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820 PRIOR AUTHORIZATION REQUIREMENTS

REVISION DATES: 02/01/2012, 01/01/12, 11/01/11, 10/01/10, 07/01/10, 10/01/09, 03/01/09,
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08/01/95, 04/01/95

INITIAL

EFFECTIVE DATE: 10/01/1994

This section identifies AHCCCS Administration Fee-For-Service (FFS) PA requirements for covered services for the general FFS population not in the Federal Emergency Services Program (FESP) (refer to [Chapter 1100](#) for all requirements regarding services provided to FESP members). Prior Authorization (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/Prior Authorization (AHCCCS/DFSM/PA) Unit for services specified in Policy 820 of this Chapter when scheduling an appointment or admission for the FFS member.

The AHCCCS/DFSM procedural requirements for submitting PA requests via web portal (preferred), fax, telephone or mail, as defined in Policy 810, apply to all services identified in this section, unless specified otherwise. For purposes of this chapter, all PA requests are submitted to the AHCCCS/DFSM/PA Unit for approval or denial, unless specified otherwise.

A. BEHAVIORAL HEALTH

Description

1
2 AHCCCS covers behavioral health services (mental health and/or substance abuse
3 services) within limitations depending upon the member's age and eligibility.
4

5 Refer to [Chapter 300](#), Policy 310 of this Manual and the [Behavioral Health Services](#)
6 [Guide](#) for further information regarding AHCCCS covered behavioral health services and
7 settings.
8

9 **B. BREAST RECONSTRUCTION AFTER MASTECTOMY**

11 **Description**

12
13 AHCCCS covers breast reconstruction for eligible Fee-For-Service (FFS) members
14 following a medically necessary mastectomy.
15

16 Refer to [Chapter 300](#), Policy 310.
17

18 The physician performing the procedure and the facility in which the services are
19 provided must obtain PA from the AHCCCS Medical Director, or designee, for breast
20 reconstruction surgery provided to FFS members.
21

22 Refer to the sections of this policy addressing Hospital Inpatient Stays and Physician
23 Services for required documentation to receive PA.
24

25 **C. COCHLEAR IMPLANTATION**

27 **Description**

28
29 AHCCCS covers medically necessary services for cochlear implantation for FFS Early
30 and Periodic Screening Diagnosis and Treatment (EPSDT) members. Providers must
31 obtain approval from the AHCCCS Medical Director, or designee, for all cochlear
32 implants and related services for FFS members. Requests for PA must include

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1 documentation of the appropriate assessments and evaluations for determining suitability
2 for a cochlear implant.
3

4 Refer to [Chapter 400](#), Policy 430, in this manual for complete information regarding
5 covered cochlear implantation services.
6

7 **Procedures**

8
9 FFS provider responsibilities regarding cochlear implantation services include, but are
10 not limited to:
11

- 12 1. The member's implantation specialist (otolaryngologist or otologist) must submit a
13 written request to the AHCCCS Medical Director, or designee, for approval of the
14 implant.
15
- 16 2. The following documentation must accompany the written request:
 - 17
18 a. The member's current history and physical examination, including information
19 regarding previous therapy for the hearing impairment
20
 - 21 b. Records documenting the member's diagnosis, current medical status and plan of
22 treatment leading to the recommendation of implantation, and
23
 - 24 c. Current psychosocial evaluation and assessment for determining the member's
25 suitability for implant.
26
- 27 3. The AHCCCS Medical Director, or designee, will review the submitted
28 documentation and provide a written response for approval or denial to the member's
29 implant specialist. If approved, the written response will include the following
30 information:
 - 31
32 a. Stipulates that the implantation center must be an AHCCCS registered provider

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b. Instructions for obtaining PA for each implant service component, and

c. Coverage limitations.

4. 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 Chapter 400, Policy 430, for complete information regarding covered dental services for these members.

For members 21 years of age and older, refer to Chapter 300, Policy 310D 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:

- Removable dental prosthetics, including complete dentures and removable partial dentures
- Cast crowns

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

5 PA requests for dental prosthetics, cast crowns, pre-transplant dental services, and

6 orthodontic services may be submitted via web portal, fax, telephone, mail. PA is not

7 necessary in emergency circumstances.

8

9 Written dental PA requests must be accompanied by:

10

- 11 1. Dentist substantiation of medical necessity of services through description of medical
- 12 condition
- 13
- 14 2. Dentist's treatment plan and schedule, and
- 15
- 16 3. Radiographs fully depicting existing teeth and associated structures by standard
- 17 illumination when appropriate.
- 18

19 E. DIALYSIS

20

21 Description

22

23 AHCCCS covers dialysis and related services furnished to AHCCCS FFS members by

24 qualified providers without PA.

25

26 Refer to [Chapter 300](#), Policy 310, for covered dialysis services for members not in FESP.

27

28 Refer to [Chapter 1100](#), Policy 1120, for information regarding FESP dialysis services.

29

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

31

1 **Description**

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

10
11 PA for these services is only required as is designated in this policy and in [Chapter 400](#),
12 Policy 430.

13
14 Refer to Chapter 400, Policy 430, for complete information regarding EPDST services
15 (overview, definitions, screening requirements, service standards, provider requirements
16 and exhibits).

17
18 **G. EMERGENCY MEDICAL SERVICES**

19
20 **Description**

21
22 A provider is not required to obtain PA for emergency medical services; however, a
23 provider must comply with the notification requirements in 9 A.A.C. 22, Article 2.

24
25 Notification of emergency admissions may be submitted via fax or telephone. A provider
26 must notify the Administration no later than 72 hours after a FFS member receiving
27 emergency medical services presents to a hospital for inpatient services. The
28 Administration may deny payment for failure to provide timely notice.

29
30 Refer to [Chapter 300](#), Policy 310 and Exhibit 310-1, for review of the Rule sections
31 regarding FFS emergency services.

1 Refer to [Chapter 1100](#) for information regarding the Federal Emergency Services
2 Program.

3 4 **H. EYE CARE/OPTOMETRY SERVICES**

5 6 **Description**

7
8 AHCCCS covers eye care/optometric services for members, within limitations. Coverage
9 is provided as described in Chapter 300, Policy 310.

- 10
11 1. Emergency eye care services do not require AHCCCS authorization.
- 12
13 2. Eye examinations and prescriptive lenses are covered only for EPSDT and KidsCare
14 members. PA is not required. Prescriptive lenses for members age 21 and older are
15 not covered unless they are the sole visual prosthetic device used by the member after
16 cataract removal surgery.
- 17
18 3. Cataract removal requires PA from the AHCCCS/DFSM/PA Unit. Children needing
19 cataract removal should be referred to Children's Rehabilitative Services. Other prior
20 authorization requests for cataract removal services may be submitted via web portal,
21 fax, telephone or mail.

22 23 **I. FAMILY PLANNING SERVICES EXTENSION PROGRAM**

24 25 **Description**

26
27 AHCCCS covers comprehensive family planning services through the Family Planning
28 Services Extension Program for Sixth Omnibus Budget Reconciliation Act (SOBRA)
29 women whose eligibility has terminated, who are uninsured, who are not eligible for any
30 other AHCCCS services, and who voluntarily choose to delay or prevent pregnancy.
31 These services may be provided for up to 24 months following date of delivery. Any

1 medical service not included in the Family Planning Services Extension Program is not
2 covered.

3
4 Refer to [Chapter 400](#), Policy 420 for a complete discussion of the Family Planning
5 Services Extension Program.

6
7 **J. HOME HEALTH**

8
9 **Description**

10
11 All home health services require PA from the AHCCCS/DFSM/PA Unit, except for the
12 first five visits following discharge from an acute facility.

13
14 Refer to [Chapter 300](#), Policy 310, for complete information regarding covered home
15 health services.

16
17 **Procedures**

18
19 PA requests for home health services should be submitted by web portal, fax, telephone
20 or mail prior to providing services.

21
22 **K. HOSPITAL INPATIENT SERVICE AUTHORIZATION**

23
24 **Description**

25
26 Hospital inpatient service authorization is a part of the utilization management process
27 that may consist of both PA and continued authorization, contingent upon concurrent
28 review findings (refer to Policy 810).

29
30 **Procedures**

31
32 Initial Service Authorization:

1
2 Under 9 A.A.C. 22, Article 2, the provider must notify the Administration no later than
3 72 hours after a FFS member receiving emergency medical services presents to a hospital
4 for inpatient services. The Administration may deny payment for failure to provide
5 timely notice.

6
7 1. Providers must obtain PA from the AHCCCS Administration or its designee for the
8 following inpatient hospital services:

9
10 a. Organ and tissue transplantations (this authorization review is performed by the
11 AHCCCS Transplant Coordinator, AHCCCS Division of Health Care
12 Management (DHCM), Medical Management Unit, with the exception of corneal
13 transplants and bone grafts that are submitted to the AHCCCS/DFSM/PA Unit.)

14
15 b. Non-emergency admissions, including psychiatric hospitalizations. For
16 psychiatric hospitalizations the following applies:

17
18 i. PA requests for non Arizona Long Term Care System (ALTCS) FFS members
19 are submitted to the Regional Behavioral Health Authority or the Tribal
20 Regional Behavioral Health Authority.

21 ii. PA requests for ALTCS FFS members are submitted to the AHCCCS/
22 DFSM/PA Unit.

23
24 c. Elective surgery, with the exclusion of any surgeries listed in 2 below.

25
26 d. Services or items furnished to cosmetically reconstruct appearance after the onset
27 of trauma or serious injury.

28
29 2. The following inpatient hospital services do not require PA:

30
31 a. Voluntary sterilization
32

- 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
- f. Hysteroscopies when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization.

3. For members **under** the age of 21 years, AHCCCS will cover up to 48 hours of inpatient hospital care for a normal vaginal delivery and up to 96 hours of inpatient hospital care for a cesarean delivery.

For members age 21 years and older, AHCCCS will cover up to 48 hours of inpatient hospital care for a normal vaginal delivery and up to 96 hours of inpatient hospital care for a cesarean delivery to the extent that the stay does not exceed the 25 day inpatient limit specified in Policy 310-K, Hospital Inpatient Services. Prior authorization is not required for hospitalizations that do not exceed 48 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. If the mother's stay in the hospital exceeds the 25 day inpatient limit, the newborn may be granted an extended stay and is not subject to the 25 day inpatient limit.

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

1 a. When the member is made eligible while still in the hospital, providers must notify
2 the Administration no later than 72 hours after the eligibility posting date for
3 emergency hospitalizations.

4
5 b. When eligibility is posted after the member is discharged from the hospital, the
6 notification requirement in 3(a) will be waived.

7
8 5. Payment for services may be denied if the hospital fails to provide timely notification
9 or obtain the required authorization number(s) within the parameters specified in this
10 policy. However, the issuance of an authorization number does not guarantee
11 payment; documentation provided from the member's medical record must support the
12 diagnosis for which the authorization was issued, and the claim must meet clean
13 claims submission requirements.

14
15 Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding pre-
16 payment review criteria and submission requirements. This manual is available online
17 at the AHCCCS Website.

18
19 6. Authorization may be provisional if further review of information or documentation is
20 needed to make a full assessment of the medical necessity for the admission, the
21 service(s), and/or to determine the appropriate length of stay. This information may be
22 obtained through on-site or telephonic concurrent review. Upon approval or denial,
23 the provisional status is removed from the authorization and the provider is notified by
24 letter of the decision.

25
26 **L. HYSTERECTOMY**

27
28 **Description**

29
30 Hysterectomy services require Prior Authorization (PA) from the AHCCCS/DFSM/PA
31 Unit. AHCCCS does not cover hysterectomy procedures when performed only for the
32 purpose of rendering an individual sterile.

1
2 Refer to [Chapter 300](#), Policy 310, for complete information regarding covered
3 hysterectomy services.

4 5 **Procedures**

6
7 PA requests for hysterectomy services may be submitted via web portal, fax, telephone,
8 or mail.

9
10 The medical record must document the medical necessity of the hysterectomy, including
11 prior medical and surgical therapy and results. Also, the member must sign a consent
12 form, which includes information that the hysterectomy will render her incapable of
13 bearing children. Women who are deemed post-menopausal are not required to sign this
14 type of consent form. PA may be granted based on these documents. Providers may use
15 the sample AHCCCS hysterectomy consent form contained in this Chapter, Exhibit 820-
16 1, or they may use other formats as long as the forms include the same information and
17 signatures as the AHCCCS hysterectomy consent form.

18
19 The provider is not required to complete a consent to sterilization form prior to
20 performing hysterectomy procedures and the 30-day waiting period required for
21 sterilization does not apply to hysterectomy procedures.

22
23 In a life-threatening emergency, authorization is not required, but the physician must
24 certify in writing that an emergency existed.

25 26 **M. MATERNAL AND CHILD HEALTH CARE**

27
28 AHCCCS covers a comprehensive set of services for pregnant women, newborns and
29 children, including maternity care, family planning services, EPSDT services and
30 KidsCare services.

31
32 AHCCCS requires FFS providers to request PA for pregnancy terminations.

1
2 Refer to [Chapter 400](#) for information on maternal and child health care services.

3
4 **N. MEDICAL SUPPLIES, DURABLE EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

5
6 **Description**

7
8 Medical supplies, durable equipment and orthotic/prosthetic devices must be prescribed
9 by a fee-for-service physician or other appropriate practitioner. Orthotic devices are
10 limited to EPSDT and KidsCare members.

11
12 Refer to [Chapter 300](#), Policy 310, for complete information regarding covered medical
13 supplies, equipment and prosthetic devices.

14
15 The following requirements apply to these services:

- 16
17 1. Prior Authorization (PA) is required for the purchase of medical equipment and
18 orthotic/prosthetic devices exceeding \$300.00. PA is required for all Durable
19 Medical Equipment (DME) equipment rentals and repairs.
- 20
21 2. PA is required for consumable medical supplies exceeding \$100.00 per month.
22 (Consumable means the supplies have limited or no potential for reuse.)
- 23
24 3. For members age 21 and over, PA is required for medically necessary incontinence
25 supplies. These incontinence supplies must be designated specifically to meet a
26 medical purpose.
- 27
28 4. Refer to [Chapter 400](#), Policy 430, for criteria related to coverage of incontinence
29 briefs for members under the age of 21.
- 30
31 5. Durable medical equipment may be purchased or rented only when there are no
32 reasonable alternative resources from which the medically necessary equipment can

1 be obtained at no cost. The total expense of renting the equipment must not exceed
2 the purchase price (i.e., if AHCCCS can purchase the equipment for less than the
3 rental fee, AHCCCS will purchase the item). All rental equipment requires PA.
4

5 6. The following items do not require PA:

- 6 a. Oral supplements for ALTCS members, and
- 7
- 8 b. Apnea management and training for premature babies up to one year of life.
- 9

10 AHCCCS does not cover the following:

- 11 1. Personal care items unless needed to treat a medical condition. Exception: AHCCCS
- 12 covers incontinence briefs for persons over 3 and under age 21 as described in Policy
- 13 430.
- 14
- 15 2. First aid supplies (except upon prescription by an authorized provider)
- 16
- 17
- 18 3. Hearing aids, cochlear implants or bone-anchored hearing aides for members 21 years
- 19 of age or older
- 20
- 21 4. Prescriptive lenses for members 21 years of age or older (except when medically
- 22 necessary following cataract removal without an implanted lens)
- 23
- 24 5. Orthotics for members 21 years of age or older
- 25
- 26 6. Penile implants or vacuum devices for members 21 years or older.
- 27

28 **Procedures**

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

1 1. In addition to information required for all PAs specified in Policy 810 of this chapter,
2 the following information must be supplied at the time of the PA request:

- 3
- 4 a. Name of ordering physician and description of medical condition necessitating the
5 supplies/equipment
- 6
- 7 b. Medical justification for supplies/equipment and anticipated outcome
8 (medical/functional)
- 9
- 10 c. Description of supplies/equipment requested
- 11
- 12 d. Duration for use of equipment and full purchase price plus any additional costs
13 and expected cost if rented
- 14
- 15 e. Provider identification number and diagnosis code
- 16
- 17 f. Home evaluation, when requested by the AHCCCS/DFSM/PA Unit.

18

19 2. The procedure for use of the web portal for a request is:

- 20
- 21 a. Use the web portal link as directed on line
- 22
- 23 b. Submit the above information via email, fax or mail
- 24
- 25 c. Once received, information is assessed and PA confirmation letter is mailed to the
26 provider denying or approving services.
- 27

28 3. The procedure for a telephone request is:

- 29
- 30 a. After receiving the information outlined above, the AHCCCS/DFSM/PA Unit
31 issues a provisional number to the provider
- 32

- 1 b. The provider must then submit the information in writing via mail or fax
- 2
- 3 c. Upon receipt of the PA request form with all required documentation, the PA
- 4 number will be validated and a PA confirmation letter will be mailed to the
- 5 provider.
- 6
- 7 4. The procedure for written (mail or fax) request is:
- 8
- 9 a. The provider must submit the information outlined above
- 10
- 11 b. Once received, information is assessed and PA confirmation letter is mailed to the
- 12 provider, denying or approving services
- 13
- 14 5. For members over the age of 21, requests for authorization of incontinence supplies
- 15 must include the following information:
- 16
- 17 a. Diagnosis of a dermatologic condition or other medical/surgical condition
- 18 requiring medical management by incontinence supplies as dressings
- 19
- 20 b. Defined length of treatment anticipated, and
- 21
- 22 c. Prescription for specific incontinence supplies.

23

24 **O. NURSING FACILITY SERVICES**

25

26 **Description**

27

28 Nursing Facility (NF) services for FFS members are covered by AHCCCS for up to 90

29 days per contract year if the member's medical condition would otherwise require

30 hospitalization. Per 9 A.A.C. 22, Article 2, in lieu of a NF, the member may be placed in

31 an alternative living facility or receive home and community-based services. PA is

32 required for these services prior to admission of the member, except in those cases for

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1 which retroactive eligibility precludes the ability to obtain PA. However, the case is
2 subject to medical review.

3
4 Refer to [Chapter 300](#), Policy 310, and [Chapter 1200](#) for complete information regarding
5 covered long term care services.

6 7 **Procedures**

8
9 PA requests may be submitted via web portal, fax, telephone, or mail. Initial PA will be
10 for a period not to exceed the anticipated enrollment period of the FFS eligible member
11 or what is determined as a medically necessary length of stay, whichever is shorter (not to
12 exceed 90 days) and includes any day covered by Medicare.

13
14 Reauthorization for continued stay is subject to concurrent utilization review and
15 continued eligibility.

16
17 AHCCCS/DFSM/PA Unit staff will request hospital personnel and/or NF staff,
18 whichever is appropriate, to initiate an ALTCS application for possible coverage of
19 nursing facility services if it is believed that the member will need a NF stay lasting
20 longer than 90 days.

21 22 **P. OBSERVATION SERVICES THAT EXCEED 24 HOURS**

23 24 **Description**

25
26 Observation services are those reasonable and necessary services provided on a hospital's
27 premises for evaluation to determine whether the member should be admitted for
28 inpatient care, discharged or transferred to another facility. Observation services include:
29 the use of a bed, periodic monitoring by hospital nursing personnel or, if appropriate,
30 other staff necessary to evaluate, stabilize or treat medical conditions of a significant
31 degree of instability and/or disability on an outpatient basis.

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

6
7 Extended stays after outpatient surgery must be billed as recovery room extensions.

8
9 Refer to [Chapter 300](#), Policy 310, for complete information regarding covered outpatient
10 health services.

11 **Procedures**

12
13
14 Observation must be ordered in writing by a physician, or other individual authorized by
15 hospital staff bylaws, to admit patients to the hospital or to order outpatient diagnostic
16 tests or treatments. There is no maximum time limit for observation services as long as
17 medical necessity exists. The medical record must document the basis for observation
18 services. Documentation must minimally include the following:

19 1. Physician Notes:

- 20
21
- 22 a. Condition necessitating Observation
 - 23
 - 24 b. Justification of need to continue Observation, and/or
 - 25
 - 26 c. Discharge plan.
 - 27

28 2. Medical Records Documentation:

- 29
- 30 a. Orders for Observation must be written on the physician's order sheet, not the
31 emergency room record, and must specify "Observation." Rubber stamped orders
32 are not acceptable.

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- b. Follow-up orders must be written at least every 24 hours
- c. Changes from "Observation to inpatient" or "inpatient to Observation" must be ordered by a physician or authorized individual
- d. Changes from inpatient to Observation must occur within 12 hours after the admission as an inpatient and have supporting medical documentation
- 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 this policy manual ([Chapter 300](#), [Chapter 400](#) and [Chapter 800](#)).

Refer to Chapter 300, 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 surgeons 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 DFSM PA Unit (refer to Chapter 300 for limitations).

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Procedures

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

R. FOOT AND ANKLE SERVICES

Description

All foot and ankle services not covered by Medicare require PA. Refer to Chapter 300, Policy 310U 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, mail.

S. PRESCRIPTION DRUG/PHARMACY SERVICES

Description

FFS pharmacy services that exceed \$500.00 per prescription require PA. All FFS pharmacy PA is conducted through the contracted Pharmacy Benefit Manager (PBM).

All pharmacy claims are subject to post-payment review pursuant to Arizona Revised Statutes §36-2903.01.

Refer to [Chapter 300](#), Policy 310, for complete information regarding covered prescription drug/pharmacy services.

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

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T. REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)

Description

Prior Authorization (PA) is required for covered occupational therapy, speech therapy and audiology services. No PA is required for covered physical therapy services. Refer to Chapter 300, 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.

Refer to Chapter 300, Policy 310 for complete information regarding covered rehabilitation services and [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
- 2 1. Nursing Facilities and agencies furnishing outpatient TPN services must obtain PA at
- 3 least one business day prior to initiation of service. Telephone requests are given
- 4 provisional PA.
- 5
- 6 2. TPN is not a covered service if the member:
- 7
- 8 a. Has the ability to absorb enteral feedings, or
- 9
- 10 b. Has a condition where TPN cannot be expected to return the member to a
- 11 functional level of health.
- 12
- 13 3. AHCCCS follows Medicare guidelines regarding the provision of TPN services.

14

15 Refer to [Chapter 300](#), Policy 310 for complete information regarding covered TPN

16 services.

17

18 **Procedures**

19

20 Written medical documentation substantiating compliance with criteria must be received

21 by the AHCCCS/DFSM/PA Unit within five business days of initial authorization

22 request. Medical documentation must include:

- 23
- 24 1. History and physical which describes member's condition and diagnosis
- 25
- 26 2. Physician's orders
- 27
- 28 3. Dietary assessment, including member's weight
- 29
- 30 4. Any pertinent progress notes (nursing/physician), which currently reflect the
- 31 member's dietary, eating and functional status
- 32

1 5. Physician progress notes indicating expected outcome of treatment

2
3 6. Nursing facility records documenting percentage of each meal's consumption by
4 member, and

5
6 7. Current laboratory data.

7
8 AHCCCS/DFSM/PA, upon receipt of documentation, will:

9
10 1. Approve, if in compliance with nutritional therapy criteria

11
12 2. Review with the AHCCCS Medical Director, or designee, for determination of
13 coverage, if not in compliance with standard criteria

14
15 3. Return the referral form to provider with findings of:

16
17 a. Approval, date, and note of any limitations; or

18
19 b. Denial of coverage reason.

20
21 **V. TRANSPLANTATION (ORGAN AND TISSUE)**

22
23 **Description**

24
25 Providers must obtain PA from the AHCCCS Transplant Coordinator for all organ and
26 tissue transplantation services to be provided to FFS members. Pursuant to §1903(v) of
27 the Social Security Act and 9 A.A.C. 22, Article 2, FESP members are not eligible for
28 transplantation services.

29
30 Refer to [Chapter 300](#) (Policy 310 and Attachment A) in this Policy for complete
31 information regarding covered transplantation or related services.

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

3
4 AHCCCS utilization management requirements, including PA, are identified below.

5
6 **Procedures**

7
8 FFS provider responsibilities regarding medically necessary organ and tissue
9 transplantation services for eligible members include, but are not limited to:

- 10
11 1. The member's transplantation specialist (hematologist/oncologist, cardiologist,
12 gastroenterologist, nephrologist, etc.) must submit a written request to the AHCCCS
13 Transplant Coordinator, DHCM, Medical Management Unit, for approval of the
14 transplantation.
- 15
16 2. The following documentation must accompany the written request:
- 17
18 a. Current history and physical, including information regarding previous therapy
19 for the disease requiring covered organ and tissue transplantations
- 20
21 b. Records of diagnostic studies documenting the diagnosis, member's current
22 medical status and plan of treatment leading to the recommendation of
23 transplantation
- 24
25 c. Summary of anticipated outcome for the member.
- 26
27 3. The AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, will
28 verify the member's eligibility. If approval is requested at the end of a month,
29 eligibility will be verified for the following month.
- 30
31 4. The AHCCCS Medical Director, or designee, will review the submitted
32 documentation, consult with appropriate specialists when necessary, and inform the

1 member's transplantation specialist whether or not transplantation is approved.

2 Written approval will include the following information:

3
4 a. Designation of the appropriate transplant centers with which AHCCCS maintains
5 a contract, and

6
7 b. Instructions for obtaining PA for each transplantation service component.

8
9 5. AHCCCS will monitor convalescence via progress reports submitted to the
10 Transplant Coordinator, DHCM, Medical Management Unit.

11
12 6. Providers must submit claims in accordance with AHCCCS policies and procedures.

13
14 Refer to the AHCCCS FFS Provider Manual for additional information. This manual is
15 available on the AHCCCS Website.

16
17 In addition to the PA requirements, providers:

18
19 1. Submit to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit,
20 utilization abstracts that include new treatments, medical progress and/or
21 complications, and laboratory results. Weekly submissions begin with the member's
22 approval for transplantation and end with discharge from convalescent care.

23
24 2. Offer recommendations for the ongoing treatment and monitoring of the member
25 after discharge.

26
27 3. Cooperate with requests from the AHCCCS Transplant Coordinator, DHCM, Medical
28 Management Unit, to supply summary data for outcomes studies.

29
30 PA requests for transplant-related services provided to AHCCCS members who have
31 undergone transplantations not covered by AHCCCS may be submitted via web portal,
32 fax, telephone, or mail.

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W. TRANSPORTATION

Description

AHCCCS covers the following transportation services:

- ~~1. Emergency transportation~~
- ~~2. Medically necessary (non-emergency) transportation, and~~
- ~~3. Medically necessary maternal and newborn transportation.~~

1. Emergency transportation - Emergency transportation does not require PA from the AHCCCS/DFSM/PA Unit, although such services are only covered to the nearest medical facility which is medically equipped and staffed to provide appropriate medical care.

Emergency transport 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 – PA is required for medically necessary (non-emergency) ground transportation when the mileage is greater than 100 miles round trip. Medically necessary transportation 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 a registered provider capable of meeting the member’s medical needs. Transportation must only

1 be provided to transport the member to and from the required covered medical
2 service.

- 3
- 4 3. Medically necessary maternal and newborn transportation - Medically necessary
5 maternal and newborn transportation, as specified in Chapter 300, does not require
6 PA.

7

8 Refer to [Chapter 300](#), Policy 310 for a complete description and discussion of covered
9 transportation services.

10

11 **Procedures**

12

13 In addition to requirements for all PAs (specified in Policy 810 of this chapter) the
14 following conditions must also be met when PA is requested for non-emergency
15 medically necessary transportation.

16

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

- 19
- 20 1. Physician's order
- 21
- 22 2. Descriptions of disability requiring special transport and/or special circumstances
- 23
- 24 3. Type of transportation and need for attendant services, as appropriate
- 25
- 26 4. Estimated cost of transportation, attendant services, meals or lodging, as appropriate.
- 27

28 PA for non-emergency medically necessary transportation provided to AHCCCS FFS
29 members or American Indian Health Plan (AIHP)-enrolled members through the use of a
30 private vehicle must be requested by the member's medical service provider. PA for
31 transportation will not be issued unless the transportation provider is an AHCCCS
32 registered provider prior to seeking PA.

1
2 Authorization Requirements to Receive Medically Necessary Non-Emergency
3 Transportation Services to Obtain AHCCCS Covered Medical Services
4

5 1. For AHCCCS American Indian members who reside either on-reservation or off-
6 reservation and are enrolled with AIHP (Contractor ID number 999998),
7 transportation services are covered on an FFS basis under the following conditions:
8

9 a. The request for transportation services is prior authorized through the
10 AHCCCS/DFSM/PA Unit when mileage is greater than 100 miles. PA is not
11 required for IHS/638 providers.
12

13 b. The member is not able to provide, secure or pay for their own transportation, and
14 free transportation is not available; and
15

16 c. The transportation is provided to and from either of the following locations:
17

18 i. The nearest appropriate IHS/Tribal 638 medical facility located either on-
19 reservation or off-reservation (facilities that are located out-of-state are
20 subject to AHCCCS rules regarding reimbursement for out-of-state
21 services), or

22 ii. The nearest appropriate AHCCCS registered provider located off-
23 reservation.
24

25 2. For American Indian members enrolled in either an acute or ALTCS managed care
26 organization, please check with the managed care organization for prior authorization
27 requirements.
28

29 3. Members who are enrolled with AIHP and live either on-reservation or off-reservation,
30 and are receiving behavioral health services as specified in Chapter 300 under Policy 310,
31 Behavioral Health Services, may receive non-emergency medically necessary on-
32 reservation transportation services as follows:

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a. Non-emergency medically necessary transportation may be provided as outlined above (#1 above) on an FFS basis for the following members:

i. An AIHP enrolled member, residing either on-reservation or off-reservation who is receiving behavioral health services but is not enrolled with an ADHS designated Regional Behavioral Health Authority (RBHA).

ii. An AIHP enrolled member who lives on-reservation but is a member of a tribe that is not designated as a Tribal Behavioral Health Authority (TRBHA) through an agreement with the ADHS, and who receives services at an IHS/Tribal 638 facility or through an off-reservation provider; or

b.If the AIHP member is enrolled with, and receiving behavioral health services through, a RBHA or TRBHA, non-emergency medically necessary on-reservation transportation is coordinated, authorized and provided by the RBHA or TRBHA.

Refer to Chapter 1200 for additional information regarding ALTCS authorization requirements.

Refer to [Chapter 800](#) for complete information regarding prior authorization for non-ALTCS FFS members.

Refer to 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

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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 Prior Authorization (PA) from the AHCCCS/DFSM/PA 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

- 1
- 2 2. The evaluation of the member's medical status meets criteria for severity of illness
- 3 and intensity of service.
- 4

5 If the provider fails to submit medical records necessary for review, or if the medical

6 records fail to meet the criteria specified in this policy, the claim may be denied.

7

8 Refer to Policy 810 of this Chapter for a description of notification and PA procedures

9 for inpatient admission or post-assessment therapy.

10

11 Refer to the AHCCCS FFS Provider Manual for information regarding service reporting

12 and billing requirements. This manual is available on the AHCCCS Website.

13

14 **Y. OTHER MEDICAL PROFESSIONAL SERVICES**

15

16 Under 9 A.A.C. 22, Article 2, the following medical professional services do not require

17 prior authorization if a member receives these services in an inpatient, outpatient or office

18 setting.

19

- 20 1. Voluntary sterilization
- 21
- 22 2. Dialysis shunt placement
- 23
- 24 3. Arteriovenous graft placement for dialysis
- 25
- 26 4. Angioplasties or thrombectomies of dialysis shunts
- 27
- 28 5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis
- 29
- 30 6. Eye surgery for the treatment of diabetic retinopathy
- 31
- 32 7. Eye surgery for the treatment of glaucoma

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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 up to the limit of 15 visits.

12. Facility services related to wound debridement.

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

