820 - FEE-FOR-SERVICE PRIOR AUTHORIZATION REQUIREMENTS

EFFECTIVE DATES: 10/01/94, 07/01/17, 03/01/19, 04/01/22[1]

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[2]

I. PURPOSE

This Policy applies to Fee-For-Service (FFS) populations ~~Programs and populations~~ [3]as ~~delineated~~ specified[4] within this Policy including: Tribal ALTCS, TRBHA, the American Indian Health Program (AIHP), and DDD Tribal Health Program (DDD THP); ~~and all FFS populations~~ excluding Federal Emergency Services Program (FESP). (For FESP, ~~see~~ refer to AMPM Chapter 1100). ~~-~~This Policy establishes the process by which AHCCCS DFSM applies FFS Prior Authorization (PA)[5] requirements for covered services.

II. DEFINITIONS

Definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.[6]

~~**Prior Authorization (PA)**~~	~~For purposes of this Policy, a process by which the AHCCCS Division of Fee-For-Service (FFS) Management (DFSM) determines in advance whether a service that requires prior approval will be covered, based on the initial information received. PA may be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. PA is not a guarantee of payment.~~
~~**Prior Authorization Request Submission Process**~~	~~The process by which authorization requests are submitted with clinical documentation supporting the medical necessity for the services requested.~~

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 A.A.C. Title 9, Chapter 34.[7]

[1] Policy revised to apply program changes effective 04/01/22.
[2] Date presented at AHCCCS Policy Committee Meeting (APC).
[3] Removed duplicative reference to "programs".
[4] Changed to align with Policy standards throughout the Policy.
[5] First time used in the Policy add acronym throughout Policy.
[6] Terms which align with the Contract and Policy Dictionary, have been removed from Policy and can be located in the Contract and Policy Dictionary.
[7] Moved from below.

AHCCCS/DFSM requirements for submitting PA requests via the AHCCCS online web portal (preferred), fax, telephone, or mail, as specified in AMPM Policy 810, apply to all services identified in this Policy, unless specified otherwise.

1. PA is not required ~~for~~:
   a. For emergency services,
   b. When AHCCCS is the secondary payer,
   c. For FFS members receiving services from Indian Health Service~~s~~ (IHS)/638 providers and facilities, or ~~forEmergency services,~~
   d. For periods of member retroactive eligibility.

~~1.~~2. Title XXI members receiving pharmacy services from an IHS/638 provider may be subject to medication authorization requirements as required by the FFS Pharmacy Benefits Manager (PBM[8]).

   Refer to Chapter 10 of the FFS IHS/638 Billing manual for IHS/638 pharmacy billing information.

~~When required, a non-IHS/638 provider or facility rendering AHCCCS covered services shall obtain PA from the AHCCCS/, Prior Authorization Unit, hereafter referred to as DFSM for services requiring authorization as specified in this Policy. PA requests shall be submitted prior to providing services.[9]~~

~~The DFSM procedural requirements for submitting PA requests via the AHCCCS online web portal (preferred), fax, telephone, or mail, as delineated in AMPM Policy 810, apply to all services identified in this Policy, unless specified otherwise. For purposes of this Policy, all PA requests are submitted to DFSM for approval or denial, unless specified otherwise. In the case of a service denial, termination, suspension, or reduction, notice will be provided in accordance with A.A.C., Title 9, Chapter 34.[10]~~

A. PRIOR AUTHORIZATION REQUEST SUBMISSION PROCESS

For additional information related to FFS authorization submission requirements and procedures, visit the PA page under the Fee-For-Service section of the American Indians page on the AHCCCS website.[11]

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

[8] Language added to specify Title XXI IHS/638 pharmacy authorization process.
[9] Information has been revised and added to lead in paragraph.
[10] Revised and moved up above
[11] Added additional language to clarify location of PA page content online.

B. OUTPATIENT BEHAVIORAL HEALTH

AHCCCS covers behavioral health ~~services~~ and/or ~~s~~Substance ~~u~~Use ~~d~~Disorder (SUD)[12] services within limitations depending upon the member's age and eligibility.

Admissions to residential treatment centers and behavioral health residential facilities require authorization. See section K,~~.~~ for inpatient Behavioral Health (BH)[13] hospital admissions.

~~Outpatient behavioral health services for Tribal ALTCS members are coordinated through the Tribal ALTCS case manager.~~ [14]
FFS providers shall coordinate behavioral health services with:

1. The assigned TRBHA,

~~1.~~2. The inpatient and/or outpatient treatment team, to include the Behavioral Health Professional (BHP)[15] ~~The behavioral health professional~~whom shall be~~is~~ responsible for the member's behavioral health treatment plan, and

3. Other individuals of the treatment team including physical health providers, as applicable.

~~Outpatient behavioral health services for FFS members assigned to a RBHA for behavioral health services are authorized by the assigned RBHA. For TRBHA assigned members, FFS providers coordinate behavioral health services with the assigned TRBHA. For AIHP members not assigned to a RBHA or TRBHA,~~ [16]
FFS providers and stakeholders may contact ~~coordinate behavioral health services with~~ DFSM for assistance as needed.[17]

Behavioral health services are also available to ~~-~~American Indian and Alaska Native (AI/AN) members ~~may also receive behavioral health services~~ at an ~~HIS~~IHS/638 facility.

Outpatient behavioral health services for Tribal ALTCS members are coordinated through the Tribal ALTCS case manager.[18]

Behavioral health services for FFS members assigned to a Regional Behavioral Health Authority (RBHA)[19] are authorized by the assigned RBHA.[20]

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[12] Added acronym for standard language use throughout policy.
[13] Spelled out acronym Behavioral Health (BH), as first time used with Policy.
[14] Moved below for better flow
[15] Added acronym for Behavioral Health Professional, first time use within Policy
[16] Section reformatted.
[17] Added language to clarify FFS provider responsibility in coordinating member BH care with other FFS providers and TRBHA as applicable.
[18] Moved from above for better flow
[19] First time acronym is used in Policy. Spelled out Regional Behavioral Health Authority
[20] Moved this sentence to the end of the section to minimize confusion related to non-FFS member BH authorizations

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

C. BREAST RECONSTRUCTION AFTER MASTECTOMY

AHCCCS covers breast reconstruction for eligible FFS members following a medically necessary mastectomy. Refer to AMPM Policy 310-C.

PA is required for breast reconstruction surgery provided to FFS members.

Refer to the sections of this Policy addressing Hospital Inpatient Stays and Physician Services for authorization documentation requirements.

D. 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 authorization request:

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

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

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

E. 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 ~~outlined~~ specified in AMPM Policy 310-D1 and AMPM Policy 310-D2. Dental services for DDD THP members 21 years of age and older are coordinated by DFSM ALTCS unit and dental services for[21] Tribal ALTCS members 21 years of age and older are coordinated by the member's Tribal Case Manager.

[21] Added language for clarification of care coordination through DFSM vs Tribal ALTCS case management.

1. 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 ~~do~~ 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 the AHCCCS/DHCM, 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.

F. DIALYSIS

AHCCCS covers dialysis and related services furnished to AHCCCS FFS members by qualified FFS providers[22] without PA.

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

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

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

EPSDT services provide comprehensive health care, as defined in ~~A.A.C., Title 9, Chapter 22, Article 2,~~A.A.C. R9-22-213 through primary prevention, early intervention, diagnosis, and medically necessary treatment of physical and behavioral health conditions for AHCCCS members who are under 21 years of age. EPSDT ~~also~~ provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, and defects, ~~or a~~to include conditions[23] identified in an EPSDT screening. Limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

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.

[22] Added FFS providers for clarification
[23] Reworded language for clarity.

H. EMERGENCY MEDICAL SERVICES

A provider is not required to obtain PA for emergency medical services~~,~~ however, a provider shall comply with the notification requirements ~~in A.A.C., Title 9, Chapter 22, Article 2 and A.A.C. R9-22-204(A)(4)~~ A.A.C. R9-22-210~~–~~ 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. DFSM may deny payment for failure to provide timely notice.

Authorization is required when an FFS member remains inpatient 72 hours or more following an emergent medical admission.
Refer to A.A.C. R9-22-210, for review of the Rule sections regarding FFS emergency services.

Refer to AMPM Policy 1100 for information regarding the Federal Emergency Services Program.

I. EYE CARE/OPTOMETRY SERVICES

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

Routine eye examinations and prescriptive lenses are covered for EPSDT and KidsCare members,~~, and~~ PA is not required.

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

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~~-~~. ~~for all FFS members~~

J. HOME HEALTH NURSING AND HOME HEALTH AIDE SERVICES

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. 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. 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.

K. 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 concurrent review findings. Refer to AMPM Policy 810.

1. Initial Service Authorization:
   As specified in ~~Under 9~~ A.A.C. 22~~, Article 2,~~-204 the provider shall notify DFSM no later than 72 hours after an FFS member receiving emergency medical or behavioral health services is emergently admitted for inpatient ~~services~~treatment. DFSM may deny payment for failure to provide timely notice.

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

   At a minimum, initial inpatient notification~~s~~ for behavioral health admissions shall be accompanied by a C~~c~~ertificate O~~o~~f N~~n~~ecessity (CON) and 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[24].

2. 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 the AHCCCS/DHCM, Medical Management Unit, with the exception of corneal transplants and bone grafts, that are submitted to the DFSM,
   b. Elective and Non-emergency inpatient admissions, ~~including acute~~
   ~~b.~~c. ~~p~~Psychiatric hospitalizations, the following applies:
      i. PA requests for behavioral health admissions for DDD members assigned to an AAC subcontractor are authorized by the subcontracted AAC health plan.
      ~~i.~~ii. PA requests for behavioral health admissions for ~~FFS~~ members assigned to a ~~Regional Behavioral Health Authority (~~RBHA~~)~~ are submitted to the RBHA,
      ~~ii.~~iii. PA requests for behavioral health admissions for members assigned to a ~~Tribal Regional Behavioral Health Authority (~~TRBHA~~)~~ are submitted to DFSM,
      ~~iii.~~iv. PA requests for behavioral health admissions for ~~acute~~ [25]FFS members ~~or~~ and DDD Tribal Health Plan members[26] who are not assigned to an AAC subcontracted health plan[27], ~~-~~RBHA, or TRBHA are submitted to DFSM, and
      ~~iv.~~v. PA requests for all acute inpatient hospital admissions [28]for[29] Tribal ALTCS members are submitted to DFSM.

[24] Added language to clarify documentation requirement for BH inpatient hospital admissions.
[25] Added clarifying language since will be applicable to DDD and FFS.
[26] Added to address DDD members acute Behavioral Health Inpatient Facility authorization requirements.
[27] Added additional language to address PA requirements for AAC integrated members.
[28] Added to clarify DFSM responsible for both physical health and behavioral health inpatient admits for Tribal ALTCS

d. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury, and [30]

~~c.~~e. Elective surgery, with the exclusion of any surgeries listed below~~, and Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury.~~

~~3. The following services do not require PA:~~

~~a. Voluntary sterilization,~~

~~b. Dialysis shunt placement,~~

~~c. Arteriovenous graft placement for dialysis,~~

~~d. Angioplasties or thrombectomies of dialysis shunts,~~

~~e. Angioplasties or thrombectomies of arteriovenous grafts for dialysis, and~~

~~Hysteroscopies when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization.~~[31]

~~f.~~

AHCCCS covers inpatient hospital care after a routine vaginal delivery and inpatient hospital care after a cesarean delivery. 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 mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is medically necessary beyond the minimum 48 or 96 hour stay.

~~4.~~3. For retrospectively eligible members, notification requirements are as follows:

a. When the member ~~is made~~becomes AHCCCS-~~-~~eligible while still in the hospital, providers shall notify 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 in 4(a) will be waived.

~~5.~~4. Payment for services may be denied if the hospital fails to provide timely notification or obtain the required authorization number(s) within the parameters specified in this Policy. ~~However, t~~The issuance of an authorization number does not guarantee payment~~,~~. D~~d~~ocumentation 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.

[29] Added to clarify acute Behavioral Health Inpatient Facility admittance are authorized by Division of Fee-For-Service Management staff.

[30] Moved up from below

[31] Removed as information duplicated in section Z.

~~6.~~5. Authorization may be provisional if further review of information or documentation is needed to make a full assessment of the medical necessity for the admission, the service(s), and/or to determine the appropriate length of stay. Upon approval or denial, the provisional status is removed from the authorization and the provider is notified by letter of the decision.

L. HYSTERECTOMY

1. 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. Medical documentation supporting the medical necessity of the hysterectomy, including prior medical and surgical therapy and results,
   b. Diagnostic test results, and
   c. 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.

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 ~~as long as~~if the forms include the same information and signatures as 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.

DRAFT

M. MATERNAL AND CHILD HEALTH CARE

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

PA is required for medically necessary pregnancy terminations. All authorization requests for medically necessary pregnancy terminations require submission of a completed AHCCCS C~~ertificate of Necessity~~ON for Pregnancy Termination (refer to AMPM Policy 410, Attachment C). Refer to AMPM Policy 410 for information regarding coverage of medically necessary p~~P~~regnancy t~~T~~erminations and other documentation requirements[32].

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

N. 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[33]. ~~Refer to AMPM Policy 310-P~~ For complete information regarding coverage of medical equipment and supplies~~,~~ including face-to-face requirements, refer to AMPM Policy 310-P .

Orthotic and prosthetic devices shall be prescribed by a physician or other appropriate practitioner. 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. PA is required for the purchase of medical equipment exceeding $300.00. PA is required for all medical equipment rentals and repairs,
   b. PA is required for consumable medical supplies (as defined in AMPM Policy 310-P) exceeding $100.00,
   c. For members age 21 and over, 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 age 21 and over are described in 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).

[32] Added language to reference other forms of documentation that may be required.
[33] Added language to encompass non-physician prescribers

2. ~~The following items~~ Apnea management and training for premature babies up to one year of life does not require PA.~~:~~
   ~~a. Oral supplements for ALTCS members, and~~[34]
   ~~b.~~a. ~~Apnea management and training for premature babies up to one year of life.~~[35]

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 supplies/equipment with anticipated outcome (medical/ functional),
   d. Clinical documentation, including documentation that meets ~~of the~~ face-to face encounter requirements, ~~and timeframes~~ (AMPM Policy 310-P),
   e. Description of supplies/equipment requested,
   f. Duration for use of equipment,
   g. ~~Full purchase~~ Item[36] price plus any additional costs and expected cost if rented,
   h. Provider identification number, and
   i. Home evaluation, when requested by DFSM.

4. For members age~~-~~ 21 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 age 21 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.

O. NURSING FACILITY SERVICES

Nursing Facility ~~(NF)~~ services for ~~an FFS acute~~ AIHP member~~s~~ 21 years of age and older ~~is~~ 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 admissions of 90 days or less that follow a DDD THP member's hospital discharge is authorized by DFSM.

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.[37]

[35] Aligned/moved up into a single sentence for flow.
[36] Revised wording to clarify intent is not to imply purchase at full cost.
[37] Added language to specify process for acute and LTSS NF services for DDD THP

PA is required for all bed hold days~~, for both acute and ALTCS members~~.

Per A.A.C. R9-28, Article 2, in lieu of a ~~NF~~nursing facility, a~~n~~ ~~Tribal~~ [38]ALTCS or DDD THP members may be placed in an alternative living facility or receive home and community-based services. PA is required for these services prior to admission of the member, except in those cases for which retroactive eligibility precludes the ability to obtain PA. However, the case is subject to medical review.

~~NF~~ Nursing facility 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.

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.

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

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

P. OBSERVATION SERVICES ~~THAT EXCEED 24 HOURS~~[39]

Observation services are those reasonable and necessary services provided on a hospital's premise for evaluation to determine whether the member should be admitted for inpatient care, discharged, or transferred to another facility.

Observation services include the use of a bed, periodic monitoring by hospital nursing personnel or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

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

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

[38] Removed "Tribal" to broaden applicability to DDD THP
[39] Observation Services are no longer limited to 24 Hours.

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

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. ~~as long as medical~~ Medical necessity must exist~~s~~ for all observation stays.[40] 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. Physician's daily progress notes shall accompany documentation.

3. Observation services do not require authorization. All claims for observation services shall be submitted with the above documentation.[41]

Q. OUTPATIENT SURGERY CENTERS

Ambulatory Surgery Centers (ASC) shall obtain PA from 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.~~'s PA number,~~ The authorization requirements for the surgeon may differ from the ASC's authorization requirement. The ASC shall only request authorization for the codes that are billable by the ASC. Billable codes for the ASC may differ from the codes that are billable by the surgeon.[42]

Documentation supporting medical necessity must be submitted prior to providing the elective/non-emergency ~~surgeries~~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. [43]

[40] Reworded for better flow
[41] Added to clarify PA and documentation requirements on Observation Services.
[42] Language added to clarify the differences in requirements for ASC vs surgeon as they relate to the PA process.
[43] Language added to clarify that the surgeon's documentation can satisfy documentation requirements where applicable.

R. PHYSICIANS AND PRIMARY CARE PROVIDERS

Physicians and other Primary Care Providers (PCPs) shall adhere to the FFS PA requirements. PA is not required for evaluation and management services.[44]

Refer to AMPM Policy 310 for information regarding covered PCP and physician services.

1. FFS ~~ee-for-service~~ 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 transplant and elective/non-emergency surgeries (except voluntary sterilization). Refer to Hospital Inpatient Service Authorization. The AHCCCS/DHCM, Medical Management Transplant Coordinator, responds to all 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 over. 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 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.[45]

S. FOOT AND ANKLE SERVICES

Medically necessary foot and ankle care ~~is covered for persons age 21 and older~~[46]~~. S~~services provided by a podiatrist or podiatric surgeon, shall be ordered by the ~~primary care provider~~ 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. PA is not required for evaluation and management services.

Refer to AHCCCS FFS Provider manual for billing requirements.

T. PRESCRIPTION DRUG/PHARMACY SERVICES

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

All pharmacy claims are subject to post-payment review pursuant to A.R.S § 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, Acute/Long Term Care, and Behavioral Health Drug Lists, and the Pharmacy/Drug PA form.

[44] Added for clarification.
[45] Added to reflect PA requirement for members under the age of 21 years.
[46] Removed reference to age to minimize confusion about age limitations – covered for all members.

U. OCCUPATIONAL, PHYSICAL AND SPEECH THERAPIES

1. Inpatient Services

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

For DDD THP members who receive therapies in an inpatient setting, contact the DDD Support Coordinator for discharge planning.[47]

For Tribal ALTCS members who receive therapies in an inpatient setting, contact the Tribal Case Manager for ~~PA requirements~~discharge planning. Refer to AMPM Policy 1250-E for information.

2. Outpatient Services

No PA is required for covered outpatient occupational and physical therapy services ~~for acute FFS members~~. Refer to AMPM Policy 310-X for limitations.

For Tribal ALTCS or DDD THP[48] members who receive therapies in an outpatient setting, contact the Tribal Case Manager or DDD Support Coordinator, as applicable, for ~~PA requirements~~care coordination. Refer to AMPM Policy ~~1250-E~~ 310-X [49]for information.

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. ~~for therapies for members under 21 years of age.~~[50] Refer to AMPM Policy 310-X for information regarding covered services ~~and AMPM Chapter 1200~~ [51]for information regarding rehabilitation services for ALTCS.

V. 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 services for EPSDT and KidsCare members.

[47] Added a section to align DDD THP with ALTCS in this section.
[48] Added DDD to align with ALTCS information.
[49] Information surrounding therapies has been moved to AMPM Policy 310-X
[50] Removed age reference is duplicative.
[51] AMPM Policy 1250-E no longer exists language has moved into AMPM Policy 310-X

PA is required for coverage of TPN. Nursing Facilities and agencies furnishing outpatient TPN services shall obtain PA prior to initiation of service. ~~Telephone requests are given provisional PA.~~ [52]

1. Written medical documentation substantiating compliance with AMPM Policy 310-~~AA~~ GG requirements shall be submitted to 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. Nursing facility records documenting percentage of each meal's consumption by member, and
   g. Current laboratory data.

W. TRANSPLANTS (ORGAN AND TISSUE)

Providers shall obtain authorization from AHCCCS for all organ and tissue transplant services to be provided to FFS member. Refer to AMPM Policy 310-DD and 310-DD Attachment A 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 ~~9~~ A.A.C. R9-22~~, Article~~ -206,[53] FESP enrolled individuals ~~members~~ 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. FFS provider responsibilities regarding medically necessary organ and tissue transplant services for eligible members include, but are not limited to:
   a. The submission of PA requests to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, for approval of the transplantation and all related transplant components, and
   b. The submission of PA requests to 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 the Provider and AHCCCS with coordinating the following transportation services:
   a. ~~Transportation, r~~Room, and board (lodging) for:

[52] Removed language due to availability of web portal for provisional PA issuance.
[53] Updated A.A.C. code to align to a specific code.

b. T~~t~~he 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,
c. T~~t~~he designated caregiver or escort as identified by the transplant facility.~~, to and from medical treatment during the time it is necessary for the member to remain in close proximity to the transplant center.~~

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

3. Requests for transportation to and from transplant services must be submitted separately from requests for meals and lodging as specified in the transportation section of this policy.[54]

~~3.~~4. Meal Cards for transplant-related travel outside the member's service area shall be requested via the AHCCCS DFSM authorization process, to include clinical documentation supporting medical necessity. Meal cards for the designated caregiver (escort) shall be authorized when an escort is determined to be medically necessary.[55]

5. ~~PA requests for t~~Transplant-related medical services provided to ~~AHCCCS~~ FFS members who have undergone transplants not covered by AHCCCS require authorization. ~~may be submitted via the AHCCCS online web portal, fax, telephone, or mail.~~[56]

X. TRANSPORTATION

Authorization is required for NEMT of 100 miles or greater one way or roundtrip, and all air NEMT regardless of the number of miles. [57]

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 DFSM, although such services are only covered to the nearest medical facility, which is medically equipped and staffed to provide appropriate medical or behavioral health 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 Non-Emergency Transportation (NEMT) ~~Services~~ to and from covered medical or behavioral health services that are rendered by ~~are covered as outlined in AMPM Policy 310-BB~~ an AHCCCS registered provider, to include IHS/638 providers, and
   ~~c.~~ Medically necessary maternal and newborn transportation is covered and does not require authorization.
   ~~d.~~c. ~~Medically necessary maternal and newborn transportation~~[58]~~,~~

[54] Added to differentiate which division issues authorizations for transplant-related transport.
[55] New language added to provide greater detail on the PA process for meals and lodging services,
[56] Removed language as submission guidelines are outlined in AMPM Policy 810.
[57] Language in sections c-e moved to beginning of section X, and language in section b streamlined.

~~e. Medically necessary transportation to and from a covered medical or behavioral health service of 100 miles or less, round trip, does not require PA,~~
~~PA is always required for medically necessary (non-emergency) air transportation regardless of the number of miles,~~
~~Transportation is limited to the cost of transporting the member to the nearest appropriate AHCCCS registered provider capable of meeting the member's medical or behavioral health needs. Transportation shall only be provided to transport the member to and from the required covered medical or behavioral health service, and~~
~~Medically necessary maternal and newborn transportationas specified in AMPM Policy 310-BB, does not require PA.~~

2. For special transportation requests, including but not limited to, specialty transportation needs and travel outside the member's service area/county of residence the following documentation shall accompany the written request as applicable.
   a. Physician's order, including medical justification for travel outside the member's service area/county of residence when applicable, case plan notes from an AHCCCS registered behavioral health provider, or other supporting documentation as needed to make a coverage determination,
   b. Descriptions of disability requiring special transport and/or special circumstances,
   c. Type of transportation and need for attendant services, as appropriate,
   d. Estimated cost of transportation, attendant services, meals or lodging, as appropriate, and/or
   e. NEMT authorization requests shall contain a valid behavioral health or physical health diagnosis~~,~~ to be authorized by DFSM staff.

   PA for transportation will not be issued unless the transportation provider is an actively registered AHCCCS transportation [59]provider on the date of service requested.

3. Authorization ~~Requirements~~responsibility ~~to~~ for ~~Receive Medically Necessary Non-Emergency Transportation~~ NEMT s~~S~~ervices ~~to Obtain AHCCCS Covered Physical or Behavioral Health Services~~.
   a. NEMT services ~~F~~for AHCCCS American Indian members enrolled with AIHP, DDD THP, and-/or assigned to a TRBHA, ~~or who receive physical or behavioral health services at an IHS/Tribal 638 facility transportation services~~ are ~~covered~~ authorized on a FFS basis ~~under the following conditions:~~by AHCCCS DFSM.
      ~~i. The request for transportation services is prior authorized through the DFSM when mileage is greater than 100 miles either one way or round trip. PA is not required for IHS/Tribal 638 transportation providers, and~~
      ~~ii. The member is not able to provide, secure or pay for their own transportation, and free transportation is not available.~~ [60]
   b. For Tribal ALTCS members, all medical and behavioral health transportation services are authorized by the Tribal ALTCS case manager.
   ~~b.~~c. For American Indian members receiving behavioral health services, who are enrolled in a RBHA, check with the RBHA for PA requirements, and

[58] Removed language to streamline verbiage.
[59] Added to clarify transportation category of service requirement for non-NEMT provider types.
[60] Moved to the beginning of section X.

~~c.~~d. For ACC plan or ALTCS MCO enrolled members, contact the ACC plan or the ALTCS MCO for PA requirements.

~~For Tribal ALTCS members, all medical and behavioral health transportation services are authorized by the Tribal ALTCS case manager.~~[61]

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

~~X.~~Y. TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS

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.

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.

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, and

2. The evaluation of the member's medical status meets criteria for severity of illness and intensity of service.

   If the provider fails to submit medical records necessary for review, or if the medical records fail to meet the criteria specified in this Policy, the claim is subject to denial.

[61] Moved up to 3b.

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.

~~Y.~~Z. OTHER MEDICAL PROFESSIONAL SERVICES

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

1. Voluntary sterilization (No PA limited to AIHP and Tribal ALTCS members aged 21 years and older.[62] (Note: 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 (No PA required for – first five visits following an acute hospitalization).[63]
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. (Note: PA is required for DDD THP members.)
11. Outpatient physical and occupational therapy for Acute members age 21 years or older are described in detail in AMPM Policy 310-X.~~each limited to:~~
    a. ~~15 visits per benefit year to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain that function once restored, and~~
    ~~15 visits per benefit year to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired, visits shall not exceed a total of 30 visits for physical therapy per benefit year and 30 visits for occupational therapy per benefit year.~~[64]

[62] Added language to specify that removal of PA requirement is limited to AIHP and Tribal ALTCS members >20 yrs of age.
[63] Clarified PA requirements for Home Health
[64] Removed and directed to AMPM Policy 310-X to prevent misaligning.

12. Facility services related to wound debridement, or

13. Apnea management and training for premature babies up to one year of life.

~~Z.~~AA. CHEMOTHERAPY AND RADIATION ONCOLOGY SERVICES

Chemotherapy and radiation oncology services do not require prior authorization, except for Intensity Modulated Radiation Therapy (IMRT). IMRT requires prior authorization. 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.

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