

## 810 – FEE-FOR-SERVICE UTILIZATION MANAGEMENT

EFFECTIVE DATES: 10/01/94, 08/01/19, 04/01/22, [UPON PUBLISHING](#)

APPROVAL DATES: 03/14/97, 10/01/98, 10/01/01, 05/01/04, 01/01/05, 10/01/08, 03/01/09,  
07/01/10, 09/01/12, 03/01/14, 10/01/15, 02/07/19, 12/16/21, [04/24/26](#)

### I. PURPOSE

This Policy applies to Fee-For-Service (FFS) populations and Programs as specified within this Policy including: Tribal ALTCS, TRBHA, the American Indian Health Program (AIHP), and DDD Tribal Health Program (DDD THP), excluding Federal Emergency Services (~~FES~~) Programs ([FESP](#)). (For FES-Programs, refer to AMPM Chapter 1100). This Policy provides an outline of the utilization management functions that are performed by AHCCCS Division of Fee for Service Management (DFSM).

### II. DEFINITIONS

Refer to the [AHCCCS Contract and Policy ACOM and AMPM<sup>1</sup> Dictionary](#) for common terms found in this policy.

### III. POLICY

#### A. UTILIZATION MANAGEMENT METHODOLOGIES

Utilization Management (UM) methodologies include, but are not limited to the following:

1. Prior Authorization (PA) (does not apply to emergency services [or medically necessary non-emergency ambulance transports that originate from a call via a 911 or emergency response system](#)). [Services billed by an IHS or 638 provider are also not subject to PA.](#)<sup>2</sup>
2. [Continued stay \(concurrent review\)](#)<sup>3</sup>, and/or
3. Retrospective review.
4. Care management.

#### B. PRIOR AUTHORIZATION ([PA](#))

[The](#) PA is issued for [medically necessary](#) covered services within certain limitations, based on the following:

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<sup>1</sup> Revised to updated title and link.

<sup>2</sup> Added to align with revised language added in AMPM Policy 820.

<sup>3</sup> Clarifying same service type.

1. The member's AHCCCS eligibility at the time of the PA request, as confirmed through AHCCCS online verification.
2. Provider status as an AHCCCS-registered provider.
3. The service requested is an AHCCCS covered service requiring PA, refer to AMPM Policy 820 for additional information regarding PA.
4. Information received by AHCCCS/DFSM meets the requirements for issuing a PA number.
5. The service requested is not covered by another primary payer (e.g., commercial insurance, Medicare, ~~etc.~~).

The PA request determinations are made during regular business, M-F 8am to 5pm<sup>4</sup>. The PA requests, however, may be submitted 24 hours a day, seven days a week using the AHCCCS online web portal or when necessary, by fax as specified below.

6. The process for a provider submitting a PA request, and obtaining a PA number prior to providing an AHCCCS covered service, is as follows:
  - a. Providers may submit a PA request four ways:
    - i. AHCCCS Online Provider Portal (Required for most submissions, except in limited circumstances): <https://ao.azahcccs.gov/Account/Login.aspx>. Refer to the PA Submission page for more guidance on the FFS PA submission requirements at: <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/submissionprocess.html><sup>5</sup>
    - ii. Fax:  
Faxes are permitted in limited circumstances that include:
      - a) Requests for acute services for Tribal ALTCS members,
      - b) Provider Portal technical outages, or
      - c) Service dates that are expected to occur during the interim period while the provider is awaiting receipt of their Provider Portal credentials for online PA submissions.<sup>6</sup>

Providers shall use the fax number for the appropriate PA area:

- a) Medical PA - (602) 256-6591,
- b) Medical Utilization Review (UR) - (602) 254-2304,
- ~~b)c~~ Behavioral Health PA – 602-253-6695<sup>7</sup>
- ~~c)d~~ Long Term Care (LTC) - (602) 254-2426,
- ~~d)e~~ Transport (excludes Tribal ALTCS<sup>8</sup>) - (602) 254-2431,

<sup>4</sup> Added to specifically state business hours.

<sup>5</sup> Added reference for guidance on PA submission process and clarification of PA submission process requirements.

<sup>6</sup> Aligns with information provided on Prior Authorization (PA) Submission page.

<sup>7</sup> Added existing Behavioral Health (BH) Prior Authorization (PA) fax information.

<sup>8</sup> Clarifies this language is not applicable to Tribal ALTCS as NEMT goes through the T ALTCS CM

~~e)f~~ DDD THP – (602)252-2298, or

~~g~~ AIHP Transplants – 602-256-4860<sup>9</sup>

~~ii~~.iii. Telephone (Urgent Requests) -

Urgent requests should be submitted online **and** followed up with a phone call to **PA Customer Service** staff to provide notification ~~notify~~ that an urgent request has been submitted.

1-602-417-4400 (Phoenix area direct line to the PA),

1-800-433-0425 (In state outside Phoenix area, direct line into the PA),

1-800-523-0231 (Out-of-state line to AHCCCS switchboard 602-417-4400 or ask for the PA Area), or

~~iii~~.iv. Mail (least preferred)

AHCCCS-Division of Fee-for-Service (FFS) Management  
Care Management Systems Unit (CMSU), Mail Drop 8900

~~801 East Jefferson Phoenix, AZ 85034~~ 150 N. 18<sup>th</sup> Avenue, Phoenix, AZ 85007<sup>10</sup>,

b. Providers shall be prepared to submit the following information:

i. Caller name, provider name and provider ID,

ii. Member name and AHCCCS ID number,

iii. Type of admission/service,

iv. Service date,

v. ICD-10 diagnosis code(s),

vi. Applicable billing codes (CPT, CDT, HCPCS, or revenue codes),

vii. Anticipated charges (if applicable), and

viii. Medical justification, ~~and~~

c. If the PA request is submitted through the AHCCCS online web portal, the provider shall attach documentation using the online attachment feature. If the provider is utilizing fax, the appropriate FFS form shall be downloaded from the AHCCCS Website, required fields shall be completed, and the FFS form shall be submitted as the cover sheet or the second page within the fax.

Upon receipt AHCCCS/DFSM will:

i. Issue a provisional PA number, pending an assessment of the information provided,

ii. Issue an approval, a request for additional information, or a denial of coverage, and

iii. Generate a PA confirmation letter which is mailed to the provider the next business day notifying the provider of their authorization status.

A PA is not required for FFS members receiving services from Indian Health Service/638 Tribal (IHS/638) providers and facilities. Non-IHS/638 providers ~~or~~ and/or facilities ~~iesy~~ rendering AHCCCS covered services that are subject to PA <sup>11</sup> shall obtain the PA from AHCCCS/DFSM for services specified in AMPM Policy 820, unless otherwise noted<sup>12</sup>.

<sup>9</sup> Added existing FFS Transplant fax information.

<sup>10</sup> Updated to current AHCCCS location.

<sup>11</sup> Clarifying language that require Prior Authorization (PA).

<sup>12</sup> Added clarifying language related to accommodate Pharmacy Benefit Manager (PBM), ALTCS, etc.

~~PA satisfies Electronic Visit Verification (EVV) requirements for services delivered to FFS members in their home that require PA. For more information regarding EVV services and EVV service requirements refer to the EVV web page~~ A PA meets EVV requirements for in-home services delivered to FFS members when those services require a PA. For details on EVV services and requirements, see AMPM Policy 540 and the AHCCCS EVV webpage.<sup>13</sup>

For information identifying which items or services require FFS PA refer to the PA Guidelines resource on the Medical Coding and Resources web page.<sup>14</sup>

For additional information regarding the PA submission process refer to the PA Submission web page.<sup>15</sup>

For additional information regarding ~~and~~ documentation requirements, refer to the FFS PA Web page at:  
~~<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>~~ and AMPM Chapter 820.<sup>16</sup>

For all requirements related to the grievance system, refer to A.A.C.,<sup>17</sup> Title 9, Chapter 34.

### C. CONTINUED STAY REVIEW

1. Continued stay review is performed as follows:
  - a. Continued stay review is provided by AHCCCS\_DFSM or an AHCCCS contracted review organization that employs licensed health care professionals to perform reviews,
  - b. Continued stay review begins when AHCCCS\_DFSM initiates and conducts the review or notifies the contracted review organization of the admission or need for review, and
  - c. Continued stay review is conducted at intervals appropriate to the member's condition, based on the review findings. During review, the following are considered in addition to the necessity of admission and/or appropriateness of service setting:
    - i. Quality of care,
    - ii. Length of stay,
    - iii. Whether services meet the coverage requirements for the eligibility type,
    - iv. Discharge needs, and
    - v. Utilization pattern analysis.

<sup>13</sup> Added to address overlap in Prior Authorization (PA) and Electronic Visit Verification (EVV) requirements for some services.

<sup>14</sup> Refers providers to resource identifying which services request FFS Prior Authorization (PA).

<sup>15</sup> Reference to an additional resource.

<sup>16</sup> Reference to an additional resource.

<sup>17</sup> Revised to align with Section 504 of the Rehabilitation Act.

2. Continued stay review determinations are performed as follows:
  - a. When the Continued stay -review is initiated and conducted by AHCCCS/DFSM Unit, the PA staff determines the appropriateness of continued services in consultation with the AHCCCS Chief Medical Officer (CMO) and/or DFSM Medical Director as needed. AHCCCS/DFSM issues a denial notice when it is determined that the services no longer meet AHCCCS coverage criteria,
  - b. There are conditions when the continued stay review function is outsourced to a contracted review organization. These include but are not limited to length of stay or Level of Care (LOC) cases, and medical necessity cases where the medical need is in question, and
  - c. If the continued stay review is outsourced to the contracted review organization, both the contracted review organization and AHCCCS/DFSM determine the appropriateness of continued services in consultation with contracted physician advisors, as necessary. If it is determined that the service no longer meets coverage criteria, the contracted review agency will initiate a recommendation of denial.

#### **D. CONTINUED STAY DENIAL**

1. Continued stay services may be denied when one of the following occurs:
  - a. A member no longer meets intensity and severity criteria,
  - b. A member is not making progress in a rehabilitative program,
  - c. A member can be transferred safely to a lower LOC, or
  - d. Services do not meet the coverage criteria.
2. Consultation with the AHCCCS Medical Director or contracted review organization physician may occur to review the need for a continued stay.
3. The provider is notified in writing regarding a denial of coverage and the denial date by the entity that has the continued stay review responsibility.
  - a. When the contracted review organization is the responsible entity, the following also applies:
    - i. The contracted review organization immediately notifies AHCCCS/DFSM verbally, and
    - ii. The contracted review organization forwards written notification of denial of coverage to the following:
      - a) The attending physician,
      - b) The hospital, and
      - c) AHCCCS/DFSM (within five business days of initiation of denial).
4. The provider has the options of:
  - a. Submitting a request with supporting documentation to AHCCCS/DFSM for reconsideration of the denial, or
  - b. Following the appeals process on the AHCCCS website.

#### E. RETROSPECTIVE REVIEW

AHCCCS/DFS~~M~~ conducts retrospective medical reviews of specified claims for each AHCCCS eligibility category to verify appropriateness and effectiveness of service utilization. Criteria for these medical claim reviews focus on factors including, but not limited to:

- a. ~~d~~Diagnosis,
- b. ~~u~~Utilization pattern,
- c. ~~s~~Selected types of surgery,
- d. ~~h~~Hospital admissions,
- e. ~~The~~ LOC provided, and
- f. ~~t~~The length of stay in conjunction with the admission criteria.

Focused medical reviews are conducted and may be applied to a sample of claims or all claims, depending on the reason for conducting the review.

All transplant services are reviewed by AHCCCS/DFS~~M~~ ~~Division of Health Care Management (DHCM)/Medical Management Unit, AHCCCS Transplant Coordinator~~<sup>18</sup>.

#### F. TIMEFRAMES FOR SERVICE AUTHORIZATION DECISIONS

The date and time AHCCCS DFSM receives the request is considered the date and time of receipt. The date and time is used to determine the due date for completion of the PA decision, depending on the timeframe that is applicable to the particular type of service request. AHCCCS DFSM may use electronic date stamps or manual stamping for logging the receipt. If AHCCCS DFSM subcontracts PA to a delegated entity, the date or time the delegated entity receives the request, whichever is applicable, is used for establishing that date and time of receipt.

Review timeframes differ depending upon whether the service authorization request is a standard request, an expedited request, and whether the service request relates to medications. All references to “days” in this Policy mean “calendar days” unless otherwise specified. When a service authorization request is submitted, AHCCCS DFSM shall ensure completion and issuance of the service authorization decision within the following timeframes:

1. Standard Authorization Decision Timeframe for Service Authorization Requests that do not pertain to Medications - AHCCCS DFSM shall issue service authorization decisions which do not pertain to medications as expeditiously as the member’s condition requires but no later than 14 calendar days from receipt of the request for the service, regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona as specified in 42 CFR 438.210(d).

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<sup>18</sup> DFSM handles all FFS transplants.

For service authorization requests lacking sufficient information for AHCCCS DFSM to make a decision regarding the service authorization request, AHCCCS DFSM shall make sufficient attempts to obtain the missing information and document such outreach attempts to the provider. AHCCCS DFSM shall allow the provider sufficient time for a peer-to-peer to occur before issuing its decision regarding the service authorization request. AHCCCS DFSM may issue a Notice of Extension, as specified in 42 CFR 440.230 (e)(1)(i).

2. Expedited Service Authorization Decision Timeframe for Service Authorization Requests that do not pertain to Medications - AHCCCS DFSM shall issue an expedited service authorization decision, as expeditiously as the member's health condition requires but no later than 72 hours from receipt of the request for service consistent with 42 CFR 440.230 (e)(~~1~~2)(ii) regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.

The following requests shall be treated as expedited: An expedited (urgent) PA request, as defined in AAC R9-34-306(B), is applicable when adhering to the standard processing timeframe could seriously jeopardize a FFS member's life, health, or ability to attain, maintain, or regain maximum function.

Expedited service authorization requests that do not pertain to medications and that are determined not to meet the criteria for expedited review will be processed in accordance with the standard authorization decision timeframes outlined in this policy. Notification will be provided to the service provider within 72 hours of receipt when an expedited authorization request fails to meet the requirements for expedited consideration. The requesting provider shall be permitted to send additional documentation supporting the need for an expedited authorization.

AHCCCS DFSM may extend the 72-hour timeframe to make a decision by up to an additional 14 calendar days if the criteria for a service authorization extension are met regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

3. Service Authorization Decision Timeframe for Medications - AHCCCS DFSM or the Pharmacy Benefits Manager (PBM) designee shall issue service authorization decisions for medications no later than 24 hours from receipt of the submitted request for service authorization regardless of whether the due date for the medication authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.

If the service authorization request lacks sufficient information for AHCCCS DFSM or the PBM designee to render a decision for the medication, AHCCCS DFSM or the PBM designee shall send a request for additional information to the prescriber no later than 24 hours from receipt of the request. For service authorization requests lacking information AHCCCS DFSM or the PBM designee shall make sufficient attempts to obtain the missing information and document such outreach attempts to the prescriber. In cases where an extension is needed to obtain additional information to render a decision for a medication AHCCCS DFSM or the PBM designee shall issue a final decision no later than seven working days from the initial date of the request.

#### **G. NOTICE OF EXTENSION REQUIREMENTS**

AHCCCS DFSM shall extend the timeframe for medications, standard, and expedited services to allow time to make a decision when a decision is not reached within the required timeframe or when there is insufficient or conflicting information regarding medical necessity, when :

- a. The member/Health Care Decision Maker (HCDM) or provider (with written consent of the member/HCDM) affirmatively requests an extension, or
- b. AHCCCS DFSM determines that there is not sufficient clinical information for AHCCCS/DFS~~SM~~ to make a service authorization decision within the applicable standard or expedited timeframes. In these circumstances, AHCCCS DFSM shall issue an extension to obtain needed information. AHCCCS DFSM shall not pursue the Notice of Extension until AHCCCS/DFS~~SM~~ has made sufficient attempts to first obtain the necessary information from the requesting provider within the standard or expedited timeframe, whichever is applicable. AHCCCS DFSM shall document all attempts made to the requesting provider for the needed information:
  - i. Standard service authorization requests (requests that do not involve medications) that lack sufficient information to render a decision, may be extended by up to an additional 14 calendar days, not to exceed 28 calendar days from the service request date regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona, as specified in AAC R9-34-306,
  - ii. Expedited Service authorization requests (requests not involving medications) that lack sufficient information to render a decision, may be extended by up to an additional 14 calendar days regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona, and
  - iii. Medications service authorization requests that lack sufficient information to render a decision may be extended up to no later than seven working days from the initial date of the request.<sup>19</sup>

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<sup>19</sup> Added to align with Managed Care Organization (MCO) language in ACOM Policy 414.

**H. TIMEFRAMES FOR COMPLETING NOTICES OF ADVERSE BENEFIT DETERMINATIONS (NABD)**

1. For termination, suspension, or reduction of a previously authorized service, the Notice of Adverse Benefit Determination (NABD) shall be mailed at least 10 calendar days before the date of the proposed termination, suspension, or reduction.
  
2. For Service Authorization decisions that deny or limit services AHCCCS/DFSM shall provide a NABD within following timeframes:
  - a. Standard requests- For a non-medication request for authorization, A NABD shall be rendered as expeditiously as the member's health condition requires but no later than 7 calendar days from the receipt of the request regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, unless there is a Notice of Extension. When an extension has been issued on an authorization request for non-medication a NABD shall be rendered no later than 7 calendar days from the service request date from the initial date of the request. regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona,
  - b. Expedited requests: A NABD shall be rendered for expedited service authorization requests (not involving medications), as expeditiously as the member's health condition requires but no later than 72 hours from the receipt of the request regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, unless there is a Notice of Extension. When an extension has been issued on an expedited service authorization request for non-medication a NABD shall be rendered in no later than 14 calendar days following the end of the initial 72 hours expedited review timeframe regardless of whether the extended review due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona, and
  - c. Medication requests: A NABD shall be rendered no later than 24 hours from the receipt of a request for medication authorization regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. When an extension has been issued on an authorization request for a medication a NABD shall be rendered no later than seven working days from the initial date of the request.
  
3. If AHCCCS DFSM extends the timeframe to make a decision, AHCCCS DFSM shall:
  - a. Give the member/HCDM and DR written notice of the reason for the decision to extend the timeframe in easily understood language,
  - b. Include what information is needed to make a determination,
  - c. Inform the member/HCDM and DR of the right to file a grievance (complaint) if they disagree with the decision to extend the timeframe, and
  - d. Issue and carry out the decision as expeditiously as the member's condition requires and no later than the date the extension expires.

4. Service Authorization Decisions Not Reached Within the Timeframes:

A service authorization decision that is reviewed by AHCCCS DFSM within the required timeframe but for which a decision is not reached within the required timeframe constitutes a denial. AHCCCS DFSM shall issue a NABD denying the request on the date that the timeframe expires.<sup>20</sup>

**F.I. REIMBURSEMENT**

The PA is not a guarantee of payment. Reimbursement is based on a variety of factors including but not limited to:

1. Accuracy of the information received with the original PA.
2. Whether or not the service is substantiated through continued stay and/or retrospective review.
3. Whether the claim meets clean claims submission requirements, including meeting timely filing submission requirements.<sup>21</sup>

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<sup>20</sup> Added to align with Managed Care Organization (MCO) language in ACOM Policy 414.

<sup>21</sup> Included to reinforce claims timely filing requirements