CHAPTER 6:

Medical Policies and Prior Authorization

Reviewed/Revised: 09/24, 01/24, 5/25, 12/25

6.0 MEDICAL POLICIES OVERVIEW

For most commercial plans, Blue Cross® Blue Shield® of Arizona (BCBSAZ) or (AZ Blue Plans) uses many nationally recognized medical policy guidelines. This includes best-in-class, evidence-based criteria developed by eviCore, Change Healthcare InterQual®, American Specialty Health (ASH), and the National Comprehensive Cancer Network® (NCCN®). We also use policies developed by the BCBS Association and develop our own proprietary evidence-based criteria, based on emerging science and technology, medical literature, and credible clinical data. Please note: Blue Cross Blue Shield of Arizona Health Choice contracted vendor(s) may establish evidence-based criteria for services they provide or administer on our behalf.

Clinical Criteria Review
We review most clinical criteria applicable to Blue Cross Blue Shield of Arizona Health Choice-administered plans at least annually, and more often as new material data becomes available. Medical and scientific resources for these criteria include, but are not limited to:

- High-grade, published, peer-reviewed, medical, and scientific literature
- Expert specialty reviews
- Professional medical organizations' position statements to support determinations concerning such matters as medical necessity, procedural coverage, and benefit determination and development

Credible criteria must meet the following requirements:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the technology's effect on health outcomes.
- The technology must improve the patient's net health outcome.
- The technology must be as beneficial as any established alternative.
- The improvement must be attainable outside of the investigational setting.

Healthcare evidence reviews: Evidence Street®
Evidence Street is a proprietary, subscription-based web platform of the Blue Cross Blue Shield Association, dedicated to transparent, efficient healthcare evidence reviews. During certain review periods, healthcare products and pharmaceutical manufacturers may submit their peer-reviewed evidence for consideration.

Impact of changes in medical technology on claim coding and processing

Rapid changes in the practice of medicine and use of associated supporting technologies can sometimes impact claim adjudication. A procedure or diagnostic test may be considered eligible for coverage when applied in one way or to a particular diagnosis and not considered eligible for coverage when applied in a new way or for a different diagnosis because recognition of its efficacy in these new circumstances is still developing.

An existing CPT or HCPCS code may not accurately describe the combination of a procedure or diagnostic test and the corresponding utilization. Consequently, Blue Cross Blue Shield of Arizona Health Choice may inadvertently pay a claim that properly should have been denied as non-covered or excluded, and vice versa.

When Blue Cross Blue Shield of Arizona Health Choice receives information about a technology that is being considered for use in a new way, we assess that application for medical safety and efficacy. This assessment may result in a clarification to our clinical criteria. If so, that can result in denials of new claims for procedures that were previously paid or payment of new claims for procedures that were previously denied.

6.1 MEDICAL POLICIES - ACCESS

How to access medical policies

TYPE OF PLAN	HOW TO ACCESS MEDICAL POLICIES
ACA StandardHealth with Health Choice Plan	https://www.azblue.com/medicaid/providers/clinical-guidelines https://www.azblue.com/provider/resources/prior-authorization-and-medical-policies
BCBSAZ Commercial Plans	Access the following resources in the azblue.com secure provider portal at "Practice Management > Medical Policies" • eviCore Guidelines • InterQual criteria • BCBSAZ Proprietary Policies • Site-of-Service Requirements (for certain medications) • ASH Chiropractic Guidelines • Pharmacy Coverage Guidelines If you can't find policies by accessing the above resources, call 602-864-4614

	Check the back of the member ID card for utilization management information
BlueCard® (Out-of-Area) Plans	Access the BlueCard medical policy router tool in the azblue.com secure provider portal at "Practice Management > Medical Policies" • fepblue.org/legal/policies-guidelines • EviCore guidelines • BCBSAZ proprietary policies

6.2 PRIOR AUTHORIZATION OVERVIEW

Prior authorization is not a guarantee of payment

Prior authorization is the process Blue Cross Blue Shield of Arizona Health Choice uses to determine a member's eligibility for a requested procedure or service before the service is rendered. Authorization decisions are based on the member's eligibility, condition, specific benefit plan, and any related evidence-based clinical criteria and pharmacy coverage guidelines.

Regardless of prior authorization decisions, patient care decisions are made between the provider and patient. The fact that a provider has prescribed, ordered, recommended, or approved a service or supply does not make it medically necessary or make the service eligible for benefits, even though it is not expressly excluded in the member's benefit book.

Prior authorization requirements

Prior authorization is required for all scheduled inpatient admissions and certain outpatient procedures, services, items, and medications. For provider reference, we post prior authorization requirements online. Refer to the ACA StandardHealth with Health Choice prior authorization grid for the most updated list of services requiring prior approval. This "grid" can also serve as a reference guide and answer questions not directly referred to in the chapter text. Submit Prior Authorization requests through our Secure Provider Portal or fax the Prior Authorization form found on our website. PA Guidelines | ACA StandardHealth Health Choice

Some plans use other requirements, including:

- BlueCard (out-of-area) plans are governed by the member's BCBS Plan.

Prior authorization process

Prior authorization must be requested *before* the service is rendered. The review typically considers:

- Member eligibility and benefit coverage, including contract limitations, exclusions, waiting periods, waivers, or benefit maximums that apply to the requested service or procedure
- Provider network status and any site-of-service requirements
- Medical necessity of procedures or treatments based on applicable clinical standards and

criteria
- The use of procedures or items that might be considered experimental or investigational

Note: Even if a service has been authorized and rendered, all benefit plan provisions (e.g., eligibility, waiting periods, limitations, exclusions, waivers, and benefit maximums) still apply, even if they weren't readily determinable at the time prior authorization is given.

Inpatient care requires notification and/or prior authorization
All our benefit plans require notification and/or prior authorization for all scheduled and unscheduled inpatient admissions and continued stays. For plan-specific information and time frames, check eligibility and benefits, and refer to the prior authorization requirement resources.

Transfers to different levels of care require prior authorization
If a member is moved or transferred between different levels of inpatient care, even within the same facility, the member's cost-share obligation may change to match that level of care. Since prior authorization is required for all non-emergency inpatient care, a new authorization must be obtained before the member begins receiving a different level of inpatient care.

Notifications and prior authorization requests
Any provider may request prior authorization for services requiring prior authorization. Most notifications and requests can be made online.

We require the following information to process a notification or prior authorization request:
- Member/subscriber name, date of birth, and ID number
- Provider name(s), NPI, specialty, and contact information
- Date, type, and place of service
- Applicable procedure(s) and procedure code(s)
- Applicable diagnoses and diagnosis code(s)
- Other relevant information specific to the request

Penalties
For most BCBSAZ and BlueCard (out-of-area) commercial benefit plans, BCBSAZ will assess a $500.00 penalty to the servicing network provider for failure to obtain prior authorization for services requiring prior authorization as per the member's benefit plan. For facility-related prior authorization requirements (such as inpatient admissions, SNF, EAR, and LTAC), the penalty applies to the facility and not the professional provider. Providers considered in-network for the member's benefit plan may not bill the member for this penalty amount.

Exception: For members with commercial PPO plans, a penalty may be applied to the member when the rendering provider is out-of-network, and a required prior authorization was not obtained.

To avoid unnecessary penalties, ensure all required prior authorization is obtained *before* servicing the member. If you have received prior authorization, include the identifier on your claim submission.

Out-of-network referrals require prior authorization
Blue Cross Blue Shield of Arizona Health Choice network providers must refer members only to contracted providers considered in-network for the member's benefit plan. When non-emergency covered services are not reasonably available within the member's specific network, prior authorization is required for the use of an out-of-network provider. The referring provider must also advise the member of non-network status (except in emergency situations).

If Blue Cross Blue Shield of Arizona Health Choice authorizes an exception:

- **Members with HMO plans** are covered for the authorized out-of-network service and held harmless against any balance billing.
- **Members with PPO plans** have an out-of-network benefit with higher out-of-pocket costs. The approved prior authorization will give the member the in-network coinsurance and deductible. The member is still responsible for any balance bill, unless within scope for the balance billing protections in the No Surprises Act (NSA).

Prior authorization requirements for medications
For medications covered under the **retail/mail-order pharmacy benefit:**

- For commercial plans, you can access detailed information at azblue.com/Pharmacy.

For medications covered under **medical benefits**:

- For commercial plans, prior authorization requirements are included in the Blue Cross Blue Shield of Arizona Health Choice prior authorization code lists, available in the azblue.com secure provider portal at "Practice Management > Prior Authorization."

6.3 PEER-TO-PEER REQUESTS

Peer-to-Peer Conversations
A Blue Cross Blue Shield of Arizona Health Choice peer-to-peer conversation is a one-on-one discussion between a medical director or clinical advisor and a treating physician (e.g., M.D., D.O.), nurse practitioner (N.P.) or physician assistant (P.A.). These phone conversations are intended to help you understand how we determine if medical necessity criteria have been fully met.

Here are the guidelines:

- **For our commercial plans,** a peer-to-peer conversation is about an adverse medical necessity decision on a prior authorization request that was submitted ***before*** the service was rendered. You must request the peer-to-peer conversation within seven calendar days of the date on the prior authorization denial letter and ***before*** initiating the member appeal process.

How to prepare for a Peer-to-Peer conversation
Peer-to-Peer conversations focus on medical necessity. The following steps will help you determine if a peer-to-peer conversation is appropriate and how to prepare:

- Access to the clinical criteria for the service or procedure.
- Review the clinical criteria to check for applicable indications for the patient's condition or illness.
- Check to see if the criteria for the applicable indications have been met or mostly met.
- Check to see if the submitted medical records document that criteria are met.

Situations that are not eligible for a Peer-to-Peer conversation
Below are some common situations and topics that do *not* qualify for a peer-to-peer conversation:

- Benefit plan exclusions and non-covered benefits; examples of this would be dosing outside the FDA-recommended doses, out-of-network services, and services and items considered experimental or investigational
- Retrospective reviews where prior authorization was required but not obtained prior to the services being rendered

Denied claims—for any reason

- Active, denied, or upheld member appeals—for claims or prior authorization
- Decision about credentialing or waivered conditions
- BCBSAZ clinical criteria
- Requests received after seven calendar days from the prior auth denial letter receipt date

How to request a Peer-to-Peer conversation
For ACA StandardHealth with Health Choice members, call us at 1-800-322-8670.

Member appeals
A member appeal/reconsideration process is available if a prior authorization request for a service or procedure is not approved.

6.4 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 health needs have been met. If upon review of the circumstances, the health 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.

6.5 PRIOR AUTHORIZATION DETERMINATIONS

Prior authorization requests submitted with the correct and appropriate clinical documentation 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 requirements, and authorization is not granted. The requesting Provider and member will receive a denial notification letter.
3. **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.

6.6 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. ,

6.7 PRE-SERVICE DENIALS

Members will be notified of an adverse benefit determination within 72 hours for Expedited requests, and within 7 *calendar* days for Standard request (excluding situations in which a 14-day extension is exercised). When an adverse determination is issued, the health plan must inform the member of the reason for denial in the form of a "Notice of Adverse Benefit Determination" (NOA).

Written information that communicates an adverse benefit determination will also be sent to the requesting Provider (or their designee). Provider letters are sent to the Provider 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.
- We 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.

6.8 BEHAVIORAL HEALTH SERVICES PRIOR AUTHORIZATIONS

Blue Cross Blue Shield of Arizona Health Choice does not require prior authorization for most behavioral health services. Refer to the ACA StandardHealth with Health Choice prior authorization grid for the most updated list of services requiring prior authorization. This "grid" can also serve as a reference guide and answer questions not directly referred to in the chapter text.

The following services always require prior authorization: Behavioral Health Inpatient Facilities for persons under 21(BHIF/RTC), Behavioral Health Residential Facilities (BHRF), Electroconvulsive Therapy (ECT), Transcranial Magnetic Therapy (TMS), and out-of-network requests.

All prior authorization requests must be completed fully with all supporting documentation. For a copy of the Prior Authorization request form, visit our request forms page on the ACA StandardHealth with Health Choice website. BHIF, BHRF, ECT, and TMS authorization requests with supporting documents should be faxed to (480) 760-4732. Out-of-network prior authorization requests for Electroconvulsive Therapy (ECT), Transcranial Magnetic Therapy (TMS), and outpatient services should be faxed to 1-877-422-8120 using the Medical Service and Behavioral Health Prior Authorization form. For BHIF and BHRF, out-of-network requests should be faxed to (480) 760-4732.

To request additional days for Behavioral Health Inpatient Facilities (BHIF/RTC) and Behavioral Health Residential Facilities (BHRF), fax the request form and supporting documentation to (480) 760-4732 within one day of the last covered day.

Blue Cross Blue Shield of Arizona Health Choice requires admission and discharge notification for Behavioral Health Inpatient Facilities (BHIF) and Behavioral Health Residential Facilities (BHRF) within one day of discharge.

6.9 RETROSPECTIVE REVIEWS

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

- 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 utilize clinical guidelines including but not limited to InterQual Level of Care Criteria and NCD/LCD as an adjunct for all retrospective reviews. The Medical Claims 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.

6.10 PROVIDER-PREVENTABLE CONDITIONS

We review claims in accordance with 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.

6.11 PROVIDER PORTAL

For your assistance, the "Provider Portal" (listed under "For Providers" link drop-down) of the Blue Cross Blue Shield of Arizona Health Choice website allows Providers/Offices who become registered to log into the secure Provider Portal and utilize helpful features, such as:

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

6.12 HOSPITAL SERVICES: INPATIENT AND OUTPATIENT SERVICES

All non-emergency hospital admissions, including Acute, Observation, Rehabilitation, Skilled Nursing, and Hospice require prior authorization.

All facilities must notify us and obtain 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 admission to the facility**. Inpatient Notification Fax Number: (480)760-

4732.

We prefer access to the facility EMR to conduct admission, concurrent, and discharge planning reviews however, 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 24 hours, 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. Health Choice will consider Prior Authorization requests for "medical necessity exceptions" where the provider believes a case must be performed in the hospital outpatient setting.

6.13 PSYCHIATRIC INPATIENT HOSPITALIZATION

For all initial and continued stay requests, submit the Health Choice **Prior Authorization and Continued Stay Request Form for Psychiatric Hospitals and Sub-Acute Facilities** and supporting documentation, within one business day of admission. To obtain this form, 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).

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 the next review date. The facility is responsible for submitting updated clinical information by noon on the last authorized day. Reviews not meeting medical necessity guidelines are referred to a Medical Director for review.

Clinical information for medical necessity review may include, but is not limited to:

- Hospital records include, but not limited to history of presenting problem, diagnostic tests, psychiatric prescriber evaluations, psychosocial history, medication records, treatment plans, discharge needs and progress notes.

Discharge Planning begins within 24 hours of admission to an inpatient facility. This includes planning and scheduling follow-up appointments with a Behavioral Health Medical Professional and PCP. 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.

6.14 OBSTETRIC SERVICES

Refer to Chapter 16, *Maternal Health and Children's Services*, for information.

6.15 OUTPATIENT LABORATORY SERVICES

We contract with Laboratories to provide all laboratory services. Please refer to the prior authorization grid regarding laboratory services that require prior authorization. The use of a non-contracted Laboratory will require prior authorization.

ACA StandardHealth with Health Choice has labs designated on the (Provider Office Laboratory Testing (POLT) list for providers to perform in their office. Refer to our websites under 'Provider Notices' or 'Provider Education' for a complete listing of In-Office Laboratory Testing descriptions and CPT Codes.

POLT List: Education | ACA StandardHealth Health Choice

6.16 OPHTHALMOLOGY AND OPTOMETRY

We cover eye and optometric services by qualified professionals, based on member age and eligibility.

Our contracted Ophthalmology and Optometry providers offer cataract surgery, keratoconus treatment, and pediatric vision services.

Refer to Chapter 2: Member Eligibility and Member Services, the Benefits Guide for details about covered eye and vision services.

6.17 DURABLE MEDICAL EQUIPMENT

We have several contracted Durable Medical Equipment (DME) providers. Requests for DME are to be sent directly to us 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.

6.18 ORTHOTICS/PROSTHETICS

We have several contracted orthotics and prosthetic providers in the geographical areas we serve. Requests for customized orthotics/prosthetics must be sent to us by the requesting physician/provider on a prior authorization form with the supporting clinical documentation.

6.19 PHARMACY AUTHORIZATIONS

Refer to Chapter 17 *Pharmacy and Drug Formulary.*

6.20 AFFIRMATIVE STATEMENT REGARDING INCENTIVES

Affirmative Statement regarding Incentives

We affirm:

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