

Revision Dates: 9/12/2019; 3/25/2019; 10/1/2018; 4/26/18; 2/15/18; 10/01/2015, 08/01/2015, 08/14/2014, 08/07/2014

General Information

Prior authorization (PA) is not required for emergency services.

The following **do not** require Prior Authorization:

- **Emergency services;**
- IHS or Tribal 638 services for Fee-for-Service, Title XIX members;
- IHS or Tribal 638 non-pharmacy services for Title XXI (KidsCare) members;
- The member has Medicare, third party liability (TPL), or commercial insurance coverage *and* the services are covered by Medicare, TPL, or commercial insurance; or
- Services provided prior to the posting of the member's retroactive eligibility.

Note: PA should not be requested for services rendered to FESP members. Please refer to chapter 1100 of the AMPM regarding extended services eligibility for outpatient dialysis services. All emergency services under the Federal Emergency Services Program (FESP), in any setting, are subject to retrospective review to determine if an emergency did exist at the time of service.

Many non-emergent services require prior authorization from the prior authorization Division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU) for acute care services or from the member's Tribal ALTCS case manager for long term care services.

Note: The Division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU) is DFSM's prior authorization unit, and will be referred to as **DFSM** in the rest of this chapter.

Receiving an authorization approval does not guarantee payment. The medical treatment for which the authorization was issued must be supported by medical documentation establishing medical necessity. In addition, the claim must meet all AHCCCS criteria including, but not limited to, clean claim and timely filing.

Prior authorization (PA) for services is also based on other factors including:

- The member's eligibility status at the time of service,
- The provider's status as an AHCCCS-registered Fee-for-Service provider, and
- Whether or not the service is an AHCCCS-covered service that requires PA.

Refer to the Prior Authorization webpage for the most up-to-date information regarding covered services and services requiring prior authorization at:

<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html>

Prior Authorization Procedures

For complete information regarding how to request for prior authorization and what is needed with a prior authorization request please refer to the following AMPM Chapters:

- AMPM 820, Prior Authorization; and
- AMPM 810, Utilization Management.

The AMPM can be found at:

<https://www.azahcccs.gov/shared/MedicalPolicyManual/>

AHCCCS Online Provider Portal

The preferred method of PA submission is via the AHCCCS Online Provider Portal. This is the quickest way to submit for PA and to check the status of a PA request, and it can be accessed on the AHCCCS website at:

<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>

Prior Authorization Mandatory Fax Forms:

<https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html>

A pended PA number may be assigned to prior authorization requests after they are reviewed. Once reviewed either an approval or a denial will be issued, or the authorization will be pended for additional information to substantiate compliance with AHCCCS criteria.

AHCCCS generates a PA confirmation letter with appropriate approval, denial, or pending information. The letter is mailed to the provider by the next working day.

When a PA is denied concurrently, AHCCCS also generates a Notice of Action letter that is mailed to the member within three working days of the request. No denial letters are sent to members for services that are denied retrospectively.

Per A.A.C. R9-22-703 (D)(3) all services reimbursed, whether prior authorized or not, are subject to post-payment audit and recoupment if DFSM determines that the services were not medically appropriate.

Claim Submission Directions

It is not necessary for the provider to enter the PA number on the claim form. If a valid PA exists for the service, the AHCCCS claims system will automatically match the claim information against established PA files and choose the correct one.

The information entered on the claim form must match what has been prior authorized and listed on the PA confirmation letter. If there are any discrepancies the system will not find the appropriate PA and the claim will be denied. Any known PA discrepancies should be corrected prior to submitting a claim.

If a PA discrepancy is discovered after the claim has been paid, then the provider must submit a PA correction request with supporting documentation. PA correction requests should be entered using the web portal. The FFS Correction Form can be uploaded as an attachment to ensure prior authorization staff can accurately identify which corrections need to be made. The correction form can be found on the PA website.

Once the PA correction request has been reviewed and approved, then a replacement claim can be submitted. This process is also followed for Tribal ALTCS requests that were authorized by prior authorization staff. PA status can be verified by using the AHCCCS Online Provider Portal.

For correction of authorizations that were entered by the member's Tribal ALTCS Case Manager, if the claim has already been paid then the provider must submit a PA correction request with supporting documentation.

Note: PA correction requests for long term care services authorized by a Tribal ALTCS member's Tribal ALTCS Case Manager are called "open line requests." These open line requests may be faxed in using the FFS Medical Documentation Form, and should be labeled as an "open line request." Once the PA open line request has been reviewed and approved, then a replacement claim can be submitted.

Prior Authorization of Acute Services

Pursuant to Arizona Administrative Code the following list identifies acute services requiring prior authorization. (ALTCS authorization requirements are discussed in Chapter 21, ALTCS Services.)

A.A.C. R9-22-204 (A)(1) advises that providers shall obtain PA from AHCCCS for the following inpatient services:

- Nonemergency and elective admission, including psychiatric hospitalization;
- Non-emergency/Elective surgery; and
- Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.

A.A.C. R9-22-211(G) (1) advises that providers shall obtain PA from AHCCCS for any medically necessary nonemergency transportation services when the distance traveled exceeds 100 miles one-way or round trip.

For additional information on other services that require PA, please refer to [AMPM 820, Prior Authorization Requirements](#), and to the Fee-For-Service Prior Authorization web page at:

<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>

A.A.C. R9-22-215 B (1 – 14) advises the following acute services do not require PA:

- Voluntary sterilization;
- Dialysis shunt placement;
- Arteriovenous graft placement for dialysis;
- Angioplasties or thrombectomies of dialysis shunts;
- Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
- Eye surgery for the treatment of diabetic retinopathy;
- Eye surgery for the treatment of glaucoma;
- Eye surgery for the treatment of macular degeneration;
- Home health visits following an acute hospitalization (limited up to five visits);
- Hysteroscopy (up to two, one before and one after) when associated with a family planning diagnostic code and done within 90 days of hysteroscopic sterilization;
- Occupational therapy (see the Rehabilitative Services section for information on limitations);
- Physical therapy (see the Rehabilitative Services section for information on limitations);
- Facility services related to wound debridement;
- Apnea management and training for premature babies up to the age of one;
- Hospitalization for vaginal delivery that does not exceed 48 hours;
- Hospitalization for cesarean section delivery that does not exceed 96 hours; and
- Other services identified by the Administration through the Provider Participation Agreement.

Note: As of 10/1/2017 outpatient occupational therapy is a covered service, and no prior authorization is required for Acute members.

Please refer to the AHCCCS Medical Policy Manual (AMPM) at <https://www.azahcccs.gov/shared/MedicalPolicyManual/> for additional information on covered services.

Authorization Requirements for Specific Services

Abortions

All medically necessary abortions require PA, except in cases of medical emergency.

In the event of a medical emergency, all documentation of medical necessity must accompany the claim when it is submitted for reimbursement.

The request for PA must be accompanied by a completed AHCCCS Certificate of Medical Necessity for Pregnancy Termination, which is available as Attachment C under AMPM 410, Maternity Care Services in the AMPM. For additional information regarding coverage requirements for pregnancy terminations please refer to AMPM Policy 410, Maternity Care Services.

DFSM will review the request and the certification for medical necessity prior to issuing an authorization decision.

Ambulatory Surgery Center (ASC)

Ambulatory surgical facilities furnishing non-emergency surgical services must obtain a PA number for scheduled ambulatory surgery, except voluntary sterilization procedures and dialysis related services, including FES on Extended Services.

The facility's PA number is separate from the surgeon's PA number and PA requirements may differ for these providers.

Apnea Management and Training

No PA is required for the first 12 months of life.

Apnea management, training, and use of the apnea monitor must be billed using procedure code E0618 or E0619 and the proper modifier, and must be prior authorized.

The NU, LL, and RR modifiers are all permitted.

- RR – Rental of DME
- NU – Purchase of DME
- LL – Lease/Rental of DME

PA requests must include the charge for the service, including the charges for management, training, and use of the apnea monitor.

Behavioral Health Services

Prior Authorization is required for acute, non-emergency psychiatric hospitalizations.

- PA requests for AIHP members enrolled in a Regional Behavioral Health Authority (RBHA) are submitted to the RBHA,
- PA requests for AIHP members enrolled in a Tribal Regional Behavioral Health Authority (TRBHA) are submitted to DFSM,

- PA requests for AIHP members, who are not enrolled with a RBHA or TRBHA, are submitted to DFSM, and
- PA requests for Tribal ALTCS members are submitted to DFSM.

For further information regarding behavior health services refer to Chapter 19, Behavioral Health Services, of the Fee-For-Service Provider Billing Manual, and AMPM 820, Prior Authorization.

Dental Services

PA is not required for preventive/ therapeutic dental services for EPSDT members except for:

- Removable dental prosthetics, including complete dentures and removable partial dentures;
- Cast crowns;
- Medically necessary dental surgery services;
- Orthodontia services; and
- Medically necessary pre-transplant dental services. PA is given by the AHCCCS transplant coordinator and reviewed by the AHCCCS Dental Director or Designee.

PA is required for:

- Medically necessary pre-transplant dental services for adults. PA is given by the AHCCCS transplant coordinator and reviewed by the AHCCCS Dental Director or Designee.
- Surgical services provided by a dentist to an adult age 21 years and older, only to the extent that such services may be performed under State law by either a physician or a dentist, and the services would be considered physician services if furnished by a physician.

Dialysis

PA is not required for monthly dialysis supervision or services. For additional information on dialysis services please refer to Chapter 15, Dialysis, of the Fee-For-Service Provider Billing Manual.

FES members are required to have a Monthly Certification of Emergency Medical Condition kept on file in the physician's office, and this can be found as Exhibit 1120-2 in the AMPM.

Prior authorization for outpatient dialysis for FESP members is met when:

- The treating physician has submitted the completed and signed Initial Dialysis Case Creation Form to AHCCCS; and

- When the treating provider has completed and signed a Monthly Certification of Emergency Medical Condition for the month in which outpatient dialysis services are received.

For information on FESP dialysis services please refer to AMPM 1120 for FESP and to Chapter 18, FES, of the Fee-For-Service Provider Billing Manual.

Home Health Services

All home health services for acute care members require prior authorization, except for the first 5 visits following discharge from an acute hospital stay.

All home health services for ALTCS members require prior authorization from the case manager.

Hospital Admissions

All non-emergency and elective admissions, including all organ and tissue transplantation services require prior authorization.

Notification to DFSM *must* be provided within 72 hours of a behavioral health emergency hospitalization. (This does not apply to FES inpatient admissions.)

- If the required notification day falls on a weekend or state holiday, notification must be provided no later than the next working day.
- If approved, the CMSU nurse will authorize the admission.
- Continued authorization/approval of services may be determined through concurrent review.

Note: Notification of an emergent physical health admission must be provided when the member remains inpatient 72 hrs or more. (This does not apply to FES inpatient admissions.)

When a member's eligibility is posted after the beginning date of service and prior to the end date of service on the claim:

- Notification must be provided no later than 72 hours after the eligibility posting date.
- If the required notification day falls on a weekend or state holiday, notification must be provided no later than the next working day.
- If notification is not provided as required, AHCCCS may deny any portion of the stay, dependent on medical review.

Hysterectomy Services

Non-emergency and medically necessary hysterectomy services require PA.

The member must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children. Please refer to AMPM 820, Exhibit 820-1 for the AHCCCS Hysterectomy Consent and Acknowledgement Form.

Exceptions:

The member was already sterile before the hysterectomy. The physician must certify in writing that the member was already sterile at the time of the hysterectomy and specify the cause of sterility.

The member requires a hysterectomy because of a life threatening emergency situation, in which the physician determines that the prior acknowledgement is not possible. The physician must certify in writing that the hysterectomy was performed under a life threatening emergency situation, in which the physician determined that prior acknowledgement was not possible.

In a life-threatening emergency PA is not required.

Medical Equipment, Medical Appliances, Medical Supplies, and Orthotic and Prosthetic Devices

Certain EPSDT medical equipment, appliances, and supplies and orthotic/prosthetic services may require PA. Refer to AMPM 430, EPSDT Services for further information about required PA documentation, coverage limitations and exclusions.

The purchase of medical equipment and appliances requires PA when the purchase price for the item exceeds \$300.00 for acute members and \$500.00 for ALTCS members.

Consumable medical supplies (supplies which have limited potential for re-use) require PA when the cost exceeds \$100.00 per month. For members 21 years of age and older, PA is required for medically necessary incontinence supplies.

For additional information regarding coverage and limitations of medical equipment, appliances and supplies refer to AMPM 310-P.

PA is required for the purchase of orthotic/prosthetic devices for adult members 21 years and older, when the purchase price exceeds \$300.00. For additional information regarding coverage of orthotic and prosthetic devices refer to AMPM 310-JJ, Orthotic and Prosthetic Devices. Refer to Chapter 13, DME, Orthotics, Prosthetics, and Medical Supplies, of the Fee-For-Service Provider Billing Manual for additional information regarding the required PA documentation, coverage, limitations and exclusions. For information on criteria related to coverage of

incontinence briefs for members under the age of 21, please refer to AMPM 430, EPSDT Services.

All rental equipment and equipment repairs require PA.

For acute members prior authorization should be sent to DFSM.

For ALTCS and Tribal ALTCS members, prior authorization requests for long term care services should be sent to the Tribal ALTCS Case Manager. For and Tribal ALTCS members, prior authorization requests for *acute* care services should be sent to DFSM.

Non-Emergency Medical Transportation (NEMT)

All NEMT services provided by air transport require PA.

Non-emergency transportation provided by ground ambulance and non-ambulance vehicles requires PA over 100 miles.

Only codes for the base rate, mileage, and waiting time (not covered under 100 miles) will be prior authorized.

For additional information please refer to Chapter 14, Transportation Services, of the Fee-For-Service Provider Billing Manual.

Nursing Facilities

PA must be obtained before admission of an acute care member unless another insurance or Medicare is primary, or the member becomes retroactively eligible for AHCCCS.

No PA is required during the retrospective eligibility period, but the stay is subject to medical review.

Initial authorization will not exceed the member's anticipated Fee-for-Service enrollment period or a medically necessary length of stay; whichever is shorter (not to exceed 90 days).

Reauthorization for continued stay is subject to concurrent utilization review by AHCCCS or its designee.

AHCCCS will allow up to 90 days (including Medicare days) of nursing facility care in a contract year (10/01 – 09/30).

As a part of discharge planning, prior authorization staff may request hospital personnel to initiate an ALTCS application for potentially eligible members.

For Tribal ALTCS members, PA must be obtained before admission to a nursing facility, even if the member has other insurance or Medicare as the primary insurance.

- The Tribal ALTCS Case Manager must coordinate and provided service authorization for members who need a lower level of care at a nursing facility.
- For nursing facility specialty rates (that are above level of care facility rates), the Tribal ALTCS Case Manager must assist in obtaining any needed documentation and must coordinate with DFSSM for approval *prior* to the Tribal ALTCS Case Manager entering the service authorization.

Pharmacy

For information regarding pharmacy services and prior authorization, please refer to Chapter 12, Pharmacy Services, of the Fee-For-Service Provider Billing Manual.

Rehabilitative Services

Outpatient speech therapy is not covered for non-ALTCS members age 21 years or older.

Outpatient physical and occupational therapy visits do not require prior authorization, but are subject to the following limitations:

Effective 1/1/2014, outpatient physical therapy for adults (age 21 years or older) is limited to:

- a. 15 visits per contract year to restore a particular skill or function the individual previously had but lost due to injury or disease and to maintain that function once restored; and
- b. 15 visits per contract year to attain or acquire a particular skill or function never learned or acquired and to maintain that function once acquired.

Effective 10/1/2017, outpatient occupational therapy for adults (age 21 years or older) is limited to:

- c. 15 visits per contract year to restore a particular skill or function the individual previously had but lost due to injury or disease and to maintain that function once restored; and
- d. 15 visits per contract year to attain or acquire a particular skill or function never learned or acquired and to maintain that function once acquired.

The above limitations are not applicable to EPSDT members. For members under 21 years of age, AHCCCS covers medically necessary inpatient and outpatient physical therapy, occupational therapy and speech therapy. Authorization is not required for rehabilitation therapies for members under 21 years of age.

For additional information please refer to Chapter 10, Individual Practitioner Services, of the Fee-For-Service Provider Billing Manual and to AMPM 310-X, Occupational, Physical and Speech Therapies, for further information.

Surgeons

Surgeons must obtain a separate and distinct PA from that of the facility for:

- Elective or non-emergency surgery, except voluntary sterilization;
- Both the primary surgical procedure and any surgical procedure designated in the *CPT Manual* as a separate procedure;
- Surgeries scheduled more than 72 hours after initial emergency admission of a continuous hospitalization; and
- Organ transplantation not covered by Medicare.

Assistant surgeons and anesthesiologists do not require separate PAs.

Total Parenteral Nutrition (TPN)

Facilities and agencies furnishing outpatient TPN services must obtain PA at least one working day prior to initiation of services.

Telephone requests are assigned an authorization number and pended until required documentation is received and reviewed.

The following documentation must be received by DFSM at the time of the initial TPN authorization request:

- History and physical, which describe member's condition and diagnosis;
- Physician's orders;
- Dietary assessment, including member's weight;
- Any pertinent progress notes (nursing/physician) which reflect the member's dietary, eating, and functional status;
- Physician progress notes indicating expected outcome of treatment;
- Nursing home records showing the percentage of each meal's consumption by the member; and
- Current laboratory data.

TPN is covered for members over 21 years of age when it is medically necessary and the only method to maintain adequate weight and strength. To obtain prior authorization this must be reflected in the provided documentation with the PA request.

TPN is also covered for EPSDT and KidsCare members when medically necessary. To qualify for coverage TPN does not have to be the sole source of nutrition for EPSDT and KidsCare members. To obtain prior authorization medical necessity must be shown.

For additional information on TPN please refer to AMPM 310-AA, Total Parenteral Nutrition.

American Indian Health Program (AIHP)

AHCCCS members who are enrolled with the American Indian Health Program (AIHP) may receive services from Indian Health Services (IHS), a tribally operated 638 facility, or AHCCCS Fee-For-Service providers.

Non-IHS/638 providers must obtain authorization from DFSM before they can provide certain medically necessary services to American Indian Health Program members. For additional information in regards to what services require prior authorization when provided at a non-IHS/638 facility, please refer to the FFS prior authorization list in this chapter and to AMPM 820, Prior Authorization.

References

Refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process and services that require PA, which can be found at:

<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html>

Refer to AMPM 820, Prior Authorization Requirements for further information regarding covered services and those services requiring prior authorization.

Refer to the Fee-For-Service Provider Billing Manual, Chapter 12, Pharmacy Services, for additional information about prior authorization for pharmacy services.

Refer to Exhibit 12-1 in the Fee-For-Service Provider Billing Manual, under the Pharmacy Services chapter, for the prior authorization form for OptumRx.

Refer to the IHS/Tribal Provider Billing Manual, Chapter 6, Authorizations, for additional information about prior authorization when services are rendered by or at an IHS/638 provider or facility.

Refer to the Fee-For-Service Provider Billing Manual, Chapter 15, Dialysis Services, and AMPM 1120, Federal Emergency Services Program Dialysis and its exhibits for

additional information on prior authorization of dialysis services for Federal Emergency Services Program (FESP) members.

Revision History

Date	Description of changes	Page(s)
9/12/2019	References to AMPM 310-E, Dialysis removed since the AMPM policy has been reserved (removed and incorporated into other policies).	Throughout
3/25/2019	Observation Services section removed as it is no longer applicable.	10
10/1/2018	Clarifying language was added to the General Information section.	1
	Clarifying language was added to the Prior Authorization Procedures section.	2
	The following was added: <i>AHCCCS Online Provider Portal</i> <i>The preferred method of PA submission is via the AHCCCS Online Provider Portal. This is the quickest way to submit for PA and to check the status of a PA request, and it can be accessed on the AHCCCS website at:</i> https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f	2
	Clarifying language was added to the Claim Submission Directions section	2-3
	The Prior Authorization of Acute Services section was updated. <ul style="list-style-type: none"> The second bullet point under A.A.C. R9-22-204 (A)(1) was updated to read as “non-emergent/elective surgery.” A.A.C. R9-22-211(G)(1) was updated to have “one way or round trip” added to it for clarification. The reference to A.A.C. R9-22-215(B) was removed and instead the following was added: For additional information on other services that require PA, please refer to AMPM 820, Prior Authorization Requirements, and to the Fee-For-Service Prior Authorization web page at: https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html 	3-4
	Clarifying language added to the Ambulatory Surgery Center section. The Behavioral Health Services section was updated with integration information (changed “Acute FFS” to “AIHP”) Clarifying language added to Hospital Admissions section, including:	5 5

	<p><i>Note: Notification of an emergent physical health admission must be provided when the member remains inpatient 72 hrs or more. (This does not apply to FES inpatient admissions.)</i></p> <p>Medical equipment section updated – “ALTCS” was removed and only “Tribal ALTCS” was kept. “Retro eligibility” changed to “retrospective eligibility” Added clarification regarding surgeons obtaining PA. It was changed to “elective or non-emergency surgery, except <i>voluntary</i> sterilization;” Updated reference to 310-AA Total Parenteral Nutrition policy and added clarifying language.</p>	<p>7</p> <p>8</p> <p>9</p> <p>11</p> <p>11</p>
4/26/18	The link to the FFS Prior Authorization webpage was added.	1-2; 12
2/23/18	Updated verbiage for the prior authorization department from the AHCCCS Administration to DFSM	All
2/15/2018	<p>General Information section updated</p> <p>Prior Authorization Procedures section updated</p> <p>Prior Authorization of Acute Services section updated</p> <p>Behavioral Health Services section updated</p> <p>Dental Services section updated</p> <p>Dialysis section updated</p> <p>Medical Equipment, Appliances, Supplies, and Orthotics and Prosthetics section updated (formerly it was called DME)</p> <p>NEMT section updated</p> <p>Observation Services updated with recovery room extension information.</p> <p>Rehabilitative Services section updated with OT information</p> <p>Total Parenteral Nutrition section updated</p> <p>American Indian Health Program section updated</p> <p>References section added</p> <p>Phone numbers & fax numbers updated</p> <p>Formatting</p>	<p>1</p> <p>2-3</p> <p>3-4</p> <p>5</p> <p>5-6</p> <p>6</p> <p>8</p> <p>8-9</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>12</p> <p>All</p> <p>All</p>
10/1/2015	Replace “ICD-9” with “ICD”	3
08/1/2015	Orthotics benefit changes effective 08/01/2015	6