inpatient and outpatient hospital services for all FFS and DDD THP members:
   a. Elective inpatient admissions,
   b. Elective and urgent outpatient surgical procedures (see section FF for exclusions),
   c. Non-emergent inpatient admissions (including transfers and other urgent admissions),
   d. Emergent physical health inpatient admissions that exceed 72 hours,
   e. Psychiatric inpatient admissions regardless of the length of stay,
   f. Admissions for vaginal delivery that exceed 72 hours,
   g. Admissions for c-section delivery that exceeds 96 hours,
   h. Newborn stays that exceed the PA threshold for the delivery type when the parent's continued stay in the hospital is medically necessary beyond the minimum 72 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. Non-emergent outpatient surgical procedures require authorization for the hospital. The hospital PA requirements may differ from the PA requirements for the surgeon.

   The Extended stays after outpatient surgery shall be billed as recovery room extensions. The dates authorized for recovery room extensions shall match the dates billed on the claim. The authorization of extended recovery room services requires submission of supporting documentation of daily progress notes and/or discharge summary documenting medical necessity of continued stay beyond same day surgery.

6. The payment for services may be denied if the hospital fails to provide timely notification or obtain PA when required, as specified in the Hospital section of this Policy, or for failure to provide an inpatient discharge summary prior to billing the claim.

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 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.

A PA may be granted based on these documents. The 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.

Genetic testing, rapid whole genome sequencing, and a biomarker testing require FFS PA. Refer to AMPM Policy 310-II for information and criteria on coverage of Genetic testing and rapid whole genome sequencing. Refer to AMPM policy 310-KK for information on coverage of Biomarker testing. PA requests for rapid whole genome sequencing shall include documentation that is consistent with coverage criteria for the service. 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. The rationale for choosing the particular biomarker test requested.

5. Medical literature citations as applicable.

6. For Biomarkers Testing requirements, refer to AMPM Policy 310-KK.

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 providers.

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 for medically necessary pregnancy terminations that are submitted by an IHS /638 provider must include a copy of the AHCCCS Certificate of Medical Necessity for Pregnancy Termination or submission of documentation that addresses all of the documentation elements as specified in AMPM Policy 410, Attachment C.
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

The 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.

The orthotic and prosthetic devices shall be prescribed by a physician or other appropriate practitioner. A 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. A PA is required for the purchase of medical equipment exceeding $300.00. PA is required for all medical equipment rentals and repairs,
   b. A PA 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 do 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 such 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. A 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. The 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. A 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. The Augmentative and Alternative Communication Device Evaluation. The PA Evaluation requests must include the following information or documentation. A detailed written order or prescription by the member's provider. The detailed written order shall:
   a. Be signed and dated by the provider, familiar with the member dated within 365 days of the PA request,
   b. Include the National Provider Identifier (NPI) numbers of the prescribing qualified health professional, and
   c. Indicate the prescription is for an Augmentative and Alternative Communication evaluation.

7. The Augmentative and Alternative Communication Device System Purchase Documentation Requirement. The 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. The documentation to demonstrate how the prescribed Augmentative and Alternative Communication device system is medically necessary.

8. The 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. The Augmentative and Alternative Communication Device System Replacement Documentation Requirements.

   The PA requests must include a joint statement from the prescribing practitioners and a licensed speech-language pathologist.

10. The Augmentative and Alternative Communication Device System Treatment (Training).

    The PA requests must include 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.

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

The 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 (HCBS). The PA 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 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

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

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 Observation service criteria.

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.

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.

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

Except for physician buy and bill drugs that are subject to PA, 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-E for information.

2. Outpatient Services

   No PA is required for covered outpatient occupational and physical therapy services, including when these services are provided by a home health agency. Refer to the Home Health section of this policy for more information on home health services.

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

   AHCCCS covers outpatient speech therapy services for all members receiving inpatient care at a hospital, NF, custodial care facility, or on an outpatient basis when services are medically necessary and ordered by the member's PCP or attending physician. 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.

   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.

The written medical documentation substantiating compliance with AMPM Policy 310-GG requirements shall be submitted to AHCCCS DFSM to support the authorization request. The medical documentation shall 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. The NF records documenting percentage of each meal's consumption by the member.

7. Current laboratory data.

Z. TRANSPLANTS (ORGAN AND TISSUE)

The Providers shall obtain PA from AHCCCS for all organ and tissue transplant services, bone grafts, and corneal transplants to be provided to FFS members. 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 (SSA) 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 provider serving FFS members 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. Room and board (lodging) for:
   a. 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,
   b. 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 of 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 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.

A PA is not required when the ambulance transport is initiated by 911 or other emergency response system for NEMT services, for facility to facility transports over 100 miles in accordance with ARS 36-2907(G) which waives PA for medically necessary ambulance services initiated by calling 911 or another designated emergency response system.

1. AHCCCS covers the following transportation services as specified in AMPM Policy 310-BB:
   a. Emergency transportation:
   b. Emergency transportation does not require PA from AHCCCS DFSM, although such services are only covered to the nearest medical facility even if it exceeds 100 miles, which is medically equipped and staffed to provide appropriate medical or BH care. Emergency transportation to out-of-State facilities is covered only when the out-of-State facility is the nearest appropriate facility,
   c. 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
   d. Medically necessary maternal and newborn transportation is covered and does not require authorization.

2. The 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. 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.

   The 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. The 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).

A 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. A 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. Refer to AMPM Policy 310-X for rehabilitative therapies.

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). All 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.