



Health Choice Arizona PRIOR AUTHORIZATION GUIDELINES

It is with great pleasure that Health Choice provides services for members who live in the following counties:

Maricopa, Pima, Santa Cruz, Yuma, La Paz, Apache, Coconino, Mohave and Navajo

Additional information is available at our website:

www.HealthChoiceAZ.com



Prior authorization requests may be submitted to these numbers:

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| <p>Medical Services 1- 877- HCA - 8120 (fax) 1- 877 - 422 - 8120 (fax)</p> | <p>Pharmacy Benefits 1- 877- HCA - 8130 (fax) 1- 877- 422 - 8130 (fax)</p> |
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| <p>Imaging Services and Select Cardiac Testing and Procedures MedSolutions (MSI), Intelligent Cost Management</p> <p>On-line Provider Portal http://www.medsolutionsonline.com Phone 1-888-693-3211 Fax 1-888-693-3210</p> |
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Please see **Attachment A** for the full listing of CPT and HCPCS codes which require Prior Authorization. Please see **Attachment B** for the full listing of CPT codes which require Prior Authorization if not performed at an ASC.

To check on the status of a prior authorization, use the HCA Provider Portal at www.healthchoiceaz.com. For imaging and cardiac testing or procedures authorized by MedSolutions, use <http://www.medsolutionsonline.com> OR call 1-888-693-3211

Time sensitive requests which cannot wait up to 72 business hours due to a medical reason, or to obtain additional assistance, call Health Choice Arizona at 1-800-322-8670

Please refer to the HCA Authorizations and Referrals Chapter 6 (www.HealthChoiceAZ.com) of the Provider Manual for additional details regarding authorizations and PA submission forms. (The AHCCCS Medical Policy Manual (www.azahcccs.gov) gives more details on AHCCCS-covered/excluded services).

The following directives apply to ALL Health Choice Prior Authorizations

- ✓ Authorizations are valid for 90 days from the date issued. Exceptions apply.
- ✓ Only one Medical/Pharmacy service may be requested per PA form
- ✓ HCA does not perform prior Authorization for Emergency Services.
- ✓ The member must be eligible at the time the covered HCA service is rendered.

All routine services rendered by non-contracted providers require prior authorization.



Primary Care Physicians (PCP) Services

Only those services listed in Attachment A require prior authorization. Please refer to the HCA Formulary for preferred prescription medication; see also the Pharmacy section of this guideline for injections that require authorization. **All unlisted, “by report”, and temporary codes require prior authorization.**

Specialist Consultations and Follow-up Care

Only the specialty services listed below require authorization for consultative and/or follow-up services. If the specialty is not listed, authorization is not required.

All codes listed in **Attachment A** require prior authorization.

| Specialty | Consultation | Follow-up Visits |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Allergy and Immunology | Yes for age 0-20 | Yes for age 0-20 PA needed for allergy testing for members age > 21 |
| Behavioral Health (i.e. Psychology; Psychiatry) | Special Instructions: Refer member to the Regional Behavioral Health Authority (see Exhibit 18-2) | |
| Cardiology | Yes for age 0-20 | Yes for age 0-20 |
| Chiropractic | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 |
| Dental | For members age 0-20: Refer to the HCA Dental Matrix (Exhibit 6-7) For members 21 and older HCA determines payment coverage after performing a retrospective claim and medical record review based on AHCCCS limited adult dental services. | |
| Dermatology | Yes for ALL ages | Yes for ALL ages |
| Developmental Pediatrics | Yes for ALL ages | Yes for ALL ages |
| Endocrinology | No for ALL ages | Yes for age 0-20 |
| ENT / Otolaryngology | No for ALL ages | Yes for age 0-20 |
| General Surgery | No for ALL ages | Yes for age 0-20 PA needed for Bariatric Surgical Consultations and Procedures |
| Genetics/Genetic Testing | Yes for ALL ages | Yes for ALL ages |
| GI/Gastrointestinal | No for ALL ages | Yes for age 0-20 |
| Maternal Fetal Medicine | Yes for ALL ages | Yes for ALL ages |
| Neurology | No for ALL ages | Yes for age 0-20 |
| Neurosurgery | No for ALL ages | Yes for age 0-20 |
| Neuropsychiatry | Yes for ALL ages | Yes for ALL ages |
| Nutritional Education/Dietician | Yes for age > 21 | Yes for ALL ages |
| Obstetrics | Special Instructions: PA needed for Total OB Packages | |



| | PA needed for Pregnancy Termination (and per AHCCCS guidelines) | |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------|
| Occupational Therapy | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 | Yes for ALL ages Not an AHCCCS covered benefit for age > 21 |
| Ophthalmology and Retinal Optometry (<i>Nationwide Vision Centers and Affiliates</i>) | No for ALL ages Referral Form (see Exhibit 6-8.A and 6-8.B) | Yes for ALL ages No for ALL ages Referral Form (see Exhibit 6-8.A and 6-8.B) |
| Oral and Maxillofacial surgery | Yes for ALL ages | Yes for ALL ages |
| Orthopedics | No for ALL ages | Yes for age 0-21 |
| Pain Management | Yes for ALL ages | Yes for ALL ages |
| Physical Medicine & Rehab | Yes for ALL ages | Yes for ALL ages |
| Physical Therapy | Yes for ALL ages (* Limited to 15 visits per year for age > 21) | Yes for ALL ages (* Limited to 15 visits per year for age > 21) |
| Plastic & Reconstructive and Hand Surgery | Yes for ALL ages | Yes for ALL ages |
| Podiatrists (Doctors of Podiatric Medicine) | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 |
| Pulmonology | No for ALL ages | Yes for age 0-20 |
| Rheumatology | No for ALL ages | Yes for age 0-20 |
| Speech Therapy | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 |
| Transplant Services | Yes for ALL ages | |
| Urology | No for ALL ages | Yes for age 0-20 |
| Wound Care Centers | Yes for ALL ages | Yes for ALL ages |

Imaging and Select Cardiac Testing and Procedures

All “high-tech” radiology services (MRI, MRA, CT and PET), as well as both general and obstetrical ultrasounds, require prior authorization. Nuclear cardiac stress testing, echocardiography, and heart catheterizations also require prior authorization. The full listing of service codes are identified in **RED** text within **Attachment A** below. Prior Authorizations for these services must be obtained through the MedSolutions (MSI) on-line web portal (<http://www.medsolutionsonline.com>), by phone 1-888-693-3211 or by fax 1-888-693-3210. The MSI prior authorization forms for each type of service request are available on the web portal and can also be requested by calling MSI.

NOTE - ALL MedSolutions Expedited requests, or requests for multiple (recurring) units of an Obstetrical test, MUST be performed by phone: 1-888-693-3211.



Ancillary Services and Durable Medical Equipment

The following ancillary services require prior authorization for **each service**.

| Service | Prior Authorization and Special instructions |
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| Automated Implantable Cardiac Defibrillators and Bi-Ventricular ICD | Yes for ALL ages |
| Bone Anchored Hearing Aids | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 |
| Bone Growth Stimulators | Yes for ALL ages |
| Cardiac Rehabilitation | Yes for ALL ages ONLY when >36 sessions are requested/provided per AHCCCS calendar year |
| Cochlear Implants | Yes for age 0-20 Not an AHCCCS covered benefit for age > 21 |
| Durable Medical Equipment | All requests should be submitted to Preferred Homecare |
| Enhanced External Counterpulsation | Yes for ALL ages |
| Hearing Aids | Not an AHCCCS covered benefit for age > 21 |
| High Frequency Chest Wall Oscillation vests | Yes for ALL age 0-21 Not an AHCCCS covered benefit for age > 21 |
| Home Health | Yes for ALL ages |
| Home Infusion | Yes for ALL ages (use Preferred Home Care) |
| Hyperbaric Oxygen (HBO) | Yes for ALL ages |
| Implanon | Yes for ALL ages |
| Incontinence briefs | AHCCCS covers briefs for persons over age 3 and under age 21 as described in AHCCCS Policy 430. |
| Insulin Pumps (new) | Yes for ALL age 0-20 Not an AHCCCS covered benefit for age > 21 |
| Negative Pressure Wound Therapy | Yes for ALL ages |
| Neurologic Stimulation Devices (i.e. Deep brain/Spinal cord stimulators; Sacral/Vagal nerve stimulators) | Yes for ALL ages |
| Nutritional support services | Preferred Home Care [i.e. TPN; non-WIC infant formulas; supplements] |
| Obstetrical support services | Alere (Matria) Homecare |
| Orthotics * <u>Submit to HCA contracted provider</u> * | Yes for ALL ages Not an AHCCCS covered benefit for age > 21 with the following exceptions: L0859; L0861; L0980; L0982; L0984; L2810; L2840; L2850; L4000; L4002; L4010; L4020; L4030; L4060; L4070; L4080; L4090; L4100; L4110; L4130; L4205; L4210; L4392; L4394. |
| Prosthetics | Yes for ALL ages |
| Prescriptive lenses (eye glasses) | No for age 0-21, single pair per year, Nationwide Vision Not an AHCCCS covered benefit for age > 21 except if medically necessary following cataract removal (requires authorization) |
| Phototherapy | Yes for ALL ages |
| Pulmonary Rehabilitation | Yes for ALL ages ONLY when >12 sessions are |



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| | requested/provided per AHCCCS calendar year |
| Polysomnography / MSLT | Yes for ALL ages |
| Wearable Cardiac Defibrillator | Yes for ALL ages |

Inpatient Services Requiring Prior Authorization

All hospital admissions, including Acute, Observation, Rehabilitation, Long Term Care and Skilled Nursing Facilities (Hospice is not an AHCCCS covered benefit for age > 21) require prior authorization.

All facilities must notify HCA and obtain an authorization prior to, or at the time of, ALL admissions. Plan authorization and/or notification is accepted and approved by the HCA Medical Services PA Department.

In the event that acute inpatient hospitalization services delivered are to evaluate and stabilize an Emergency medical condition, concurrent plan notification/authorization is not required for payment for medically necessary, AHCCCS-covered services. However, the plan must be notified of emergent inpatient services within 10 calendar days of emergent member presentation. HCA strongly recommends that plan notification from the facility occur as quickly as possible to help guarantee full coverage of medical services rendered.

NOTE: For pre-planned, medically reviewed and/or prior-authorized admissions, the facility must call HCA at the time of admission to activate the authorization number when the member presents for admission to the facility.

Outpatient Services Requiring Prior Authorization

All codes listed in Attachment A require prior authorization. When authorization is obtained by the requesting provider, no plan notification is required.

NOTE: All Outpatient Procedures listed on **Attachment B** 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 - HCA will entertain Prior Authorization requests for “medical necessity exceptions” where the Provider believes a case must be performed in the Hospital Outpatient setting.

These services are approved through the HCA Medical Services PA Department.

Pharmacy

Providers should utilize the HCA listing of preferred medication selections (see the www.HealthChoiceAZ.com website under “Formulary”).

Specialty medications – HCA utilizes CuraScript as our specialty drug provider, with few exceptions. Oral specialty drugs (i.e. Tarceva; Gleevec) must also be provided by the HCA contracted PBM. For “single source” specialty drugs that utilize ‘hub’ specialty drug provider, submit for PA and/or contact the HCA Pharmacy Services department.

Note: For Synagis (palivizumab) requests the Provider must utilize the HCA contracted service providers (generally Los Ninos Maricopa and Pima counties and central Flagstaff; Cura Scripts for all other counties). Please utilize the HCA coverage criteria and dedicated PA form (see Exhibit 16-6).



“Specialty” medications (injectable; infusion; implant) which may be provided in a contracted Provider office when Prior Authorization is first obtained

| Medication description | J Code |
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| ADALIMUMAB (HUMIRA) | J0135 |
| AGALSIDASE, 1 MG (FRABRAZYME) | J0180 |
| ALGLUCERASE, 10 UNITS (CEREDASE) | J0205 |
| 17 ALPHA-HYDROXYPROGESTERONE CAPROATE (GESTIVA) | J3490 |
| ALPHA 1 - PROTEINASE INHIBITOR - HUMAN, 10 MG (PROLASTIN) | J0256 |
| AMINOLEVULINIC ACID HCL 20% TOPICAL SOLUTION, LEVULAN KERASTICK | J7308 |
| AMPHOTERICIN B (ABELCET, AMPHOTEC, AMBISOME) | J0287, J0288, J0289 |
| ANIDULAFUNGIN, 1 MG (ERAXIS) | J0348 |
| ABATACEPT 250 MG (ORENCIA) | J0129 |
| BORTEZOMIB, 0.1 MG (VELCADE) | J9041 |
| BEVACIZUMAB, 10 MGA (AVASTIN) | J9035 |
| CETUXIMAB, 10 MG (ERBITUX) | J9055 |
| DALTEPARIN SODIUM (FRAGMIN) * see foot note | J1645 |
| DARBEPOETIN ALFA, 1 MICROGRAM (NON-ESRD USE) (ARANESP) | J0881 |
| DARBEPOETIN ALFA, 1 MICROGRAM (FOR ESRD ON DIALYSIS) (ARANESP) | J0882 |
| DEFEROXAMINE MESYLATE, 500 MG (DESFERAL) | J0895 |
| DESMOPRESSIN INJ. (DDAVP) | J2597 |
| DOLASETRON MESYLATE, 10MG (ANZEMET) ** | J1260 |
| ENFUVRTIDE (FUZEON) | J1324 |
| ENOXAPARIN SODIUM, 10 MG (LOVENOX)* see foot note | J1650 |
| EPOETIN ALFA, 1000 UNITS (FOR ESRD ON DIALYSIS) (EPOGEN/PROCRIT) | J0886 |
| EPOETIN ALFA, 1000 UNITS (FOR NON-ESRD USE) (EPOGEN/PROCRIT) | J0885 |
| EPOPROSTENOL, 0.5 MG ((FLOLAN/GENERIC EPOPROTENOL) | J1325 |
| ETANERCEPT, 25 MG (ENBREL – SPECIALTY PHARMACY DELIVERY) | J1438 |
| ETONOGESTREL IMPLANT, 68 MG (IMPLANON) | J7307 |
| ETOPOSIDE (TOPOSAR) | J9181 & J9182 |
| FACTOR VII & VIII | J7185, J7186, J7187, J 7189 J7190, J7191 & J7197 |
| FILGRASTIM (G-CSF), 300 MCG (NEUPOGEN) | J1440 |
| FILGRASTIM (G-CSF), 480 MCG (NEUPOGEN) | J1441 |
| FONDAPARINUX SODIUM, 0.5 (ATRIXTRA) | J1652 |
| FOSAPREPITANT, 1MG (EMEND) ** | J1453 |
| GANCICLOVIR SODIUM, 500 MG (CYTOVENE) | J1570 |
| GEMCITABINE, 200 MG (GEMZAR) | J9201 |
| GRANISETRON HCL, 100 MCG (KYTRIL) ** | J1626 |
| HISTRELIN IMPLANT, 50 MG (SUPPRELIN LA/VANTUS) | J9225 J9226 |



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| HYALURONIC ACID (SODIUM HYALURONATE) FOR HYALGAN & SUPARTZ PRODUCTS | J7321 |
| HYALURONIC ACID FOR EUFLEXXA | J7323 |
| HYALURONIC ACID FOR ORTHOVISC | J7324 |
| HYALURONIC ACID FOR SYNVISIC / SYNVISIC ONE | J7325 |
| IBANDRONATE SODIUM, 1MG (BONIVA) | J1740 |
| IMIGLUCERASE, PER UNIT (CEREZYME) | J1785 |
| IMMUNE GLOBULIN IM | J1460, J1470, J1480, J1490, J1500, J1510, J1520, J1530, J1540, J1550 & J1560 |
| IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG (CARIMUNE) | J1566 |
| IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG | J1459, J1561, J1568 & J1569 |
| IMMUNE GLOBULIN, INTRAVENOUS, 500 MG | J1459, J 1572 |
| INFLIXIMAB, 10 MG (REMICADE) | J1745 |
| INTERFERON ALFA -2A (PEGASYS) | J9213 |
| INTERFERON ALFA – 2B (INTRON A/REBTRON KIT) | J9214 |
| INTERFERON ALPHACON-1, 1 MCG (INFERGEN) | J9212 |
| INTERFERON BETA-1A (AVONEX) | J1825 |
| IRON DEXTRAN, 50 MG (InFED) <u>HCA PREFERRED IRON PRODUCT</u> | J1750 |
| IRON SUCROSE, 1 MG (VENOFER) | J1756 |
| LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 3.75 MG (ELIGARD/LUPRON, LUPRON-3/LUPRON-4/LUPRON DEPOT) | J1950 |
| LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG (ELIGARD/LUPRON DEPOT) | J9217 |
| LINEZOLID INJ 200MG (ZYVOX) | J2020 |
| MECASERMIN INJ 1 MG (IPLEX, INCRELEX) | J2170 |
| MEROPENEM, 100 MG (MERREM) | J2185 |
| NATALIZUMAB, 1 MG (TYSABRI) | J2323 |
| OCTREOTIDE, NON-DEPOT FORM FOR INTRAMUSCULAR INJECTION, 25mcg (SANDOSTATIN) | J2354 |
| OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG (SANDOSTATIN LAR) | J2353 |
| OMALIZUMAB, 5 MG (XOLAIR) | J2357 |
| ONDANSETRON HYDROCHLORIDE, PER 1 MG (ZOFRAN) ** SEE FOOT NOTE | J2405 |
| PALIVIZUMAB 50 MG (SYNAGIS) | J3490 |
| PAMIDRONATE DISODIUM, PER 30 MG (ARELIA) | J2430 |
| PALONOSETRON HCL, 25 MCG (ALOXI) ** SEE FOOT NOTE | J2469 |
| PANITUMUMAB 10 mg (VECTIBIX) | J9303 |
| PEGFILGRASTIM, 6 MG (NEULASTA) | J2505 |
| RENIBIZUMAB, 0.5MG (LUCENTIS) | J2778 |
| RIMABOTOTULINUM TOXIN B, 100 UNITS (MYOBLOC) | J0587 |
| RITUXIMAB, 100 MG (RITUXAN) | J9310 |
| SARGRAMOSTIM (GM-CSF), 50 MCG (LEUKINE) | J2820 |



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| SOMATROPIN, 1 MG (HUMATROPE/GENOTROPIN NUTROPIN/BIOTROPIN/GENOTROPIN/GENOTROPIN MINIQUICK/NORDITROPIN/NUTROPIN/ NUTROPIN AQ, SAIZEN/SAIZEN SOMATROPIN RDNA/SEROSTIM/SEROSTIM RDNA/ZORBTIVE) (THE HCA FORMULARY COVERS TEV-TROPIN AND SEROSTIM ONLY) | J2941 |
| TERIPARATIDE 250 MCG (FORTEO) | J3110 |
| TESTOSTERONE CYPIONATE, 1 CC, 200 MG (DEPO TESTOSTERONE) | J1080 |
| TESTOSTERONE SUSPENSION, UP TO 50 MG | J3140 |
| TESTOSTERONE CYPIONATE, UP TO 100 MG (DEPO TESTOSTERONE) | J1070 |
| TESTOSTERONE CYPIONATE AND ESTRADIOL CYPIONATE, UP TO 1 ML (DEPO-TESTADIOL) | J1060 |
| TESTOSTERONE ENANTHATE, UP TO 100 MG (DELATESTRYL) | J3120 |
| TESTOSTERONE ENANTHATE, UP TO 200 MG (DELATESTRYL) | J3130 |
| TESTOSTERONE PROPRIONATE, UP TO 100MG | J3150 |
| THYROTROPIN ALPHA, 0.9 MG (TYROGEN) | J3240 |
| TOBRAMYCIN, INHALATION SOLUTION, 300MG (TOBI) | J7682 |
| TREPROSTINIL, 1 MG (REMODULIN) | J3285 |
| TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, ADMINISTERED THROUGH DME | J7683 |
| ZOLEDRONIC ACID, 1 MG (ZOMETA) | J3487 |
| UNCLASSIFIED DRUGS | J3490 |
| UNCLASSIFIED BIOLOGICS | J3590 |
| UNCLASSIFIED ANTINEOPLASTIC DRUGS | J9999 |

* Enoxaparin (Lovenox) J1650 and Dalteparin (Fragmin) J1645 are HCA approved (without PA) for up to a 10 day supply or 20 syringes (whichever is less). Therapy for greater than 10 days or 20 syringes require HCA PA.

** No PA needed when contracted Hematologist/Oncologist administers in office or facility based therapy.

