CHAPTER 17 PRIOR AUTHORIZATION REQUIREMENTS

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PURPOSE

This program description outlines the Prior Authorization (PA) process for Members enrolled with one of the Division's subcontracted health plans, those receiving Home Community Based Services (HCBS), and Members enrolled in the Tribal Health Program (THP).

DEFINITIONS

1. "Business Day" means Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
2. "Calendar Day" means every day of the week including weekends and holidays.
3. "Expedited Service Authorization Request" means a request for services in which the requesting provider indicates that following the standard timeframes for issuing an authorization decision could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function and requires the authorization decision within 72 hours from the receipt of the service request.
4. "Home and Community-Based Services" or "HCBS" as defined in A.R.S § 36-2931, means home and community based services that may be provided in a member's home, at an alternative residential setting as prescribed in A.R.S section 36-591 or at other behavioral health alternative residential facilities licensed by the department of health services and approved by the director of the Arizona health care cost containment system administration and that may include:

a. Home health
b. Licensed health aide services
c. Home health aide
d. Homemaker
e. Personal care
f. Adult day care
g. Habilitation
h. Respite care
i. Transportation
j. Home delivered meals
k. Other services or licensed or certified settings approved by the director.

In addition, Home and Community-Based Services may be provided in a member's home, in an adult foster care home as prescribed in A.R.S. section 36-401, in an assisted living home or assisted living center as defined in A.R.S. section 36-401 or in a level one or level two behavioral health alternative residential facility approved by the director by program contractors to all members who do not have a developmental disability as defined in A.R.S section 36-551 and are determined to need institutional services. Members residing in an assisted living center must be provided the choice of single occupancy. The director may also approve other licensed residential facilities as appropriate on a case-by-case basis for traumatic brain injured members.

5. "Legal Holiday" means, as defined by the State of Arizona, are:

a. New Year's Day - January 1
b. Martin Luther King Jr./Civil Rights Day - 3rd Monday in January
c. Lincoln/Washington Presidents' Day - 3rd Monday in February
d. Memorial Day - Last Monday in May
e. Independence Day - July 4
f. Labor Day - 1st Monday in September
g. Columbus Day - 2nd Monday in October
h. Veterans Day - November 11
i. Thanksgiving Day - 4th Thursday in November
j. Christmas Day - December 25

When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday.

6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "Notice of Extension" or "NOE" means a written notice to a Member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if criteria for a service authorization extension are met.
8. "Prior Authorization" or "PA" is a process that authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness and any applicable contract provisions.
9. "Provider" means any individual or entity contracted with the AdSS that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.

PROGRAM DESCRIPTION

A. PRIOR AUTHORIZATION REQUIREMENTS

1. The Provider shall confirm PA requirements on the AHCCCS, Division, or health plan website at the time of request for services.
2. The Provider, for Members enrolled in the Tribal Health Program (THP), shall confirm PA requirements with the AHCCCS/Division of Fee For Service Management (DFSM) at the time of request for services.
3. The Provider shall adhere to the oversight requirements put forth by the Division and its subcontracted health plans, including adherence to benefit coverage and timeliness of PA requests as outlined in Division Medical Policy 1020.

B. PRIOR AUTHORIZATION TIMELINES

1. The Provider shall complete standard PA requests within 14 calendar days of receipt of the PA request or as expeditiously as the Member's condition requires.
2. The Provider may issue a Notice of Extension (NOE) to extend the timeline by an additional 14 calendar days to request additional information to support the PA request.
3. The Provider shall process an Expedited Service Authorization Request as

expeditiously as the Member's health condition requires but no later than 72 hours from the receipt of the PA request.

a. If the PA request does not meet expedited criteria, the requesting provider will be notified and given the opportunity to provide additional clinical information to support the Expedited Service Authorization Request.

b. If the additional clinical information does not support an Expedited Service Authorization Request the PA request will be downgraded to Standard PA request and processed within the specified timelines.

4. The Provider shall process all PA requests for Behavioral Health Residential Facilities within the expedited timelines.

5. The Provider shall process Medication PA requests within 24 hours from the receipt of the request, regardless of the due date falling on a weekend or legal holiday.

a. If the PA request lacks sufficient clinical information to render a decision, then a request for additional clinical information shall be sent to the Provider no later than 24 hours after receipt of the original request.

b. In these cases, the Pharmacy Benefit Manager (PBM) will issue a final decision no later than seven business days from the initial receipt of the request.

c. Members are allowed a 4-day supply of a covered outpatient prescription drug to be provided in emergent situations while PA decisions are being made.

6. The Provider may request a Peer to Peer discussion with an AdSS' Medical Director when additional clinical information is requested or when the PA request is denied.

7. The Provider shall notify the requesting party of the PA decision by utilizing the requestor's preferred method of contact.

C. SUPPLEMENTAL INFORMATION

1. The Support Coordinator or District Nurse assesses and authorizes all HCBS through the Member's planning meeting process as outlined in

Division Medical Manual Chapter 1200 and Chapter 1600.

2. PA requirements can be located in the AHCCCS Medical Policy Manual (AMPM) Chapter 300 and 820.

3. PA may be required for the following services:

    a. Behavioral Health Residential Facility;
    b. Non-emergency Acute Inpatient Admissions;
    c. Level I Behavioral Health Inpatient Facility and RTC Admissions;
    d. Elective Hospitalizations;
    e. Elective Surgeries;
    f. Medical Equipment;
    g. Medical Supplies;
    h. Home Health;
    i. Home and Community Based Services (HCBS);
    j. Hospice;
    k. Skilled Nursing Facility;
    l. Medication;
    m. Therapies - Rehabilitative andHabilitative;
    n. Routine physical and behavioral health services;
    o. Nursing facility;
    p. Emergency alert system services;
    q. Rehabilitative andHabilitative Physical and Occupational Therapy for members 21 years of age and older;
    r. Behavior Analysis;
    s. Augmentative and Alternative Communication (AAC) services, supplies, and accessories;
    t. Non-Emergency Transportation;
    u. Other services as needed.

4. Services that may not require PA:

    a. Services performed during a Retroactive Eligibility Period;
    b. When Medicare or other commercial insurance coverage is primary;
    c. Emergency Medical Hospitalization that are up to 72 hours;
    d. Emergency Admission to Behavioral Health Level 1 Inpatient facility;
    e. Some Diagnostic procedures;;
    f. Dental Care - emergency and non-emergency;
    g. Eyeglasses for members up to 21 years of age;
    h. Family Planning Services;

i. Physician and Specialty Consultations and Office Visits;
j. Prenatal Care;
k. Emergency Transportation;
l. Non-Emergency Transportation up to 100 miles.

5. AHCCCS registered Providers are required to use the provider online portal.

6. The contact for Mercy Care is as follows:

   a. Online - https://www.mercycareaz.org/dd
   b. Telephone numbers:
      i. Toll Free: 1 (800) 624-3879;
      ii. 24-hour Nurse Line: 1 (800) 624-3879 or
      iii. TTY/TDD (602) 263- 3000 option 2;
      iv. CoverMyMeds toll free: (866) 452-5017;
      v. SureScripts toll free: (866) 797-3239
   c. Fax number - 1-800-854-7614.

7. The contact information for United Healthcare Community Plan is as follows:

   a. Online - https://www.uhc.com/communityplan/arizona/plans/medicaid/developmental-disabilities
   b. Telephone number - 1-800-348-4058
   c. 24-hour Nurse Line: 1-877-440-0255

8. The contact information for the Tribal Health Plan (THP) is as follows:

   a. Address:
      AHCCCS Division of Fee for Service Management,
      Care Management Systems Unit,
      Mail Drop 8900,
      801 East Jefferson, Phoenix, AZ 85034

   b. Website: https://azweb.statemedicaid.us/Account/Login
   c. Telephone numbers:
      i. Toll Free In-state: 1 (800) 433-0425
      ii. Toll Free Out of state: 1 (800) 523-0231
      iii. Phoenix area: 1 (602) 417-4400
      iv. Prescription Medications: OptumRx 1-855-577-6310

v. 24-hour Nurse Line 480-267-7267