CHAPTER 6:

Authorizations and Notifications

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6.0 MEDICAL AUTHORIZATION AND NOTIFICATIONS OVERVIEW

We are committed to making the prior authorization process as efficient and streamlined as possible in partnership with the requesting provider. It's important to submit a complete prior authorization request form and provide clinical documentation to facilitate an effective review process.

We maintain a list of services/codes which require prior authorization. This list is referred to as the Prior Authorization Grid (PA Grid). The Chief Medical Officer (CMO), Medical Director(s), or their designees make medical necessity determinations based upon nationally recognized, evidence-based standards of care and the AHCCCS program benefits

Accurate and prompt medical necessity determinations depend upon the comprehensive content and the quality of medical documentation we (or our delegated entities) receive with each request.

6.1 MEDICAL PRIOR AUTHORIZATION AND NOTIFICATIONS

For a complete listing of services which require Prior Authorization (PA) please refer to the Prior Authorization Grid effective to the applicable date of service at www.HealthChoiceAZ.com. This "PA grid" can also serve as a reference guide and answer many questions which may arise, but which are not directly referred to in the chapter text.

Please follow these key steps when requesting a medically necessary prior authorization**:**

1. Legibly complete all necessary fields of the most current Medical Prior Authorization Request Form (Exhibit 6.2). The most current forms can be accessed on our website: www.HealthChoiceAZ.com and are available through your Provider Performance Representative.
2. Include ALL appropriate clinical documentation, ICD-10, CPT, HCPCS and J-Code or Q-codes to effectuate the Prior Authorization request in an effective and timely manner. The CPT, HCPC and J or Q codes must also identify quantity being requested for each code. Offices should only request PA for services listed on the Plan's PA Grid
3. BCBSAZ Health Choice is payor of last resort when a member has other health insurance. Notification is required for Transplant, Inpatient and Dental. [42 CFR 433.135 et seq., A.R.S. § 36-2903, and A.A.C. R9-22-1001 et seq]
4. Include ALL necessary clinical documentation to support medical necessity to avoid

inappropriate denials or unnecessary delays in the medical review process. Requests without supporting clinical documentation will be denied for lack of clinical information.

5. Clearly indicate on the prior authorization request form if the request is "Expedited" (see below for details). All expedited PA request forms MUST be signed by the ordering provider. Receipt of "Expedited" requests is taken very seriously and monitored to ensure member's emergent/urgent medical needs are met timely. Inappropriate "Expedited" requests will be downgraded to "Standard".
6. Submit prior authorization requests via fax using the current request form posted on the website or submit via the provider portal. Requests are received 24 hours a day, 7 days per week. 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.

    - Medical PA Fax Line (877) 422- 8120
    - Pharmacy PA Fax Line (877) 422-8130

eviCore Health Solutions ("eviCore") - All ''advanced imaging" radiology services (MRI, MRA, CT and PET), Level 2 obstetrical ultrasounds, nuclear cardiac testing, echocardiography, and heart catheterizations require prior authorization. The full listing of service codes is identified on the PA Grid. Prior Authorizations for these services must be obtained through the eviCore online web portal (https://www.evicore.com), by phone (888) 693-3211 or by fax (888) 693-3210. The eviCore prior authorization forms for each type of service request are available on the web portal and can also be requested by calling eviCore.

ALL eviCore Expedited requests and requests for multiple (recurring) units of a routine obstetrical ultrasound test (recurring/additional units outside of your Total OB package authorization, refer to Chapter 16: *Family Planning, Maternal Health and Children's Services* for additional guidance), **MUST** be conducted by phone: (888) 693-3211.

NOTE:

- Receipt of an authorization does not guarantee payment of services. The claim must be billed correctly and timely.
- Services rendered must be covered under the AHCCCS program.
- The member must be determined eligible on the date of service. AHCCCS is (generally) the payer of last resort and primary insurance and/or other credible coverage must be billed first, regardless of primary benefit coverage.
- Only one Medical and/or Pharmacy service may be requested per prior authorization request form.
- ALL Out of Network Providers (OON) require prior authorization. OON Providers should not be requested unless there is a compelling medical necessity reason .
- Any service request resulting in a member being seen outside of the state of Arizona requires prior authorization.
- Expedited requests which do not meet the AHCCCS definition of "Expedited" may be

downgraded to a “Standard” level request by the Plan.

- We do not require prior authorization for emergency services.
- We do not cover or pay for experimental and/or investigational services.

6.2 PRIMARY CARE REFERRALS FOR BEHAVIORAL HEALTH

Members can access behavioral health care without an authorization. All eligible members are auto assigned to a behavioral health home based on the member’s address. Members can change their behavioral health home at any time, but auto-assignment ensures all members have access to behavioral health services. To initiate services with a behavioral health provider, the member, PCP, or medical provider has several options. (1) Contact our Behavioral Member Services department at 877-923-1400 to determine the member’s assigned behavioral health home. (2) Fax the referral form to 1-855-408-3409.

6.3 SECURING SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION

The behavioral health home clinical team (Adult Recovery Team or Child and Family Team) is responsible for identifying and securing the service needs of each behavioral health recipient through the assessment and service planning processes. Rather than identifying pre-determined services, the clinical team should focus on identifying the underlying needs of the behavioral health recipient, including the type, intensity and frequency of support needed.

As part of the service planning process, it is the behavioral health home clinical team’s responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the clinical team, the behavioral health recipient, family, and natural supports.

If the service is available through the assigned behavioral health home, the patient can access the service directly. If the requested service is only available through a non-contracted provider or if the clinical team requests services from a non-contracted provider, the clinical team is responsible for coordinating with us to obtain the requested service as outlined below.

Services that are not secured through the behavioral health home clinical team process are subject to retrospective review.

6.4 SECURING SERVICES WITH NON-CONTRACTED PROVIDERS OR NON-CONTRACTED SERVICES WITH A CONTRACTED PROVIDER

If the network does not have in-network providers to perform the requested covered service or when it is clear a member would be better served by a non-network provider, we will enter into a single case agreement with that provider for a limited time. The Plan and Behavioral Health Homes are not required to offer services outside of the contracted provider network if the service is available within the network.

Non-Contracted providers must be registered with AHCCCS.

All out-of-network services require prior authorization.

Process to secure SCA:
When a Behavioral Health Home has defined the need for an enrolled member to have services provided by a non-contracted provider or for a non-contracted service by a contracted provider, the team shall submit a prior authorization request.

The Behavioral Health Home is required to submit the prior authorization request form via fax to (877) 422- 8120, all authorization forms are available on our **request forms** page. For residential services the request form should be faxed to (480)-760-4732.

We will review prior authorization requests and complete a single case agreement as needed.

In the event a request to secure covered services through a non-contracted provider is denied, a Notice of Adverse Benefit Determination must be provided in accordance with the Provider Manual, *Chapter 15: Claim Disputes, Members Appeals and Member Grievances*.

Once the single case agreement has been negotiated and executed, the single case agreement provider will be given the signed copy.

If out-of-network services that require prior authorization are **not** prior authorized or if the established single case agreement process is not utilized, the service performed by the out-of-network provider may not be reimbursed. Additionally, the member may not be billed if providers fail to follow our policies.

Both referring and receiving providers must comply with our policies, documents, and requirements that govern the prior authorization process. Failure to comply may result in delay in care for the member and a delay or denial of reimbursement.

Claims are not eligible for payment (does not apply to emergency services) unless the single case agreement is in place and the authorization (if required) has been obtained.

6.5 EMERGENCY SITUATIONS

Prior authorization is never applied when emergency services are sought or rendered. A retrospective review may be conducted after the person's immediate behavioral or physical health needs have been met. If upon review of the circumstances, the service did not meet admission authorization criteria, payment for the service may be denied. The test for appropriateness of the request for emergency services must be whether a prudent layperson, similarly situated, would have requested such services.

6.6 COVERAGE AND PAYMENT OF EMERGENCY MEDICAL CONDITION AND POST-STABILIZATION SERVICES

Emergency health services for Title XIX or Title XXI eligible members must be covered and reimbursement made to providers who furnish the services regardless of whether the provider has a contract with us.

Payment must not be denied when:

- The provider instructs a person to seek emergency services;
  An Illness, injury, symptom, or condition (including severe pain) that a reasonable person could expect that not getting medical attention right away would:
  a) Put the person's health in danger; or
  b) Put a pregnant woman's baby in danger; or
  c) Cause serious damage to bodily functions; or
  d) Cause serious damage to any body organ or body part. to bodily functions; or

- Emergency conditions must not be limited to a list of diagnoses or symptoms.
- A person who has an emergency health condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the person; and
- The attending emergency physician, or the provider treating the person, is responsible for determining when the person is sufficiently stabilized for transfer or discharge.

The following conditions apply with respect to coverage and payment of post-stabilization care services for persons who are Title XIX or Title XXI eligible. We are responsible for ensuring adherence to the following requirements, even in situations when the function has been delegated to a subcontracted provider.

Post-stabilization care services must be covered without authorization and reimbursement made to providers that furnish the services regardless of whether the provider has a contract with us for the following situations as per **R9-22-210**:

- Post-stabilization care services that were prior authorized by us
- Post-stabilization care services that were not prior authorized by us or because we did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval; or
- The treating physician and the Plan can't reach agreement concerning the member's care and a Plan physician advisor is not available for consultation. In this situation, we give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the member until a contracted physician is reached or one of the following criteria is met:
  - Physician with privileges at the treating hospital assumes responsibility for the person's care;
  - Physician assumes responsibility for the person's care through transfer;
  - The treating physician and we reach an agreement concerning the person's care; or

- The person is discharged.

6.7 TIME FRAMES FOR HEALTH PLAN PRIOR AUTHORIZATION REVIEW

[Defined by the AHCCCS Medical Policy Manual, Chapter 1000, Medical Management/Utilization Management: "Chapter Overview"; AHCCCS Contractor Operations Manual, Chapter 400, 414 – Requirements for Service Authorization Decisions and Notices of Adverse Benefit Determination and 42 CFR § 438.210 d1 and d2 (Code of Federal Regulations, Public Health section)].

- **"Standard"**: **up to 14 calendar days -** Standard means a request for which we 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* (see "*AHCCCS-required 14-day Extensions*" below) 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.
- **"Expedited": up to 72 hours**– Expedited means a request for which a provider indicates, or a Contractor determines using the standard time frame for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
  The ordering provider **must** sign the Expedited prior authorization request form to certify critical need. We must make an expedited authorization decision and provide notice as expeditiously as the member health condition requires, no later than 72 hours following the receipt of the authorization request, with possible extension*. (see "AHCCCS- required 14-day Extensions" below) 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."

Time frames for review of provider-administered medical drugs, please refer to Chapter 17: *Pharmacy and Drug Formulary*.

6.8 PRIOR AUTHORIZATION DETERMINATIONS

Prior authorization requests received with the correct and appropriate clinical documentation (and/or eviCore) will be processed and completed in one of the following standard methods:

1. **Approved** - The information received met all clinical documentation requirements to determine medical necessity to authorize the requested services. The requesting provider office is responsible for informing the member and provider (if applicable) that services have been authorized.
2. **Denied** - The information received did not meet all requirements, and authorization is not granted. The requesting Provider and member will receive a denial notification letter.
3. **14-day Extension-** In some instances where PA has been requested, the documentation received *may* suggest medical necessity exists for the service, but the records provided are insufficient to render an authorization. When this occurs, additional information may be

requested via fax or direct phone contact. When additional information cannot be obtained for us to meet AHCCCS mandated Expedited or Standard PA time frames, we will issue an AHCCCS-required "*Notice of Extension for Service Authorization*" (NOE) to both the member and the requesting provider,

This 14-day extension will afford both the requesting Provider and us up to 14 additional calendar days to obtain the additional information necessary to render a final determination. If at the end of the 14- day we haven't received the necessary additional information, the request will be denied, and both the Provider and member will be notified.

Note: The prior authorization decision will be issued no later than a total of twenty-eight (28) days for Standard requests or seventeen (17) days for Expedited requests from the date the PA request was received.

4. **Modified**: The information received met medical necessity requirements, but a partial authorization is granted. Requested services may be reduced when the documentation provided does not support the full amount, duration and/or scope of service at the time of request.
5. **Peer to Peer Consultation:** Providers may discuss a request's determination by requesting a Peer to Peer with a Medical Director if request is made within 72 hours of receiving the denial notification.

6.9 SUPPORTING DOCUMENTATION

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, Non-Formulary (NF) medication and/or non-preferred medication/product requests, specific information which explains the medical necessity for an OON, NF or non-preferred service is required. A PA is required for any service to be covered at OON providers/facilities. The OON provider/facility must be registered with AHCCCS.

6.10 PRE-SERVICE DENIALS

Members will be notified of an adverse benefit determination within 72 hours for Expedited requests, and within 14 *calendar* days for Standard request (excluding situations in which a 14-days extension is exercised). When an adverse determination is issued, the health plan must inform the member of the reason for denial in clearly understood language in the form of a "Notice of Adverse Benefit Determination" (NOA) letter.

Please be aware AHCCCS requires NOA letters to communicate the basis for a denial in "easily understood" language, therefore NOA letters will be written in a simplistic fashion to comply with this specific AHCCCS requirement. For more information about what a member can do if they receive an NOA, please see Chapter 15: *Claims Disputes, Member Appeals and Member Grievances*.

Written information which communicates an adverse benefit determination will also be sent to the requesting Provider (or their designee). Provider letters are sent to the Physician or Facility who initiated the request for prior authorization and will contain varying degrees of detail to explain the basis for denial.

Special considerations and information regarding Medical Prior Authorizations

- The Primary Care Provider (PCP) should initiate the prior authorization request (see Prior Authorization Grid).
- Members should be instructed not to self-refer to specialists without the express recommendation of their PCP.
- BCBSAZ Health Choice will provide notice of approval/denial within the allowable time frames via fax and/or phone to the requesting provider.
- If a service requires prior authorization and an authorization was not approved, or if the member was ineligible at the time of service, the claim will be denied.
- The authorization number or denial should be noted in the member's medical record.
- Prior Authorization approval number(s) should be provided BY the requesting provider TO the Specialist/Facility/Vendor PRIOR to the member's appointment.
- The Specialist, facility, or vendors are responsible to ensure necessary authorizations have been issued prior to rendering service.
- The PCP (or ordering Provider) is responsible to facilitate coordination of care and assist/alert the member to make the necessary appointments for approved services.
- When difficulty arises in coordinating and/or facilitating care, the referring provider should contact the plan for additional assistance.
- Authorization is NOT a guarantee of payment for services.
- Authorizations are valid for 90 days, except for Diabetic Supplies which are valid for 365 days. Some of the J codes are approved for longer than 90 days based on review.
- Contracted health professionals, hospitals, and other providers are required to comply with Prior Authorization policies and procedures.

6.11 INFORMAL RESOLUTIONS OF DENIALS

We use the following protocol to resolve issues regarding authorizations:

1. The requesting provider may resubmit a new prior authorization request with new/additional information pertinent to the original non-authorized request to the Prior Authorization Department.

Please note: Requests should only be resubmitted to the Plan PA Department IF new and/or additional, pertinent information is being provided with the resubmission.

2. The original information (denial packet) will be retrieved if necessary and combined with the current request which contains new/additional information and will be presented to

the Chief Medical Officer, Medical Director, or their designee for reconsideration.

3. If no new and/or additional information is received, the resubmitted request will be "Cancelled" (C) and the office notified by telephone, Email or FAX. New and/or additional information is needed to constitute a new prior authorization request. If the member wishes to file a formal appeal on a denied authorization, please refer them to their Member Handbook, Member Services, or Chapter 15 of this Provider Manual for details.
4. Providers may request a Peer to Peer with the Medical Director who denied their prior authorization request within 72 hours of the denial notification. After 72 hours the denial stands and the provider may resubmit a new request with additional information as referenced above or file an appeal.

6.12 BEHAVIORAL HEALTH SERVICES THAT REQUIRE PRIOR AUTHORIZATION AND CRITERIA

Services requiring prior authorization include but are not limited to the following:

- Non-emergency Out of Network request for services
- Non-emergency admission to and continued stay in a Behavioral Health Hospital or Sub-Acute Facility
- Admission to and continued stay in a Behavioral Health Inpatient Facility (BHIF) (Level I) for persons under the age of 21
- Behavioral Health Residential Facilities (SUD BHRF/BHRF)
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Therapeutic Foster Care (TFC)
- Adult Behavioral Health Therapeutic Homes (ABHTH)
- Some medications and prescribing practices

For a complete listing of services which require Prior Authorization (PA) please refer to the Prior Authorization Grid effective to the applicable date of service at www.HealthChoiceAZ.com. This "grid" can also serve as a reference guide and answer many questions which may arise, but which are not directly referred to in the chapter text.

A behavioral health professional is required to apply the designated authorization criteria and continued stay criteria to approve the provision of the covered service. 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, the Plan will reach out and attempt to gather the clinical information needed to decide. A decision to deny must be made by the Medical Director or physician designee. When appropriate, the Plan will provide a consultation with the requesting provider to gather additional information to make a determination. Before a final decision to deny is made, the person's attending behavioral health/medical practitioner can ask for reconsideration and present additional information.

Provider Denial Notifications

We provide written notification of behavioral health service denial to the member and requesting practitioner. The written denial notification contains the following:

- The specific reasons for the denial, in easily understandable language.
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based.
- A statement that the member can obtain a copy of the actual benefit provision, guidelines, protocol, or other similar criterion on which the denial decision was based, upon request.
- Termination, suspensions, or reduction of previously authorized Medicaid-covered services, we provide electronic or written advance notice to practitioners and members at least 10 days before the date of action. In cases of probable fraud, we may shorten to 5 days before date of action if:
    - We have facts indicating actions should be taken because of probable fraud by the member, **and**
    - The facts have been verified through secondary sources. if possible.

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, we must provide the person requesting services with a **Notice of Adverse Benefit Determination (NOA)** following:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service; and
- The denial in whole or in part, of payment for a service

The Notice must be provided in accordance with Chapter 15 of the Provider Manual: *Claim Disputes, Member Appeals and Member Grievances*.

How to Request Prior and Continued Authorization for Behavioral Health Services

Behavioral Health Inpatient Facility (BHIF) for persons under the age of 21.

- For all admissions, submit the completed Certificate of Need (CON) and the **BCBSAZ Health Choice BHIF, BHRF, TFC, and SUD-BHRF Prior Authorization and Continued Stay Request form.**
- For prior authorization request, the following documents are required:
    - Current Child and Adolescent Level of Care Utilization System (CALOCUS) reflecting current clinical presentation, or Early Childhood Level of Care Utilization System (ECSII) to demonstrate sufficient medical necessity for admission.
    - Psychiatric/Psychosocial Evaluation completed within the last 30 days.
    - Specialized testing e.g., ASD, SMB.
    - Current Treatment Plan indicating level of care being requested.
    - Most recent CFT indicating need for service requested.

All authorization requests must have an identified Licensed Attending/Treating Practitioner indicated on the request with a valid fax number.

- Prior authorizations for BHIF are valid up to 30 days. If placement is not secured within 30

days, the CFT/ART is required to submit a new updated authorization request describing current clinical presentation and treatment. The maximum days authorized per request is 30 days. Request should be faxed to (480)-760-4732.

For BHIF continued stay requests, submit the **Recertification of Need (RON)** and the BCBSAZ **BCBSAZ Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request form** seven days prior to the last authorized day.
Required Documentation:

- Monthly treatment summary
- Incident reports
- Updated medication lists
- Psychiatric Evaluation, testing, or other evaluation documentation
- Treatment Plan with measurable discharge goals and progress towards achievement
- Child and Adolescent Level of Care Utilization System (CALOCUS)

- All continued stay request are due seven days prior to last covered day.
- BHIF's are required to schedule follow-up appointment with the (PCP) and/or BHMP/specialist within seven business days of discharge. Please refer to our Provider Directory for a list of contracted providers.
- BHIFs are required to submit **BCBSAZ Health Choice Notification of Admission, Transfer, and Discharge Form and facilities DC summary** within 2 days of the event. Forms should be submitted by fax to (480) 760-4732 or BHAuthorizations@azblue.com.

Behavioral Health Residential Facilities/Substance Use Disorder Residential Facilities (BHRF) (SUD BHRF), Therapeutic Foster Care (TFC) and Adult Behavioral Health Therapeutic Homes (ABHTH)
For prior authorization request, the following documents are required:

- **BCBSAZ Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request form**.
- Current Child and Adolescent Level of Care Utilization System (CALOCUS) reflecting current clinical presentation, or Early Childhood Level of Care Utilization System (ECSII) to demonstrate sufficient medical necessity for admission.
- ASAM for members with a substance abuse or co-occurring disorder.
- Psychiatric/Psychosocial Evaluation completed within the last 30 days.
- Current Treatment Plan indicating level of care being requested.
- Most recent CFT/ART indicating need for service requested for non-SUD BHRF'S.

All authorization requests must have an identified Licensed Attending/Treating Practitioner indicated on the request with valid fax number.
Request should be faxed to (480)-760-4732.

Authorizations are valid up to 30 days. If placement is not secured within 30 days, the CFT/ART is required to submit a new authorization request. BHRF and SUD-BHRF authorizations are up to 45 days and TFC are up to 90 days.

- Continued stay requests **BCBSAZ Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request form** seven days prior to the last covered day.
    - Monthly treatment summary
    - Progress, nursing, and BHP/BHMP notes
    - Current medication list
    - Psychiatric Evaluation, testing, or other evaluation documentation
    - Treatment Plan with discharge goals and progress
- BHRF, SUD-BHRF and TFC are required to schedule follow-up appointments with the (PCP) and/or BHMP/Specialist within seven days of discharge. Please refer to our Provider Directory for a list of contracted providers.
- BHRF/TFC are required to submit BCBSAZ Health Choice Notification of Admission, Transfer, and Discharge Form within 2 days of an event. Forms should be submitted by fax to (480) 760-4732. Discharge notification shall provide dates and times for 7-day follow-up appointments with PCP/BHMP and/or specialist.
- BHRF providers are required to follow the rules outlined in AMPM Policy 320V Behavioral Health Residential Facilities, 320-W Therapeutic Foster Care for Children, and 320-X- Adult Behavioral Health Therapeutic Homes.

Electro-Convulsive Therapy (ECT) and Transcranial Magnetic Therapy

- Submit **BCBSAZ Health Choice Medical Services and Behavioral Health Prior Authorization Form** with supporting clinical documents supporting the medical necessity to fax (1-877-422-8120).

Out of Network Behavioral Health Services Requests

- We require prior authorization for all out of network providers.
- Fax the Prior Authorization Request Form and supporting documentation to (1-877-422-8120).

Additional Information

- All request forms are available on our website. Visit our **request forms** page.
- All requests must be fully completed with all supporting documentation.
- Authorization is not a guarantee of payment. The member must be eligible at the time the service was rendered.
- Discharge Planning begins within 24 hours of admission to a residential or inpatient facility. Please follow AHCCCS AMPM, Chapter 1000, and Section 1020 (Discharge Planning). This includes a follow-up appointment with PCP or specialist within 7 days, safe placement with community support, prescription medications, and medical equipment if needed.
- Providers can call after-hours for assistances at (877) 923-1400.

Medical Necessity Criteria

We apply objective and evidenced-based national, and state-recognized medical necessity criteria applied explicitly to the request included but not limited to InterQual Guidelines, AHCCCS approved Health Choice criteria and ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions, 3rd addition. All requests consider individual member circumstances and the local delivery system when making medical necessity determinations.

To obtain medical necessity criteria visit our website page "Clinical Guidelines/Medical Necessity Criteria or request by calling 1-800-322-8670. (TTY: 711).

Continued Stay When Medically Necessary Services Are Not Available at Discharge
If a person receiving inpatient services no longer requires services on an inpatient basis under the direction of a physician, but services suitable to meet the person's behavioral health needs are not available or the person cannot return to the person's residence because of a risk of harm to self or others, services may continue to be authorized as long as there is an ongoing, active attempt to secure a suitable discharge placement or residence in collaboration with the community or other state agencies as applicable. All such instances shall be logged and provided to AHCCCS upon request.

Institute for Mental Disease (IMD)*:*
A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical, nursing, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases [42 CFR 435.1010].

Members may utilize services provided in an Institute for Mental Disease (IMD). For members aged 21 through 64, Health Plans may reimburse an IMD provider so long as the member does not remain in the IMD for greater than 15 days in a calendar month, and only when the service provided in the IMD meets the requirements for in lieu of services at 42 CFR 438.3(e)(2)(i) through (iii).

We work closely with IMD facilities to ensure members don't exceed 15 inpatient days in a calendar month by the following: notifies the hospital of the number of IMD days, staffs the case with the BH Medical Director if member(s) exceeds 10 days, and assists with transfer to non-IMD facility if required.

6.13 RETROSPECTIVE REVIEWS

Services and corresponding data requiring retrospective review may include but are not limited to the following:

- Services performed during Prior Period of Coverage (PPC)

- Out of state services
- Outlier claims
- Services that were provided in an emergency
- Provider-Preventable Conditions; Healthcare Acquired Conditions

Medical Claim Review staff, in coordination with the Plan Medical Directors, determine medical necessity, quality of care, and the appropriateness of the medical setting. All retrospective reviews are conducted by a qualified nurse and Medical Director who were not involved in the prior authorization process and/or concurrent review process and are independent of any initial review.

We use clinical guidelines including but not limited to InterQual Level of Care Criteria and NCD/LCD as an adjunct for all retrospective reviews. The Medical Claim Review nurse reviews all available and applicable documentation (such as medical records and discharge information), to demonstrate medical necessity and appropriate level of care. Clinical decisions resulting from retrospective reviews are based on the presence of supporting documentation to establish medical necessity.

The Plan does not generally review requests for retrospective authorizations, as these are, by definition, contradictory. It is the responsibility of the Provider or Facility rendering care to verify insurance eligibility, as well as benefit coverage and/or authorization requirements/status and to notify us timely when rendering care/services to our members.

Providers/Facilities have the right to file a Claims Dispute if a claim is denied (see Chapter 15: *Claim Disputes, Member Appeals and Member Grievances*). If the Provider submits a claim which is denied for no PA being obtained, the claim can be grieved along with documentation of medical necessity and a basis for why PA was not obtained.

6.14 PROVIDER-PREVENTABLE CONDITIONS

We review claims In accordance with the AHCCCS AMPM, Chapter 1000 Medical Management, and 42 CFR Section 447.26 which prohibits payment for services related to Provider-Preventable Conditions. A Provider- Preventable Condition means a condition that meets the definition of a Health Care Acquired Condition (HCAC) or an Other Provider Preventable Condition (OPPC). These terms are defined as:

- **Healthcare Acquired Condition (HAC)** - means a Healthcare Acquired Condition under the Medicare program, except for Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission. (Refer to CMS for a listing of HACs).
- **Other Provider Preventable Condition (OPPC)** - means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:
    - Surgery on the wrong member
    - Wrong surgery on a member and

- Wrong site surgery

A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication." If it is determined the complication resulted from a Health Care Acquired Condition (HCAC) or Other Provider Preventable Condition (OPP), any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

If it is determined the HAC or OPPC was a result of mistake or error by a hospital or medical professional, BCBSAZ Health Choice conducts a quality-of-care investigation and reports the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

6.15 PROVIDER PORTAL

For your assistance, the "Provider Portal" area (listed under "For Providers" link drop-down) of our website allows Providers/Offices who become registered to log-in to our Provider Portal and utilize helpful features, such as:

- Checking member eligibility
  - Dental and Vision history
- Checking claims status
  - Claim reconsideration request and dispute/appeal submission
- Checking Prior Authorization Status
  - Submit Medical and Pharmacy prior authorization request
  - Submit Dental and Dental Specialty Referral prior authorization request
- Manage Provider Demographics

6.16 HOSPITAL SERVICES: INPATIENT AND OUTPATIENT SERVICES

All non-emergency hospital admissions, including Acute, Observation, Rehabilitation, Skilled Nursing, Level I Behavioral Health Inpatient Facility for <21yo, and Hospice require prior authorization.

All facilities must notify us and obtain an authorization prior to or at the time of ALL admissions. In the event acute hospitalization is required to evaluate and stabilize an Emergency Medical Condition, we **must be notified of the admission within one (1) calendar** day of emergent member presentation by faxing to the Inpatient Notification Fax Number: (480) 760-4732.

NOTE: For pre-planned, medically reviewed and/or prior-authorized admissions, the facility must notify us via fax at the time of admission to activate the authorization number **when the member presents for admission to the facility**. Inpatient Notification Fax Number: (480)760-4732.

We will request medical information and/or records to assist in deciding the appropriateness of the admission and level of care based on the clinical criteria. If the information is not received within a 24-hour period, the request will be administratively denied for lack of medical information. For concurrent reviews, the request will be made twice over 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. All hospital outpatient services listed on the prior authorization grid require a prior authorization.

> **NOTE**: All Outpatient Procedures must be performed at an in-network Ambulatory Surgical Center (ASC). Claims from locations other than an ASC will not be paid without an authorization. We will consider Prior Authorization requests for "medical necessity exceptions" where the provider believes a case must be performed in the hospital outpatient setting.

BCBSAZ Health Choice needs the following information in order to efficiently process an admission notification:

- Member Name
- Date of Birth
- Member ID
- Diagnosis
- Day and Time Admitted
- Medical Record Number
- Facility, including TIN or NPI
- Fax Number for Facility
- Admit type (e.g., Inpatient, Observation, Maternity, Behavioral Health)
- Face Sheet, if available.

We appreciate your continued commitment to ensuring the provision of effective and efficient care for our members.

6.17 PSYCHIATRIC INPATIENT HOSPITALIZATION

- For all initial concurrent and continued stay requests, submit the completed **Certificate of Need (CON) Prior Authorization and Continued Stay Request Form for Psychiatric Hospitals and Sub-Acute Facilities** and supporting documentation, within one business day of admission. For request forms, visit our website **request forms** page. All requests should be faxed to (480) 760-4732.
- Admission reviews are completed by Medical Management within one business day of notification (This does not apply to precertification). (**42 C.F.R. 456.125**.)
- Initial and continued stay authorizations are based on 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 a Medical Management Specialist prior to the end of the current authorization. Hospital UR staff are notified of 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.

- Reviews not meeting medical necessity guidelines are referred to a Medical Director or the physician designee for review.
- Clinical information for medical necessity review may include, but is not limited to:
  - 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
- Discharge Planning begins within 24 hours of admission to an inpatient facility. Please follow AHCCCS AMPM, Chapter 1000, and Section 1020 (Discharge Planning). This includes follow-up appointments with a Behavioral Health Medical Professional and PCP within 7 days of discharge, safe placement with community support, prescription medications, and medical equipment if needed. The Behavioral Health Medical Management Specialist works in concert with the hospital UR/social work staff to ensure the members post discharge needs are met including completing an assessment of post discharge needs and services, referrals to BH Care Management and programs, and assists with referrals and resources especially related to social determinants of health.
- Inpatient Facilities are required to schedule 7-day follow-up appointments with a PCP OR Behavioral Health Medical Professional (BHMP) prior to member's discharge.
- Inpatient Psychiatric Hospitals and Sub-Acute Facilities must submit a discharge notification or discharge and summary within 1 business day of discharge to fax (480) 760-4732.
- Authorization is NOT a guarantee of payment for services.

6.18 OBSTETRIC PACKAGE

Please see Chapter 16: *Family Planning, Maternal Health, and Children's Services* for information.

6.19 OUTPATIENT LABORATORY SERVICES

The BCBSAZ Health Choice Provider Network includes both LabCorp and Sonora Quest Laboratories to provide a full array of laboratory services, including reference and specialty. BCBSAZ Health Choice has specific lab services designated on the POLT (Provider Office Laboratory Testing) list for providers to perform in their office. Please refer to the prior authorization grid regarding laboratory services that require prior authorization.
In our ongoing efforts to ensure the provision of quality care and services for our members and to ensure that appropriate services are being rendered to our members, we ask that you utilize ONLY contracted providers.

Please reference below for service locations:

- LabCorp - www.labcorp.com
- Sonora Quest - www.sonoraquest.com

6.20 OPHTHALMOLOGY AND OPTOMETRY - *Special Coverage Instructions*

AHCCCS covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Vision examinations and the provision of prescriptive lenses are only covered for members under the Early and Periodic Screening, Diagnostic and Treatment Program (children under age 21), and for adults when medically necessary following cataract removal.

We currently have a statewide contract with **Nationwide Vision** to provide a full array of Optometry Services, within their scope of practice and as defined by the Arizona State Board of Optometry. Eligible patients should be directed to Nationwide Vision for initial screening examinations. For adults (>age 21) optometry services are generally not covered. Ophthalmological services are only covered for emergency medical eye conditions and cataract extractions.

Nationwide Vision provides the following services:
- Annual screening diabetic retinal exams
- All exams/corrective lenses for EPSDT-aged members (members under age 21)
- Dilated fundus examinations
- Visual field testing
- Glaucoma testing
- Evaluation and treatment of conjunctivitis
- Evaluation of cataract
- Allergy and dry eye treatment

Please visit **www.nationwidevision.com** for additional details.

6.21 DURABLE MEDICAL EQUIPMENT, INFUSION / ENTERAL THERAPY AND AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICES (AAC)

Requests for DME are to be sent directly to an in-network 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 doctor's order(s)/prescription.

Identify in-network DME providers in the Provider Directory
- Health Choice Arizona - Provider Search (healthchoiceaz.com)
- Health Choice Pathway - Provider Search (healthchoiceaz.com)

Augmentative and Alternative Communication Devices (AAC)

Augmentative and Alternative Communication Devices (AAC) and Speech Therapy providers who perform the evaluations for these devices. PCPs will assist members and refer to the appropriate providers who can conduct medically necessary evaluations and supply the devices.

Providers can reference the website for in-network Providers to refer for AAC evaluations and devices for members.

- Augmentative And Alternative Communication (AAC) - BCBSAZ Health Choice (healthchoiceaz.com)

Aveanna is the contracted service provider for Enteral Therapy services. Requests for Enterals and their DME (pumps, poles, syringes, bag systems, etc.) are to be directly faxed to Aveanna. Medical records documenting the medical necessity of the request must also be provided in addition to a current, signed provider order(s)/prescription. Aveanna will process the request and forward to us. We will complete the review for medical necessity. Once approved, we send the approval to Aveanna to coordinate with the requesting provider and/or member as needed to ensure delivery.

Submit the request to Aveanna via fax: 1-844-754-1345.

6.22 ORTHOTICS/PROSTHETICS

We have several contracted orthotics and prosthetic providers in the geographical areas we serve. T he requesting provider submits the request to us on a prior authorization form with the supporting clinical documentation.

6.23 PHARMACY AUTHORIZATIONS

Refer to Chapter 17: *Pharmacy and Drug Formulary*. You may also refer to the AHCCCS Medical Policy Manual Chapter 300, Policy 310-V.

6.24 IMPORTANT NOTICE TO ALL HEALTH CHOICE PROVIDERS

Participating providers must hold the Member, BCBSAZ Health Choice, and AHCCCS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to adhere to our prior authorization and notification guidelines as outlined in this chapter.

6.25 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those identified with Mental Illness (MI) and/or Intellectual Disability (ID) prior to initial admission of individuals to a nursing facility (NF) bed that is Medicaid certified or dually certified for Medicaid/Medicare (42 CFR 483.100-483.138, 42 CFR 438.112).

- PASRR Level I screenings are used to determine whether the person has any diagnosis or

other presenting evidence that suggests the potential presence of mental illness and/or Intellectual Disability.
- PASRR Level II evaluations are used to confirm whether the person indeed has MI and/or ID. If the person is determined to have MI and/or ID, this stage of the evaluation process determines whether the person requires the level of services in a NF and/or specialized services (inpatient/hospital psychiatric treatment).

Medicaid certified nursing facilities (NFs) must provide PASRR Level I screening, or verify that screening has been conducted, in order to identify MI and/or ID prior to initial admission of persons to a nursing facility bed that is Medicaid certified or dually certified for Medicaid/Medicare.

See also AHCCCS Medical Policy Manual (AMPM) Exhibit 1220-C, Pre-Admission and Resident Review (PASRR) and PASRR Level I Screening Document and instructions.

PASRR LEVEL 1 Screening

PASRR Level I screenings can be performed by the following professionals:
- Arizona Long Term Care System (ALTCS) Pre-Admission Screening (PAS) assessors, or case managers
- Hospital discharge planners
- Nurses
- Social workers
- Other NF staff that have been trained to conduct the Level I PASRR screening and make Level II PASRR referrals

ALTCS PAS assessors or case managers may conduct Level I PASRR screenings, but it is the responsibility of the facility where the member is located to ensure that the Level I and Level II PASRR is completed prior to the member being admitted into the receiving NF. The PASRR Level I must be completed by medical professionals such as hospital discharge planners, nurses, or social workers.

A PASRR Level I screening is not required for readmission of persons who were hospitalized and are returning to the NF, or for inter-facility transfers from another NF, if there has not been a significant change in their mental condition. The PASRR Level I screening form and PASRR Level II evaluation must accompany the readmitted or transferred person.

A PASRR Level I screening is not required if a person is being admitted to a NF for a convalescent period, or respite care, not to exceed 30 days. If later it is determined that the admission will last longer than 30 days, a new PASRR Level I screening is required. The PASRR Level II evaluation must be done within 40 calendar days of the admission date.

Review

Upon completion of a PASRR Level I screening, documents are forwarded to the AHCCCS PASRR Coordinator for a Level II evaluation of MI at PASRRProgram@azahcccs.gov. The DES PASRR Coordinator shall be contacted for Level II PASRRs of ID.

The outcome of the Level II PASRR will determine action to be taken by the NF. If the individual requires NF services, he/she may be admitted. All ALTCS enrolled members are appropriate for a nursing level of care as determined by the ALTCS Pre-Admission Screening (PAS) tool for medical eligibility. If a member is admitted and is determined to need specialized services, the NF should contact the member's case manager to arrange for the required services. If the outcome of the Level II PASRR determines the individual does not require NF services or specialized services, no admission shall take place.

Determinations may be conveyed verbally to nursing facilities and to the individual and must be confirmed in writing.

The need for specialized services for individuals with an ID as specified by DES will result in the implementation of an individualized treatment plan that:

- Allows the acquisition of skills necessary for the ALTCS individual to function as independently as possible, and
- Prevents or decreases regression or loss of the ALTCS individual's current optimal level of functioning

The need for specialized services for individuals with a MI as the result of a Level II PASRR evaluation will result in the implementation of an individualized treatment plan that:

- Is developed and supervised by an interdisciplinary team composed of a physician, qualified behavioral health professionals, and other professionals
- Prescribes specific therapies and services for the treatment of ALTCS individuals experiencing an acute episode of mental illness which requires intervention by trained behavioral health personnel
- Reduces the individual's behavioral symptoms and improves the individual's level of functioning

If the individual's mental health condition changes, or new medical records become available that indicate the need for a Level II PASRR, a new Level I screening must be completed as soon as possible and a referral made.

Any individual can request a hearing when he or she believes the State has made an erroneous determination regarding the preadmission and annual resident review requirements of section 1919(e)(7) of the Act. The AHCCCS rules for the administrative dispute resolution process are delineated in A.A.C. Title 9, Chapter 34.

PASRR LEVEL II Evaluations for Mental Illness

When Health Choice receives a PASRR Level II request from AHCCCS, the Plan will determine which health home should be assigned based on where the member is currently located, not where the member may be enrolled.

- The PASRR Level II for individuals with MI must be completed within 5 business days of the referral.

The PASRR Level II evaluation report must include the components of the PASRR level II Form (**Level II PASRR Psychiatric Evaluation**) and the **Pre-Admission Screening and Resident Review (PASRR) Invoice**.

- *Preexisting data.* Evaluators may use relevant evaluative data, obtained prior to initiation of preadmission screening or annual resident review, if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, to supplement and verify the currency and accuracy of existing data, the State's PASRR program may need to gather additional information necessary to assess proper placement and treatment. (42 CFR 483.128)
- Personnel requirements (Per 42 CFR 483.134).
    - A Behavioral Health Medical Practitioner completes the PASRR psychiatric evaluation
    - If the history and physical examination are not performed by a physician, then a physician must review and concur with the conclusions.

Cease Process and Documentation

If at any time in the PASRR process it is determined that the person does not have a MI or ID, or has a principal/primary diagnosis identified as an exemption in the Level I screening (primary diagnosis of dementia including Alzheimer's Disease or a related disorder or a non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness, and does not have a diagnosis of ID or a related condition), the evaluator must cease the PASRR process of screening and evaluation and document such activity.

Appeal and Notice Process Specific to PASRR Evaluations

Appeals shall be processed, consistent with the requirements in **Title XIX/XXI Notice and Appeal Requirements, under Chapter 15.4.1**) or the appeal process for members determined to have a SMI described in **SMI and Non-SMI/Non-Title XIX/XXI, above under 15.4.2**

For individuals who have a Serious Mental Illness (SMI) designation, appeals shall be processed in accordance with A.A.C. R9-21-401 and ACOM Policy 444 (Contractors).

6.26 DENTAL AUTHORIZATIONS AND NOTIFICATIONS

See Provider Manual Chapter 20: *Oral Health Services.*

6.27 AFFIRMATIVE STATEMENT REGARDING INCENTIVES

Affirmative Statement regarding Incentives

We affirm:

- UM decisions are made based solely on appropriateness of care and service and existence of coverage.
- We do not specifically reward its peer clinical reviewers or clinical review staff for issuing denials of coverage or services.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.