

# AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Health Plans

*Released: March 20, 2020*

*Updated: March 23, 2020 (updates highlighted in yellow)*

*Last Updated: March 27, 2020 (updates highlighted in blue)*

This memo outlines the updated AHCCCS prior authorization and concurrent review standards for AHCCCS Health Plans in response to Governor Ducey's declaration of a public health emergency for COVID-19 and **is effective immediately, March 20, 2020 through the duration of the emergency. These standards are subject to change as the emergency conditions evolve.**

All services reimbursed must be medically necessary, cost-effective, federally and state reimbursable, and will be subject to post-payment review.

## I. Behavioral Health Services (3/23/20 Updated)

Initial prior authorization is still required for Residential Treatment Center (RTC), Behavioral Health Residential Facility (BHRF) and Therapeutic Foster Care (TFC) levels of care.

Health Plans may continue with current Standard Operating procedures or have the flexibility to extend concurrent reviews from 30 to 90 days for Residential Treatment Center (RTC), Behavioral Health Residential Facility (BHRF) and Therapeutic Foster Care (TFC) levels of care. The focus should be on monitoring continued stays and making decisions based on the clinical status of the individual, their progress and ability to transition to the appropriate level of care.

Clinical Staffings, Child and Family Teams (CFTs), Adult Recovery Team (ARTs), and coordination of care between facilities and outpatient providers should continue to inform appropriate levels of care and continued stay. Telehealth and telephonic modalities are strongly encouraged for these staffings and coordination.

## II. Dental Services

All Health Plan dental prior authorization approvals which are within 60 days of expiration must be extended for 6 months.

Health Plans must remove prior authorization for the following dental codes:

- D7140 through D7270
- D3230
- D3240
- D3310 through D3330

### III. Pharmacy Services

#### A. Refill-too-soon edits and 90 day fills (3/27/2020 Updated)

1. All Health Plans must remove the refill-too-soon edit on all non-controlled medications.
  - a. Members may continue to fill prescriptions for up to a 30-day supply or they may fill a 90-day supply of maintenance medications, both of which may be done early once the edit is lifted.
  - b. Specialty medications which are filled for a 30-day supply and delivered to the member's home may be filled early for the same day's supply as previously filled.
  - c. When the refill-too-soon edit is lifted, Pharmacy Benefit Managers (PBMs) must check to ensure that quantity limits and duplicate therapy edits currently in place will not cause a rejection when the prescription is refilled early.
2. Controlled Substances may be refilled early when the pharmacy staff has checked with the prescribing clinician and the clinician has agreed to the early refill. The pharmacy staff or the prescribing clinician shall contact the health plan's PBM help desk for an immediate override. Please ensure that quantity limits and duplicate therapy edits will not cause a rejection when these claims are provided an override.
3. Removal of prior authorization for specific therapeutic classes
  - a. Health Plans must remove all prior authorization requirements for the following Therapeutic Classes:
    - Antibiotics
    - Antimalarials
    - Antivirals
    - Beta2 Agonist Inhalers and Inhalant Solutions
    - Long-acting Beta2 Agonist-Corticosteroid Combination Inhalers
    - Long-acting Beta2 Agonist-Anticholinergic Combination Inhalers
    - Corticosteroid Inhalers and Inhalant Solutions
    - Corticosteroid Oral Agents
    - Nebulizers (must be available through pharmacies)
    - Cough and Cold products
      - Antihistamines
      - Nasal Decongestants
      - Combination products of antihistamines and nasal decongestants
      - Cough suppression products including guaifenesin and combination products
      - Guaifenesin oral tablets and combination products
      - Analgesics / Anti-febrile products (aspirin, ibuprofen, acetaminophen, acetaminophen suppositories, etc.)
    - Mast Cell Stabilizers
    - Methylxanthines (aminophylline and theophylline)

## B. Prior Authorization Extensions

For Health Plan approved prior authorizations for all medications which are within 60 days of expiration, the Health Plan must extend the approval for an additional 90 days. The pharmacy may have to contact the provider for an approval to request a fill of an expired prescription, but a prior authorization will not have to be submitted during the 90 day prior authorization extension.

## C. Addressing Drug Shortages

1. The AHCCCS Drug List has preferred medications in which the AHCCCS Medical Policy Manual (AMPM) 310-V requires to be utilized prior to a non-preferred agent. However, in the event of a shortage, a non-preferred medication must be approved. For example, ProAir is the preferred albuterol inhaler. Using ProAir as an example, if there is a shortage of ProAir, the health plans must allow all other branded and generic albuterol products to be reimbursed through the pharmacy claims system without prior authorization.
2. When there is a drug shortage and the health plans' network pharmacies are unable to obtain the medication in a timely manner, the health plans shall open up their pharmacy network to pharmacies that have the medication as long as they have an AHCCCS registered ID.
3. Please check the FDA web links daily for shortage updates:
  - o <https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>
  - o <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-supply-chain-update>
4. Health Plans must instruct their PBMs to remove the PBM system flag that requires the member to pay a copayment at the pharmacy.
5. To ensure access to care, health plans must not require a prior authorization for compounded drugs for children under the age of ten years old.

## IV. Physical Health Services

### A. COVID-19 Testing and Treatment Services

1. Health Plans are not permitted to implement prior authorization or concurrent review for services related to testing, diagnosis, and/or treatment of COVID-19.
2. Health Plans must reimburse AHCCCS registered in-network and out-of-network providers for services related to testing, diagnosis, and/or treatment of COVID-19 as outlined in ACOM 203.

### B. Inpatient Services (3/23/20 Updated)

1. During the COVID-19 emergency, Health Plans must remove any prior authorization and concurrent review requirements for the following levels of care:
  - o Observation units;
  - o Acute Inpatient hospitalization;
2. Notification of admission will allow Health Plans to assist in discharge planning.

3. Health Plans must remove any prior authorization requirements for admission to the following levels of care. Concurrent review is maintained for these levels of care:
  - o Assisted Living Facilities/Centers;
  - o Skilled Nursing Facilities (SNFs); and
  - o Inpatient Rehabilitation Facilities
  - o Long Term Acute Care Hospitals)
4. Health Plans must continue ongoing care management activities to ensure members stable for discharge to a lower level of care have safe and effective transitions of care. These care management activities may be conducted telephonically or via telehealth.
5. Prior Authorization approvals for elective inpatient services which are within 60 days of expiration must be extended for 6 months.

#### **C. Outpatient Services (3/27/2020 Updated)**

1. All Health Plan outpatient service prior authorization approvals which are within 60 days of expiration must be extended for 6 months.
2. For outpatient services requested during the COVID-19 emergency, other than testing, diagnosis and treatment, the document submission period for Prior Authorization will be extended to 90 days. Covid-19 testing, diagnosis and/or treatment are mandated exempt from Prior Authorization. Please see IV. 1.
3. Effective March 21, non-essential elective surgeries are limited in Arizona licensed facilities by Executive Order (EO). Health Plans must issue approvals for elective procedures that meet criteria for medical necessity. The approval letter sent to the member must reference that delays in receiving the requested elective service will apply as required by the EO. Approvals issued will be effective for a period of 6 months. Health plans are expected to anticipate, educate, inform and provide case management services to members who may face scheduling delays subsequent to the EO.

#### **V. Medical Equipment (previously known as Durable Medical Equipment (DME) (3/23/20, 3/27/20 Update)**

1. In-person evaluations cannot be required for DME requests. Information obtained via telephonic or telehealth must be strongly encouraged and accepted.
2. Physical (written or electronic) signatures must not be required to confirm medical equipment delivery. A medical equipment DME provider may attest to verbal confirmation from the member of delivery.