



820 PRIOR AUTHORIZATION REQUIREMENTS

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INITIAL
EFFECTIVE DATE: 10/01/1994

This Policy identifies AHCCCS Administration Fee-For-Service (FFS) Prior Authorization (PA) requirements for covered services for the general FFS population excluding Federal Emergency Services Program (FESP) members (refer to AMPM Policy 1100 for all requirements regarding services provided to FESP members). PA is not required for FFS members receiving services from Indian Health Services (IHS)/638 providers and facilities. A non-IHS/638 provider or facility rendering AHCCCS covered services must obtain PA from the AHCCCS/Division of Fee-For-Service Management Care Management Systems Unit (CMSU) for services requiring authorization as specified in this Policy.

NOTE: Long Term Care services for Tribal ALTCS members are authorized by the member's ALTCS tribal case manager.

The AHCCCS/DFSM procedural requirements for submitting PA requests via web portal (preferred), fax, telephone or mail, as defined 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 the AHCCCS/DFSM CMSU Unit for approval or denial, unless specified otherwise.

A. BEHAVIORAL HEALTH

Description

AHCCCS covers behavioral health services (behavioral health and/or substance use services) within limitations depending upon the member's age and eligibility.

Outpatient behavioral health services for Tribal ALTCS members are coordinated through the ALTCS tribal case manager. Outpatient behavioral health services for acute FFS members assigned to a RBHA are authorized by the assigned RBHA. For TRBHA assigned members, FFS providers coordinate behavioral health services with the assigned TRBHA. American Indian members may also receive behavioral health services at an Indian Health Service or tribally owned or operated 638 facility.



Refer to Section J of this Policy for behavioral health inpatient admission authorizations.

Refer to AMPM Policy 310 and the AHCCCS Covered Behavioral Health Services Guide for further information regarding AHCCCS covered behavioral health services and settings.

B. BREAST RECONSTRUCTION AFTER MASTECTOMY

Description

AHCCCS covers breast reconstruction for eligible Fee-For-Service (FFS) members following a medically necessary mastectomy.

Refer to AMPM Policy 310.

The physician performing the procedure and the facility in which the services are provided must obtain PA from the AHCCCS Medical Director, or designee, 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.

C. COCHLEAR IMPLANTATION

Description

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. Providers must obtain approval from the AHCCCS Medical Director, or designee, for all cochlear implants and related services for FFS members. Requests for PA must 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 implantation services.

Procedures

FFS provider responsibilities regarding cochlear implantation services include, but are not limited to:



1. The member's implantation specialist (otolaryngologist or otologist) must submit a written request to the AHCCCS Medical Director, or designee, for approval of the implant.
2. The following documentation must accompany the written request:
 - a. The member's current history and physical examination, including information regarding previous therapy for the hearing impairment
 - b. Records documenting the member's diagnosis, current medical status and plan of treatment leading to the recommendation of implantation, and
 - c. Current psychosocial evaluation and assessment for determining the member's suitability for implant.

The AHCCCS Medical Director, or designee, will review the submitted documentation and provide a written response for approval or denial to the member's implant specialist.

3. If a cochlear implant is denied, notice will be provided in accordance with Arizona Administrative Code (A.A.C.) 9 A.A.C. 34.

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

D. DENTAL SERVICES

Description

AHCCCS provides dental services for members who are under the age of 21 in both the Medicaid (EPSDT Program) and KidsCare Programs. Refer to AMPM Policy 430, for complete information regarding covered dental services for these members.

For members 21 years of age and older, refer to AMPM Policy 310-D1 and AMPM Policy 310-D2 regarding services that may be provided by a dentist and under what circumstances.

Procedures

Preventive and therapeutic dental services for members who are under the age of 21 in both the Medicaid (EPSDT Program) and KidsCare Programs do not require PA. However, the following services for these members do require PA:

1. Removable dental prosthetics, including complete dentures and removable partial dentures,
2. Cast crowns,



3. Orthodontia services, and
4. Pre-transplant dental services (these services require PA by the AHCCCS transplant coordinator and review by the AHCCCS Dental Director or Designee)

PA requests for dental prosthetics, cast crowns, pre-transplant dental services, and orthodontic services may be submitted via web portal, fax, telephone, mail. PA is not necessary in emergency circumstances.

Dental PA requests must be accompanied by:

1. Dentist substantiation of medical necessity of services through description of medical condition,
2. Dentist's treatment plan and schedule, and
3. Radiographs fully depicting existing teeth and associated structures by standard illumination when appropriate.

E. DIALYSIS

Description

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

Refer to AMPM Policy 310, for covered dialysis services for members not in FESP.

Refer to AMPM Policy 1120, for information regarding FESP dialysis services.

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

Description

EPSDT services provide comprehensive health care, as defined in 9 A.A.C. 22, Article 2, through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening. Limitations and exclusion, other than the requirement for medical necessity, do not apply to EPSDT services.



PA for these services is only required as is designated in this policy and in AMPM Policy 430.

Refer to AMPM Policy 430, for complete information regarding EPSDT services (overview, definitions, screening requirements, service standards, provider requirements and exhibits).

G. EMERGENCY MEDICAL SERVICES

Description

A provider is not required to obtain PA for emergency medical services; however, a provider must comply with the notification requirements in 9 A.A.C., Article 2.

Notification of emergency admissions may be submitted via web portal or via fax. PA is required when a FFS member remains inpatient 72 hours or more following an emergent admission. A provider must notify the Administration no later than 72 hours after a FFS member's emergent inpatient admission. The Administration may deny payment for failure to provide timely notice.

Refer to AMPM Policy 310 and Exhibit 310-1, for review of the Rule sections regarding FFS emergency services.

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

H. EYE CARE/OPTOMETRY SERVICES

Description

AHCCCS covers eye care/optometric services for members, within limitations. Coverage is provided as described in AMPM Policy 310.

1. Emergency eye care services do not require AHCCCS authorization.
2. Eye examinations and prescriptive lenses are covered only for EPSDT and KidsCare members. PA is not required. Prescriptive lenses for members age 21 and older are not covered unless they are the sole visual prosthetic device used by the member after cataract removal surgery.
3. Cataract removal requires PA from the AHCCCS/DFSM/CMSU Unit. Children needing cataract removal should be referred to Children's Rehabilitative Services (CRS). Refer to AMPM Policy 330, for CRS covered services. Other prior authorization requests for cataract removal services may be submitted via web portal, fax, telephone or mail.



I. HOME HEALTH

Description

All home health services require PA from the AHCCCS/DFSM/CMSU Unit, except for the first five visits following discharge from an acute facility.

Refer to AMPM Policy 310, for complete information regarding covered home health services.

Procedures

PA requests for home health services should be submitted by web portal, fax, telephone or mail prior to providing services.

J. HOSPITAL INPATIENT SERVICE AUTHORIZATION

Description

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).

Procedures

Initial Service Authorization:

Under 9 A.A.C. 22, Article 2, the provider must notify the Administration no later than 72 hours after a FFS member receiving emergency medical services is emergently admitted for inpatient services. The Administration may deny payment for failure to provide timely notice.

1. Providers must obtain PA from the AHCCCS Administration or its designee for the following inpatient hospital services:
 - a. Organ and tissue transplantations (this authorization review is performed by the AHCCCS Transplant Coordinator, AHCCCS Division of Health Care Management (DHCM), Medical Management Unit, with the exception of corneal transplants and bone grafts that are submitted to the AHCCCS/DFSM/CMSU Unit),
 - b. Non-emergency admissions, including psychiatric hospitalizations. For acute psychiatric hospitalizations the following applies:
 - i. PA requests for Acute FFS members assigned to a Regional Behavioral Health Authority (RBHA) are submitted to the RBHA,
 - ii. PA requests for members assigned to a Tribal Regional Behavioral Health Authority (TRBHA) are submitted to the AHCCCS/DFSM/CMSU Unit,



- iii. PA requests for Acute FFS members who are not assigned to a RBHA or TRBHA are submitted to the AHCCCS/ DFSM/CMSU Unit, and
 - iv. PA requests for Tribal ALTCS members are submitted to the AHCCCS/ DFSM/CMSU Unit.
 - c. Elective surgery, with the exclusion of any surgeries listed in 2 below, and
 - d. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury.
2. 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
 - f. Hysteroscopies when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization.

AHCCCS covers inpatient hospital care for a normal vaginal delivery and inpatient hospital care for a cesarean delivery. PA is not required for hospitalizations that do not exceed 72 hours of inpatient hospital care for a normal vaginal delivery or do not exceed 96 hours of inpatient hospital care for a cesarean delivery.

The attending health care provider, in consultation with 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 stay in the hospital is medically necessary beyond a 48/96 hour stay.

3. For retrospectively eligible members, notification requirements are as follows:
- a. When the member is made eligible while still in the hospital, providers must notify the Administration 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.
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, the issuance of an authorization number does not guarantee payment; documentation provided from the member's medical record must support the diagnosis for which the authorization was issued, and the claim must meet clean claims submission requirements.

Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding pre-payment review criteria and submission requirements. This manual is available online at the AHCCCS website.



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. This information may be obtained through on-site or telephonic concurrent review. Upon approval or denial, the provisional status is removed from the authorization and the provider is notified by letter of the decision.

L. HYSTERECTOMY

Description

Hysterectomy services require PA from the AHCCCS/DFSM/ CMSU Unit. Hysterectomies are not covered when [42 CFR 441.255]:

1. Performed solely for the purpose of rendering an individual permanently incapable of reproducing, or
2. 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.

Refer to AMPM Policy 310, for additional information regarding covered hysterectomy services.

Procedures

PA requests for hysterectomy services may be submitted via web portal, fax, telephone, or mail.

The medical record must document the medical necessity of the hysterectomy, including prior medical and surgical therapy and results.

The member must sign a consent and acknowledgment of receipt of information that the hysterectomy will render her incapable of reproducing. [42 CFR 441.255]

Women who are deemed post-menopausal or women who are already sterile at the time of the hysterectomy are not required to sign this acknowledgement. The physician performing the hysterectomy must certify in writing that the woman was already sterile and identify the cause of sterility.

Prior acknowledgement may not be possible if the hysterectomy is performed because of a life-threatening emergency situation as determined by the physician. The physician performing the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she



determined prior acknowledgment was not possible. The physician must also include a description of the nature of the emergency.

PA may be granted based on these documents. Providers may use the sample AHCCCS Hysterectomy Consent and Acknowledgement Form (Exhibit 820-1), or they may use other formats as long as the forms include the same information and signatures as the AHCCCS hysterectomy acknowledgement form.

Refer to AMPM Policy 310 for complete 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 must certify in writing that an emergency existed.

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.

AHCCCS requires FFS providers to request PA for medically necessary pregnancy terminations. All authorization requests for medically necessary pregnancy terminations require submission of a completed AHCCCS Certificate of Necessity for Pregnancy Termination (see Exhibit 410-4). Refer to AMPM Policy 410 for complete information regarding coverage of medically necessary Pregnancy Terminations.

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

N. MEDICAL SUPPLIES, DURABLE EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES

Description

Medical supplies, durable equipment and orthotic/prosthetic devices must be prescribed by a fee-for-service physician or other appropriate practitioner. Orthotic devices covered for EPSDT and KidsCare members. Effective 8/1/2015, Orthotics are covered for AHCCCS members 21 years of age and over. Refer to AMPM Policy 310 for complete information regarding coverage of orthotic devices.



Refer to AMPM Policy 310, for complete information regarding covered medical supplies, equipment and prosthetic devices.

The following requirements apply to these services:

1. PA is required for the purchase of medical equipment and orthotic/prosthetic devices exceeding \$300.00. PA is required for all Durable Medical Equipment (DME) rentals and repairs,
2. PA is required for consumable medical supplies exceeding \$100.00 per month, (Consumable means the supplies have limited or no potential for reuse.)
3. For members age 21 and over, PA is required for medically necessary incontinence supplies. These incontinence supplies must be designated specifically to meet a medical purpose. AHCCCS covers incontinence briefs for ALTCS members age 21 and over as described in AMPM Policy 310,
4. Refer to AMPM Policy 430, for criteria related to coverage of incontinence briefs for members under the age of 21,
5. DME 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 must not exceed the purchase price (i.e., if AHCCCS can purchase the equipment for less than the rental fee, AHCCCS will purchase the item). All rental equipment requires PA, and
6. The following items do not require PA:
 - a. Oral supplements for ALTCS members, and
 - b. Apnea management and training for premature babies up to one year of life.

AHCCCS does not cover the following:

1. Personal care items unless needed to treat a medical condition. Exceptions:
 - a. AHCCCS covers incontinence briefs for persons over three and under age 21 as described in AMPM Policy 430, and
 - b. AHCCCS covers incontinence briefs for ALTCS members age 21 and over as described in AMPM Policy 310.
2. First aid supplies (except upon prescription by an authorized provider),
3. Hearing aids, cochlear implants or bone-anchored hearing aids for members 21 years of age or older,
4. Prescriptive lenses for members 21 years of age or older (except when medically necessary following cataract removal without an implanted lens),



5. Orthotics for members 21 years of age or older. Effective 8/1/2015, orthotics are covered for AHCCCS members 21 years of age and over. Refer to AMPM Policy 310 for complete information regarding coverage of orthotic devices, and
6. Penile implants or vacuum devices for members 21 years or older.

Procedures

PA for supplies/equipment may be submitted via web portal, fax, telephone, or mail.

1. In addition to information required for all PAs specified in AMPM Policy 810, the following information must be supplied at the time of the PA request:
 - a. Name, and dated signature,
 - 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. Description of supplies/equipment requested,
 - e. Duration for use of equipment,
 - f. Full purchase price plus any additional costs and expected cost if rented,
 - g. Provider identification number, and
 - h. Home evaluation, when requested by the AHCCCS/DFSM/CMSU Unit.
2. The procedure for use of the web portal for a request is:
 - a. Use the web portal link as directed online,
 - b. Submit the above information via, fax with a completed FFS form as the coversheet, and
 - c. Once received, a pended authorization number is given, information provided is reviewed, and a PA confirmation letter is mailed to the provider indicating a denied, approved or pended authorization status.
3. The procedure for a telephone request is:
 - a. AHCCCS/DFSM/CMSU will issue a provisional authorization number to the provider,
 - b. The provider must then submit the prescription or MD order and clinical documentation as described above by fax to AHCCCS/DFSM/CMSU, and
 - c. Upon receipt of the PA request form with all required documentation, the PA request will be reviewed, and a PA confirmation letter will be mailed to the provider indicating the PA determination.
4. The procedure for faxed requests is:
 - a. The provider must submit the information outlined above, and
 - b. Once received, information is reviewed, and PA confirmation letter is mailed to the provider indicating a denied, approved, or pended authorization status.



5. For members over the age of 21, requests for authorization of incontinence supplies must 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.
6. For ALTCS members over the age of 21, refer to AMPM Policy 310 for complete information on authorization requirements. Incontinence supplies for Tribal ALTCS member are authorized by the ALTCS tribal case manager.

O. NURSING FACILITY SERVICES

Description

Nursing Facility (NF) services for FFS acute members are covered by AHCCCS for up to 90 days per contract year if the member's medical condition would otherwise require hospitalization. Per 9 A.A.C. 22, Article 2, in lieu of a NF, a Tribal ALTCS member 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 services for Tribal ALTCS members are authorized by the ALTCS tribal case manager.

Refer to AMPM Policy 310, and AMPM Chapter 1200 for complete information regarding covered long term care services.

Procedures

PA requests may be submitted via web portal, fax, telephone, or mail. Initial PA will be for a period not to exceed the anticipated enrollment period of the FFS 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.

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



P. OBSERVATION SERVICES THAT EXCEED 24 HOURS

Description

Observation services are those reasonable and necessary services provided on a hospital's premises 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 must be billed as recovery room extensions.

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

Procedures

Observation must 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 necessity exists. The medical record must document the basis for observation services. Documentation must 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 must be written as a physician's order, and must specify "observation".
 - b. Orders for observation must be signed and dated by a physician within 24 hours of the order,
 - c. Follow-up orders must be written at least every 24 hours,
 - d. Changes from "observation to inpatient" or "inpatient to observation" must be ordered prior to the member's discharge from the facility, and
 - e. Physician's daily progress notes.



Q. PHYSICIANS AND PRIMARY CARE PROVIDERS

Description

Physicians and other Primary Care Providers (PCPs) must adhere to the PA requirements identified in AMPM Chapter 300, Chapter 400 and Chapter 800.

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

1. Fee-for-service surgeons, or the hospital employing the surgeon, must obtain a separate and distinct AHCCCS PA number from that of the hospital prior to providing the transplantation and elective/non-emergency surgeries (except voluntary sterilization). Refer to Hospital Inpatient Service Authorization. The AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, responds to all transplant requests. Assistant surgeon's essential to the service and anesthesiologists do not require a PA number.
2. Effective 05/01/2010, allergic immunotherapy evaluation and treatment for members 21 years of age and over must be prior authorized by the AHCCCS/DFSM/CMSU Unit (refer to AMPM Chapter 300 for limitations).

Procedure

PA requests may be submitted via mail, fax or telephone prior to providing service.

R. FOOT AND ANKLE SERVICES

Description

Effective date of service 10/1/2016 and later medically necessary foot and ankle care is covered for persons age 21 and older when provided by a podiatrist or podiatric surgeon, when ordered by the primary care provider, attending physician or practitioner, for AHCCCS eligible recipients. Recipient's medical record must document the ordering information. PA is not required.

Refer to FFS Provider manual for billing requirements.

Refer to FFS Provider manual for information regarding service dates prior to 10/1/2016.

Refer to AMPM Policy 310-U for complete information regarding covered foot and ankle services.



Procedures

PA requests for foot and ankle services may be submitted via web portal, fax, telephone, or mail.

S. PRESCRIPTION DRUG/PHARMACY SERVICES

Description

All FFS pharmacy PA is conducted through the contracted Pharmacy Benefit Manager (PBM).

All pharmacy claims are subject to post-payment review pursuant to A.R.S §36-2903.01.

Refer to AMPM Policy 310, for complete information regarding covered prescription drug/pharmacy services.

Refer to the AHCCCS Website for drug availability and authorization request form.

T. REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)

Description

PA for rehabilitation therapies is included in the facility authorization for members 21 years of age and older..

No PA is required for covered outpatient physical therapy services. Refer to AMPM Policy 310 for limitations.

AHCCCS covers outpatient speech or occupational therapy only for members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs, and ALTCS-enrolled members of any age. Authorization is not required for rehabilitation therapies for members under 21 years of age.

Refer to AMPM Policy 310 for complete information regarding covered rehabilitation services and AMPM Chapter 1200 for complete information regarding rehabilitation services for ALTCS.

U. TOTAL PARENTERAL NUTRITION

Description

Total Parenteral Nutrition (TPN) is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not



allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition.

Amount, Duration and Scope

AHCCCS covers 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.

1. Nursing Facilities and agencies furnishing outpatient TPN services must obtain PA at least one business day prior to initiation of service. Telephone requests are given provisional PA.
2. TPN is not a covered service if the member:
 - a. Has the ability to absorb enteral feedings, or
 - b. Has a condition where TPN cannot be expected to return the member to a functional level of health.
3. AHCCCS follows Medicare guidelines regarding the provision of TPN services.

Refer to AMPM Policy 310 for complete information regarding covered TPN services.

Procedures

Written medical documentation substantiating compliance with criteria must be received by the AHCCCS/DFSM/CMSU Unit within five business days of initial authorization request. Medical documentation must include:

1. History and physical which describes member's condition and diagnosis,
2. Physician's orders,
3. Dietary assessment, including member's weight,
4. Any pertinent progress notes (nursing/physician), which currently reflect the member's dietary, eating and functional status,
5. Physician progress notes indicating expected outcome of treatment,
6. Nursing facility records documenting percentage of each meal's consumption by member, and



7. Current laboratory data.

AHCCCS/DFSM/CMSU, upon receipt of documentation, will:

1. Approve, if in compliance with nutritional therapy criteria,
2. Review with the AHCCCS Medical Director, or designee, for determination of coverage, if not in compliance with standard criteria, and
3. Return the referral form to provider with findings of:
 - a. Approval, date, and note of any limitations, or
 - b. Denial of coverage reason.

V. TRANSPLANTATION (ORGAN AND TISSUE)

Description

Providers must obtain PA from the AHCCCS Transplant Coordinator for all organ and tissue transplantation services to be provided to FFS members. Pursuant to §1903(v) of the Social Security Act and 9 A.A.C. 22, Article 2, FESP members are not eligible for transplantation services.

Refer to AMPM Policy 310 and Attachment A for complete information regarding covered transplantation or related services.

AHCCCS also requires providers to obtain PA for transplant related services provided to AHCCCS members who have undergone transplantations not covered by AHCCCS.

AHCCCS utilization management requirements, including PA, are identified below.

Procedures

FFS provider responsibilities regarding medically necessary organ and tissue transplantation services for eligible members include, but are not limited to:

1. The member's transplantation specialist (hematologist/oncologist, cardiologist, gastroenterologist, nephrologist, etc.) must submit a written request to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, for approval of the transplantation,
2. The following documentation must accompany the written request:
 - a. Current history and physical, including information regarding previous therapy for the disease requiring covered organ and tissue transplantations,



- b. Records of diagnostic studies documenting the diagnosis, member's current medical status and plan of treatment leading to the recommendation of transplantation, and
 - c. Summary of anticipated outcome for the member.
3. The AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, will verify the member's eligibility. If approval is requested at the end of a month, eligibility will be verified for the following month.
4. The AHCCCS Medical Director, or designee, will review the submitted documentation, consult with appropriate specialists when necessary, and inform the member's transplantation specialist whether or not transplantation is approved. Written approval will include the following information:
 - a. Designation of the appropriate transplant centers with which AHCCCS maintains a contract, and
 - b. Instructions for obtaining PA for each transplantation service component.
5. AHCCCS will monitor convalescence via progress reports submitted to the Transplant Coordinator, DHCM, Medical Management Unit.
6. Providers must submit claims in accordance with AHCCCS policies and procedures.

Refer to the AHCCCS FFS Provider Manual for additional information. This manual is available on the AHCCCS Website.

In addition to the PA requirements, providers:

1. Submit to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, utilization abstracts that include new treatments, medical progress and/or complications, and laboratory results. Weekly submissions begin with the member's approval for transplantation and end with discharge from convalescent care.
2. Offer recommendations for the ongoing treatment and monitoring of the member after discharge.
3. Cooperate with requests from the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, to supply summary data for outcomes studies.

PA requests for transplant-related services provided to AHCCCS members who have undergone transplantations not covered by AHCCCS may be submitted via web portal, fax, telephone, or mail.



W. TRANSPORTATION

Description

AHCCCS covers the following transportation services:

1. Emergency transportation - Emergency transportation does not require PA from the AHCCCS/DFSM/CMSU Unit, 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.

Emergency transportation to out-of-state facilities is covered only when the out-of-state facility is the nearest appropriate facility.

2. Medically necessary Non-Emergency Transportation (NEMT) – Effective service date on or after January 1, 2017, prior authorization is required for medically necessary NEMT to and from covered behavioral health services when the trip exceeds 100 miles one way or round trip. PA is required regardless of the diagnosis code billed on the claim.
3. PA is required for medically necessary non-emergency ground transportation to and from covered medical or behavioral health services when the mileage is greater than 100 miles one way or round trip. 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 must only be provided to transport the member to and from the required covered medical or behavioral health service.

4. Medically necessary maternal and newborn transportation - Medically necessary maternal and newborn transportation, as specified in Chapter 300, does not require PA.

Refer to AMPM Policy 310 for a complete description and discussion of covered transportation services.



Procedures

In addition to requirements for all PAs (refer to AMPM Policy 810) the following conditions must also be met when PA is requested for non-emergency medically necessary transportation.

The following information may be requested when requesting PA via web portal, telephone or fax:

1. Physician's order, including medical justification for travel outside the member's area 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,
2. Descriptions of disability requiring special transport and/or special circumstances,
3. Type of transportation and need for attendant services, as appropriate.
4. Estimated cost of transportation, attendant services, meals or lodging, as appropriate, and/or
5. NEMT authorization requests to and from covered behavioral health services for TRBHA members who are enrolled with an MCO for acute care services must contain a valid behavioral health diagnosis to be authorized by AHCCCS DFSM CMSU staff.

PA for transportation will not be issued unless the transportation provider is an AHCCCS registered provider prior to seeking PA.

Authorization Requirements to Receive Medically Necessary Non-Emergency Transportation Services to Obtain AHCCCS Covered Medical or Behavioral Health Services.

1. For AHCCCS American Indian members enrolled with AIHP, and /or assigned to a TRBHA, or who receive medical or behavioral health services at an IHS/Tribal 638 facility transportation services are covered on a FFS basis under the following conditions:
 - a. The request for transportation services is prior authorized through the AHCCCS/DFSM/CMSU Unit when mileage is greater than 100 miles either one way or round trip. PA is not required for IHS/Tribal 638 transportation providers,
 - b. The member is not able to provide, secure or pay for their own transportation, and free transportation is not available, and
 - c. The transportation is provided to and from either of the following locations:



- i. The nearest appropriate IHS/Tribal 638 medical or behavioral health facility , or
- ii. The nearest appropriate AHCCCS registered medical or behavioral health provider.

Refer to AMPM Policy 310 for a complete description and discussion of covered transportation services.

1. For American Indian members receiving behavioral health services who are enrolled in either a RBHA or ALTCS managed care organization, please check with the RBHA or managed care organization for prior authorization requirements.
2. For MCO enrolled members receiving services with a non-behavioral health (medical) primary diagnosis, please contact the MCO for prior authorization requirements.

For Tribal ALTCS members, all medical and behavioral health transportation services are authorized by the tribal case manager.

Refer to AMPM Chapter 800 for complete information regarding prior authorization for Acute FFS members.

Refer to AHCCCS Contractors Operation Manual (ACOM) Policy 205, Ground Ambulance Transportation Reimbursement Guidelines for Non-Contracted Providers, for information regarding reimbursement.

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. TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS

Description

Triage/emergency medical screening and evaluation services are the medically necessary screening and assessment services provided to FFS, acute care and ALTCS 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.



Amount, Duration, and Scope

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 the AHCCCS/DFSM/CMSU Unit.

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 AHCCCS FFS PA and utilization management requirements.

Providers responsible for triage, screening and/or evaluation of emergency medical conditions must submit supporting medical documentation for services rendered. At a minimum, the emergency room record of care and itemized statement must be submitted when reporting or billing services to the AHCCCS Administration for services provided to FFS members.

Medical review of emergency room records must 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 may be denied.

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 Manual for information regarding service reporting and billing requirements. This manual is available on the AHCCCS Website.

Y. OTHER MEDICAL PROFESSIONAL SERVICES

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

1. Voluntary sterilization,



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 (limit up to five visits),
10. Hysteroscopies when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization,
11. Physical therapy for persons age 21 years or older; limited to 15 visits per contract 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 contract year to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired,
12. Facility services related to wound debridement, or
13. Apnea management and training for premature babies up to one year of life.