Chapter 6:

Medical Authorizations & Notifications

Review/Revised: 01/21, 02/21, 07/21, 01/22, 03/22, 03/23, 02/24, 01/25

6.0 OVERVIEW

BCBSAZ Health Choice Pathway Chief Medical Officer, Medical Director(s), or their designees make Part C and D Organization Determinations, Appeal, and Grievances (ODAG) decisions based on nationally recognized, evidence-based criteria and standards of care. Accurate and prompt determinations of medical necessity depend upon the comprehensive content and the quality of medical documentation received with each request. [Medicare Managed Care Manual; NCQA HPA 2024, UM 4A-1, UM 4C, UM 4D]

We are committed to making the prior authorization process as efficient as possible, to ensure member access to care is timely. Please submit complete documentation to avoid unnecessary delays.

Please keep the following key points in mind when requesting a medically necessary prior authorization. For a listing of services which require Prior Authorization please refer to the Prior Authorization (PA) Grid at:

https://www.azblue.com/health-choice-pathway

The PROVIDER INFORMATION section (located in the PROVIDER drop down menu) contains the Prior Authorization grid. This section also houses the Medical and Pharmacy Prior Authorization Request forms.

6.1 THE FOLLOWING DIRECTIVES APPLY TO ALL PRIOR AUTHORIZATIONS

- Only one Medical/Pharmacy service may be requested per PA Request form
- ALL Out of Network Providers (OON) require prior authorization. OON Providers should not be requested unless required to meet the medically indicated need for the member.
- The Plan does not require prior authorization for Emergency Services
- Experimental and/or investigational services are not covered

6.2 PLEASE FOLLOW THESE STEPS WHEN REQUESTING A MEDICAL NECESSARY PRIOR AUTHORIZATION

- Offices must legibly complete all necessary fields on the most current Prior Authorization Request Form. The most current form is found on our website: https://www.azblue.com/health-choice-pathway under PROVIDERS drop down section

under commonly used forms and are included in the Provider Manual as an exhibit to this chapter (Exhibit 6.2 Medical Services and Behavioral Health Prior Authorization Form). Providers can submit prior authorization requests via the provider portal.

- Offices should include accurate ICD-10 codes which support the request, and must provide specific CPT codes, HCPCS codes, and J-codes as well as quantity per code.
- Offices should only request prior authorization for services listed on the Prior Auth Grid
- Please include ALL necessary documentation to support medical necessity to avoid unnecessary denials or inappropriate delays in the medical review/approval process. [NCQA HPA 2025, UM 6A, UM 6B, 6C]
- All **expedited** PA request forms **MUST** be signed by the ordering provider. Submission of "Expedited" requests are taken very seriously and monitored to ensure members emergent/urgent medical needs are met timely.
- Prior Authorization requests can be submitted (24 hours a day/7days a week) via the provider portal or the prior authorization fax number.

We have designated fax numbers for medical requests and pharmacy requests.

The office should confirm the fax receipt and this record should be kept for your documentation.

BCBSAZ Health Choice Pathway **Medical** PA Fax Line
(877) 424-5680

BCBSAZ Health Choice Pathway **Pharmacy** PA Fax Line
(877) 424-5690

- **eviCore Health Solutions** - All "advanced imaging" radiology services (MRI, MRA, CT and PET), nuclear cardiac stress testing, echocardiography, and heart catheterizations require prior authorization. The full listing of service codes is identified on the PA Grid.

Prior authorization for these services must be obtained through the eviCore online web portal:
(http://www.evicore.com),
Phone (888) 693-3211 or
Fax (888) 693-3210

The eviCore prior authorization forms for each type of service request are available on their web portal and can also be requested by calling eviCore.

6.3 TIME FRAME FOR MEDICAL AND BEHAVIORAL HEALTH APPROVALS

Standard: Within 14 calendar days - "Under 42 CFR 422.629 thru 422.634, "Standard" means a request for which a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if we justify a need for additional information and the delay is in the enrollee's

best interest. The requesting provider is responsible for communicating the procedure approval to the member. [Medicare Managed Care Manual; Medicare Organization Determinations; NCQA HPA 2025, UM 5A-4, UM 5B-4]

Expedited: Within 72 hours – "Under 42 CFR 422.629 thru 422.634, "Expedited" means a request for which a provider indicates, or the Plan determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. [Medicare Organization Determinations; 42 CFR 422.629 thru 422.634; NCQA HPA 2025, UM 5A-2, UM 5B-2]

We must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than 72 hours following the receipt of the authorization request, with possible extension of up to 14 days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest. The requesting provider is responsible for communicating the procedure approval to the member. [Medicare Organization Determinations; NCQA HPA 2025, UM 5A-2, , UM 5B-2,]

- Processing Requirements for Expedited Determinations - Provide notice of favorable decision to the enrollee (and the provider involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than:
    - 72 hours after receiving the request for items and services.
    - **24 hours after receiving the request for Part B drugs.**
- We may notify the enrollee verbally or in writing and notification must be received by the enrollee within:
    - 72 hours for items and services (i.e., mailing the determination within 72 hours in and of itself is insufficient).
    - **24 hours for Part B drugs.**

Outpatient Services

Select ambulatory and outpatient procedures require authorization. Providers should refer to the Prior Authorization Grid to determine which services require prior authorization.

6.4 SUPPORTING DOCUMENTATION – PRIOR AUTHORIZATION

Documentation of medical necessity must accompany all requests for prior authorization.

For most PA requests, supporting documentation should include:

- Current diagnosis and treatment already provided by the PCP/requesting Provider
- All pertinent medical history and physical examination findings
- Diagnostic imaging and laboratory reports (if applicable)
- Indications for the procedure or service
- Alternative treatments, risks, and benefits (including the indication of such discussions with patient)
- For Out-Of-Network (OON) providers/facilities/ services, and/or Non-Formulary (NF) medication requests, specific information which explains the medical necessity for an OON or NF service is required. A PA is required for any service to be covered at OON

providers/facilities. [NCQA HPA 2025, UM 6A]

6.5 ORGANIZATION DETERMINATION PROCESS

- The PCP must determine if a service requires the organization determination process.
- The PCP should initiate the authorization process. Specialists should not generally refer directly to other specialists.
- Members should not be permitted to self-refer to specialists without direct intervention of the PCP.
- The PCP must complete the Prior Authorization Request Form and submit it via Fax or the provider portal with ALL documents to support medical necessity.
- The PCP must facilitate care and/or alert the member to make the necessary appointments.
- The requesting provider must contact the plan for assistance as needed when coordinating or facilitating care.
- We will contact the Primary Care Provider (or consulting provider) with the authorization number via fax/phone upon approval.
- The PCP should document the authorization number in member's medical record.
- Authorizations are valid for the duration of medical necessity and are contingent upon continued member eligibility unless indicated otherwise on the prior authorization form that is faxed to the provider.
- Provider offices are responsible for confirming current member eligibility prior to service.
- Contracted and non-contracted health professionals, hospitals, and other providers are required to comply with prior authorization policies and procedures. Noncompliance may result in delay or denial of reimbursement.
- We do not prohibit providers from advocating on behalf of members.
- Providers are responsible for informing the member the procedure has been authorized.
- Plan Medical Directors and clinical staff are available to discuss the review determination with the attending physicians or other ordering providers. [NCQA HPA 2025, UM 7A, UM 7D]
- Criteria is available upon request by calling 800-322-8670 [NCQA HPA 2025, UM 2B-1, 2]
- Prior Authorization staff is available for PA questions and issues 8:00 am – 5:00 pm Monday through Friday [NCQA HPA 2025, UM 3A-1]
- Clinical review staff are available on an on-call basis before and after routine business hours, holidays, and weekends [NCQA HPA 2025, UM 3A-2]

Note: Receipt of authorization DOES NOT guarantee payment of services.

If the claim is billed incorrectly, or the member was not eligible on the date of service, the claim may be denied.

6.6 REFERRALS TO SPECIALISTS

Please check the Prior Authorization Grid to verify which specialties and services require medical review and a prior authorization number prior to referring a member to the specialist office or facility. If a Prior Authorization number is required, please ensure this number has been obtained and the specialist/facility has the number prior to the member's appointment. Please verify the provider/facility you are referring to is in-network except where out-of-network (OON) authorization had been obtained.

Our website has an updated listing of contracted providers at https://www.azblue.com/health-choice-pathway .

6.7 HOSPITAL SERVICES

Acute Inpatient Admissions

All elective and emergent admissions require prior authorization and/or notification. Please fax notification:

Inpatient Notification faxes are sent to 480-760-4732

Utilization Review staff will review the medical necessity criteria to make admission and level of care determinations. Continued stay review will be communicated to the hospital case management staff. Staff will assist in coordinating services identified for discharge planning as well as required follow up post discharge.

6.8 CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines (CPGs) are designed to support practitioners in developing treatment regimens that conform to current standards and national guidelines and ensure consistency in chronic disease management.

Clinical Practice Guidelines which have sound scientific basis such as clinical literature and expert consensus, are utilized to assess the appropriateness of specific healthcare decisions on outcomes of care and may reduce inter-practitioner variation in diagnosis and treatment.

They are guidelines, and as such, allow for individual medical necessity determinations and may not interfere with or cause delays in service or otherwise preclude delivery of health care services which providers, through their education, experience, and assessment of enrollee's need, deem medically necessary for enrollees. We adopt CPGs for acute, chronic, and behavioral health care that are relevant to the member population. These are adopted for the purpose of improving health care and reducing unnecessary variations in care. [NCQA HPA 2025, UM 2A-1, MED 2A]

Clinical practice guidelines are available on the website at https://www.azblue.com/health-choice-pathway , under *Providers* and then *Prior Authorization & Clinical Guidelines* Link and are available upon request [NCQA HPA 2025, UM 2B-1,2, MED 2B]

6.9 SERVICE REQUEST DENIALS

CMS rules and regulations mandate all members must be notified of a denial of medical coverage request within 72 hours for expedited requests and within 14 calendar days for standard request.

The Denial of Medical Coverage letter to the member and denial notice to the provider will contain the following:

- The reason for denial
- The criteria used to make the decision
- Description of appeal rights
- Explanation of appeal process
- Description of expedited appeal process
- How members, upon request, can obtain a copy of the benefit provision or criteria used to make the decision
  [NCQA HPA 2025, UM 7B-1,2,3, UM 7C-1,2,3]

Information regarding the denial of service will be returned to the provider (or their designee) who requested the authorization. Details of the denial language sent to the member may be less technical and at a lower reading grade level than language sent to the requesting provider. (Please see Claims Disputes, Member Appeals and Member Grievances Chapter 9 for additional information). [NCQA HPA 2025, UM 5A-2,4; UM 5B-2,4; UM 7B-1, UM 7E-1,2,3; UM 7C-1,2,3; UM 7F-1,2,3]

- If we initially provide verbal notification of our decision, we may deliver written confirmation of our decision within 3 calendar days of the verbal notification.
- Provide written notification* to the enrollee of the decision (and the provider involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than:
  - 72 hours after receiving the request for items and services.
  - **24 hours for Part B drugs.**
- If we initially provide verbal notification of our decision, we must deliver written confirmation of our decision within 3 calendar days of the verbal notification.

*"As defined by Medicare Managed Care Manual Chapter 13 – Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance."

Please note: There are no rewards or incentives offered to health plan staff for issuing denials of coverage or requested services.

6.10 PRIMARY CARE OBSTETRICIAN RESPONSIBILITY (PCO)

The PCO must notify us of each pregnant woman at the beginning of her prenatal care (initial visit) by faxing a completed Maternal Health Risk Assessment form.

This Risk Assessment form is a critical component of coordinated care between the Plan and the Obstetrician or Maternal Fetal Medicine provider and MUST be completed and submitted promptly after the member's first visit.

A copy of the member's ACOG notes may be submitted in lieu of the clinical documentation requested on the Maternal Risk Assessment form if all the requested information is included in the notes.

The Maternal Health Risk Assessment form should be **faxed to**
Maternal Health (480)760-4762

6.11 OB ULTRASOUND

CPT codes that can be used as routine OB ultrasounds are 76801/76802, 76805/76810, 76813/76814, 76815, 76816, and 76817.

6.12 EDUCATION FOR PREGNANT MEMBERS

We have a Maternal Care Management program composed of Maternal Care Managers who are skilled, culturally sensitive registered nurses who provide telephonic educational interventions, community resource referrals, and care collaboration for high-risk pregnant members during the prenatal and postpartum period.

The Maternal Care Management team provides:

- Education on prenatal care, wellness during pregnancy, and the member's high-risk condition(s).
- Referral to community resources (WIC, food, housing, clothing, counseling, MOUD, BH).
- Information on Health Choice transportation services.
- Information on family planning.
- A Comprehensive assessment to identify perinatal mood disorders
- Coordination of care between the interdisciplinary health care team.

Providers can refer high risk pregnant members to the OB Care Management team by completing the Care Management referral form (see Exhibit 5.1 Case Management Referral Form).

Please fax the completed referral form to:
Fax: **(480)760-4762**

Family Planning:
Family planning is a component of the educational process for members regardless of gender who voluntarily choose to delay or prevent pregnancy. Family planning services include covered medical, surgical, pharmacological, and laboratory benefits.

- Covered family planning services for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices (IUDs) and subdermal implantable contraceptives):

- Contraceptive counseling to increase the member's success with the family planning option, medication, and/or supplies, including, but not limited to oral and injectable contraceptives, Long-Acting Reversible Contraceptive (LARC), Immediate Postpartum Long-Acting Reversible Contraceptive (IPLARC), diaphragms, condoms, foams, and suppositories,
- Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning,
- Treatment of complications resulting from contraceptive use, including emergency treatment,
- Natural family planning education or referral to qualified health professionals,
- Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse
- Sterilization:
  - Clarification related to Hysteroscopic Tubal Sterilization:
    1. Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy,
    2. At the end of the three months, it is expected that a Hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test the member is considered sterile.

- Coverage for the following family planning services are as follows:
  - Pregnancy screening is a covered service,
  - Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions,
  - Screening and treatment for Sexually Transmitted Infections (STI) are covered services for members, regardless of gender
  - HIV testing, counseling, and referral to a specialty provider for positive results
  - Sterilization services are covered regardless of a member's gender when the requirements specified in this Policy for sterilization services are met (including hysteroscopic tubal sterilizations), and
  - Pregnancy termination is covered only as specified in AMPM Policy 410
- Limitations:
  The following are not covered for the purpose of family planning services and supplies:
  - Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility,
  - Pregnancy termination counseling,
  - Pregnancy terminations except as specified in AMPM Policy 410, and
  - Hysterectomies for the purpose of sterilization. Refer to AMPM Policy 310-L for hysterectomy coverage requirements.
  - Refer to AMPM Policy 820 for prior authorization requirements for FFS providers

Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available

- Prenatal Care
  - Prenatal Care services shall be provided by the Maternity Care Provider in compliance with the most current American College of Obstetricians and Gynecologists, (ACOG) standards for obstetrical and gynecological services. Practitioners, and licensed midwives adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults/referrals for increased-risk or high-risk pregnancies using ACOG or MICA criteria,
  - The Maternity Care Provider educates members about healthy behaviors during pregnancy, including the importance of proper nutrition, dangers of lead exposure to mother and child, tobacco cessation, avoidance of alcohol and other harmful substances, including illegal drugs, screening for sexually transmitted infections, including syphilis, vaccine status, the physiology of pregnancy, the process of labor and delivery, breast-feeding, other infant care information, prescription opioid use, history of postpartum depression and postpartum follow-up,
  - Maternity providers screening for perinatal mood disorder Members are referred for support services to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community- based resources to support healthy pregnancy outcomes. In the event where a member loses eligibility, the member shall be notified where they may obtain low- cost or no-cost maternity services,
  - Maternity Care providers maintain a complete medical record, documenting all aspects of Maternity Care,
  - High-risk pregnant members have been referred to and are receiving appropriate care from a qualified physician.
  - For Maternity Care Provider Appointments, initial prenatal care appointments for enrolled pregnant members shall be provided as follows:
    - First trimester – within 14 calendar days of request,
    - Second trimester within seven calendar days of request,
    - Third trimester within three business days of request, and
    - High risk pregnancies as expeditiously as the member's health condition requires and no later than three business days of identification of high risk by the contractor or maternity care provider or immediately if an emergency exists.
- Postpartum Care

  Postpartum services are provided by the Maternity Care Provider up to 12 months after delivery.

  Screening for perinatal depression shall be completed during the postpartum visit with appropriate counseling and referrals made if a positive screening is obtained.

6.13 PRIOR AUTHORIZATION AND REFERRALS

It is the responsibility of the PCO to obtain prior authorization for services not related to the pregnancy, i.e., if you must refer the member. In the event a PCO feels the member needs to be referred to a Maternal Fetal Medicine physician, it is the responsibility of the PCO to contact the Maternal Fetal Medicine physician's office, discuss the member's condition, and schedule the initial appointment.

Note: Contracted OB providers are required to meet minimum appointment availability standards, should make a best effort to expedite early entry into prenatal care for all members in any trimester, and see all postpartum visits within 6 weeks of delivery.

6.14 OPHTHALMOLOGY/OPTOMETRY

The following services are covered:

- Routine eye exam, limited to one exam every year.
- One pair of eyeglasses or contacts per year.
- Medicare covered eye exam for the diagnosis and treatment for diseases and conditions of the eye.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African Americans who are age 50 and older glaucoma screenings once per year are covered.
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames and replacements needed after a cataract removal without lens implant.

6.15 DURABLE MEDICAL EQUIPMENT and INFUSION / ENTERAL THERAPY

Health Choice Pathway has a network of contracted service providers statewide for Durable Medical Equipment (DME). All referrals are to be sent directly to the DME company. The DME provider will coordinate with the requesting provider and Health Choice to obtain any necessary prior authorization.

Each authorization request should include, if appropriate:

- Clinical records documenting the medical necessity of the request, and
- Certificate of medical necessity, and
- Current, signed provider order or prescription.

Home Infusion is provided through Health Choice Pathway through a network of statewide contracted infusion service providers. Requests for Infusion are to be sent to directly to the home infusion provider who will coordinate with the requesting provider in obtaining any necessary prior authorization. Medical records documenting the medical necessity of the request must also be provided in addition to a current, signed doctor's order(s)/prescription.

Enteral products/oral nutrition is provided though Health Choice Pathway's statewide contracted provider. Requests for enteral products, oral nutrition and their DME supplies (pumps, poles, syringes, bag systems, etc.) are to be directly sent to DME provider who will coordinate with the requesting provider in obtaining any necessary prior authorization. Medical records documenting the medical necessity of the request must also be provided in addition to a current, signed provider order(s)/prescription. The DME provider will process the request and forward to Health Choice who will complete the review for medical necessity. Once approved, Health Choice will send the approval to DME provider to coordinate with the requesting provider and/or member as needed to ensure delivery.

6.16 ORTHOTICS/PROSTHETICS

We have several contracted orthotics and prosthetic providers in the geographical areas we serve. The full listing of service codes that require authorization are identified on the PA Grid. Requests must be sent to the Plan by the requesting provider on a prior authorization form with the supporting clinical documentation.

6.17 PHARMACY AUTHORIZATIONS

Prescribers are required to use our Drug Formulary when prescribing medications for our beneficiaries. *Refer to Chapter 10: Prescription Benefits and Drug Formulary.*

If the patient requires medication which is listed as "prior approval required" the provider must request prior authorization using the current **Pharmacy Medication Prior Authorization Form/Exception Request Form (Exhibit 17.1)** along with appropriate documentation to support the request. Providers should also note references to step therapy (ST) edits, quantity limits (QLL), and maximum dispensing limits (MDL) prior to requesting PA. The Formulary is available on the web site at: https://www.azblue.com/health-choice-pathway

Note: If you do not have internet access, contact your Provider Performance Representative to arrange for a paper copy to be delivered.

Providers may **submit Pharmacy Prior Authorization requests online** through your secure provider portal or by visiting directly PromptPA portal: https://healthchoice.promptpa.com/.
*System Requirements: Web browser (i.e., Internet Explorer 9 or higher).

To submit an online request, please be prepared with the patient's name, ID number, and zip code.

Clinical information submitted via the PromptPA Portal will be transmitted securely into the Pharmacy Coverage Determination system for review by a Pharmacist or Medical Director. NCQA HPA 2025 UM 4E

Organization determinations for Part B drugs are made within 24 hours for expedited requests and 72 hours for standard requests. [NCQA HPA 2025 UM 5C-2,4,6]

6.18 SPECIALTY MEDICATION PROGRAM

We have instituted a special program with our pharmacy benefit manager for certain specialty medications. Examples of such medications are those used to treat multiple sclerosis, rheumatoid arthritis, and chronic hepatitis. Please refer to Chapter 10 for instructions on how to order these special medications or contact the Health Choice Pathway Pharmacy department for additional assistance.

6.19 BEHAVIORAL HEALTH PROGRAM

We require prior authorization for select behavioral health services and non-contracted providers. For a listing of services that require prior authorization, please refer to the Prior Auth Grid.

Offices must legibly complete all necessary fields of the most current Prior Authorization Request Form which can be found on our website: https://www.azblue.com/health-choice-pathway under the PROVIDER drop down section under commonly used forms and are included in the Provider Manual as an exhibit to this chapter (Exhibit 6.2 Medical Prior Authorization Form).

A behavioral health professional is required to apply the designated authorization and continued stay criteria to approve the provision of the covered service. [NCQA HPA 2025, UM 4A-2]. Request for prior authorization should include all supporting documents. Submitted clinical information and documentation relevant to the authorization request are reviewed by a behavioral health professional to determine medical necessity.

If enough clinical information relevant to the medical necessity criteria is not provided with the request, we will request the clinical information needed to make a decision. [NCQA HPA 2025, UM 6-B]. A decision to deny must be made by the Medical Director or physician designee. [NCQA HPA 2025, UM 4-D] When appropriate, we will consult with the requesting provider to obtain additional information to make a determination. [NCQA HPA 2025, UM 7A]

Behavioral Health Medical Necessity Criteria

We utilize InterQual clinical guidelines to determine medical necessity for both outpatient behavioral health services and psychiatric inpatient levels of care. [NCQA HPA 2025, UM 2A-1]

Behavioral Health Inpatient Admission and Continued Stay Review Process

For all initial concurrent and continued stay requests, submit the completed **Certificate of Need (CON) and Prior Authorization and Continued Stay Request Form for Psychiatric Hospitals and Sub-Acute Facilities,** within one business day of admission. For request forms, visit our website request form page.

All requests are submitted by faxing to **(480) 760-4732.**

Continued stay reviews will be conducted by Medical Management staff and communicated to the hospital utilization review staff. The number of days authorized is based on the member's current symptoms and behaviors. Medical Management staff will conduct and communicate an assessment of discharge needs and recommendations and assist with coordinating services as needed. Members identified as high risk and those with higher utilization will be referred to care management (see section 6.24). Transition of Care staff call members while they are still inpatient and/or three days after discharge for up to thirty (30) days to ensure the member's discharge needs are addressed.

- Admission reviews are completed by Medical Management staff within one business day of notification. (**42 C.F.R. 456.125**.) [NCQA HPA 2025 UM 4A-1]
- Initial and continued stay authorizations are based on adopted medical necessity criteria. The number of days authorized, and frequency of reviews are based on member's diagnosis, condition, and projected discharge.
- Continued stay reviews are completed by the Medical Management Staff prior to the end date of the current authorization. Hospital UR staff are notified of the next review date. The facility is responsible for submitting updated clinical information on the last authorized day.
- For concurrent reviews the request will be made twice in a 48-hour period. If the information is not received within that timeframe the continued stay will be administratively denied for lack of medical information required to make a determination.
- Reviews not meeting medical necessity guidelines are referred to the Medical Director or the physician designee for review. [NCQA HPA 2025 UM4-D]
- Clinical information for medical necessity review may include, but is not limited to: [NCQA HPA 2025 UM6-B]
    - Hospital records including, but not limited to history of presenting problem, diagnostic test, psychiatric prescriber evaluations, psychosocial history, medication records, treatment plan, and progress notes.
    - Quality of care
    - Length of stay
    - Whether services meet the member's needs
    - Discharge needs
    - Utilization pattern analysis

Behavioral Health Medications

We have formulary medications available to treat identified Behavioral Health Disorders. If the patient requires a behavioral health medication listed as "Prior Authorization Required", "Step Therapy" and/or "Quantity Limits" the provider must request prior authorization using the **Pharmacy Medication Prior Authorization Form/Exception Request Form** and submit appropriate documentation to support the request. See Exhibit 17.1.

6.20 REFERRALS TO SPECIALISTS

Please check the Prior Authorization list to verify which specialties require medical review and a prior authorization prior to requesting a member see a specialist.

It is the responsibility of the referring provider to ensure any necessary authorizations have been obtained within the allowable authorization turnaround time frames prior to a scheduled Specialist appointment. If a Prior Authorization is required, please provide the authorization number directly to the specialist in advance of the scheduled appointment to ensure services are provided timely on the scheduled date of service. The specialist and the PCP should retain a copy of the referral authorization in the member medical record.

6.21 SPECIALIST PROTOCOL

The specialist is responsible to ensure necessary authorizations have been issued (if the service requires authorization) prior to rendering service. When authorizations are required for member's consultations and/or billing, these requirements must be met to receive proper reimbursement. The specialist should verify the member's eligibility on the date of service. If the service required prior authorization and an authorization was not approved, or if the member was ineligible at the time of service, the claim will be denied.

6.22 RETROSPECTIVE AUTHORIZATION

Retrospective authorization requests (a request for authorization after services which require authorization have been rendered) will NOT be provided. The provider is encouraged to follow the appeal and grievance process per CMS guidelines. Providers must adhere to Plan policies and procedures in obtaining PA prior to any non-emergent service.

6.23 CARE MANAGEMENT

Staff will assist with coordinating the care of members with chronic or disabling conditions. Providers are encouraged to refer members to the various care management programs. (See our Model of Care)

Care management programs include the following key components:

- Identifies individuals with complex, chronic, or serious medical conditions
- Establishes and implements a care plan appropriate to the members' specific needs and medical condition(s)
- Assesses the member's physical, psychological, social environment, financial, and functional status as well as the family, community, and institutional support systems
- Includes an adequate number of direct access visits to specialists
- Ensures coordination among providers
- Considers the beneficiary's input

Our Care Management program promotes quality and care coordination by:

- Defining and tracking quality and performance indicators
- Implementing measures that contribute to improving quality of care and cost-effective management of targeted conditions
- Encouraging preventive care strategies to keep members healthy
- Promoting member education and behavioral modifications that improve health outcomes and health literacy
- Educating members on available community resources
- Monitoring outcomes and programs effectiveness

Providers may refer beneficiaries to our Care Management program by submitting a care management referral form (Exhibit 5.1) and attaching any pertinent medical documentation and faxing it to (480) 317-3358. The form is available online at https://www.azblue.com/health-choice-pathway.

Providers may also contact the Care Management Department via phone to refer a member by calling (800) 230-6044 Monday-Friday 8am – 5pm.