6 Medical Authorizations and Notifications

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Overview

Health Choice Arizona is confident Primary Care Physicians are capable of providing the majority of medically necessary healthcare services to the patients who present to them. However, should the need arise for medically necessary specialty services, the Health Choice Arizona Chief Medical Officer (CMO), Medical Director(s), or their designees make medical necessity determinations based upon nationally recognized, evidence-based standards of care and also based on the AHCCCS program benefits.

Accurate and prompt medical necessity determinations depend upon the comprehensive content and the quality of medical documentation Health Choice Arizona (or its delegated entities) receives with each request. Health Choice Arizona is committed to making the prior authorization process as efficient and streamlined as possible; however, the requesting provider is responsible for submitting complete medical records with the prior authorization form to facilitate an effective review process.

Medical Prior Authorization and Notifications

For a complete listing of services which require Prior Authorization (PA) please refer to the Health Choice Arizona Prior Authorization Grid effective to the applicable date of service at http://www.healthchoiceaz.com/providers/pa-guidelines/ . 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.

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

1. Offices must legibly complete all necessary fields of the most current Health Choice Arizona Medical Prior Authorization Request Form (Exhibit 6.2). The most current Health Choice Arizona PA forms can be accessed on our Health Choice Arizona website at: www.healthchoiceaz.com and are available through your Health Choice Arizona Provider Service Representative.
2. Offices must include **ALL** appropriate clinical documentation, ICD-10, CPT, HCPCS and J-Code codes to effectuate the Prior Authorization request in an effective and timely manner. Offices should only request PA for services listed on the Health Choice Arizona PA Grid.

3. Offices should only request services for members who are Health Choice Arizona primary. Members with other primary insurance; i.e. (such as Medicare) do not require authorization for medical services with the exception of:

- Inpatient, transplant, and dental require authorization even if the member has other primary insurance.

4. For all members under age 21, the Office should consider whether the diagnosis driving the PA request (or any other referral and/or testing that does not require PA) is a condition covered by Children's Rehabilitative Services (CRS). According to Arizona Administrative Code R9-22-1303 and R9-7-301 members under the age of 21 with CRS-eligible conditions must be referred to APIPA-CRS. (CRS-covered services are generally not paid for by acute care AHCCCS health plans, and services related to a CRS condition must either be coordinated with CRS or the member should become CRS-enrolled.)

Note: Please see the **"CRS" Section** below for additional details.

5. Offices must include **ALL** necessary clinical documentation to support medical necessity to avoid unnecessary denials or inappropriate delays in the medical review process. Requests without supporting clinical documentation will be denied for lack of clinical information.

6. Offices must clearly indicate in the check boxes provided on the Health Choice Arizona PA forms whether the request is "Standard" or "Expedited" (see below for details). All expedited PA request forms **MUST** be signed by the ordering physician. Inappropriate submissions of "Expedited" requests is taken very seriously and monitored to ensure members emergent/urgent medical needs are met timely. Inappropriate "Expedited" requests will be downgraded to "Standard" by Health Choice Arizona which may take up to 14 calendar days to complete.

7. Offices must fax the Health Choice Arizona Prior Authorization Request Form (24 hours a day/7 days per week) to the appropriate Health Choice Arizona fax number. Health Choice Arizona has designated FAX numbers for Health Choice Arizona Medical requests and Health Choice Arizona Pharmacy requests. The office should confirm the fax receipt and this record should be kept for your documentation.

- ☐ Health Choice Arizona Medical PA Fax Line (877) 422(HCA)- 8120
- ☐ Health Choice Arizona Pharmacy PA Fax Line (877) 422(HCA)-8130

eviCore Health Solutions ("eviCore") - All "high-tech" radiology services (MRI, MRA, CT and PET), and obstetrical ultrasounds, nuclear cardiac stress testing, echocardiography, and heart catheterizations also require prior authorization. The full listing of service codes are identified in the PA Grid. Prior Authorizations for these services must be obtained through the eviCore on-line 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, or requests for multiple (recurring) units of an Obstetrical test, MUST be performed by phone: (888) 693-3211.

NOTE:

- ☐ Receipt of an authorization from Health Choice Arizona **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 payor of last resort and primary insurance and/or other credible coverage must be billed first, regardless of primary benefit coverage

- ☐ Only one Medical/Pharmacy service may be requested per PA form
- ☐ ALL Out of Network Providers (OON) require prior authorization. OON Providers should not be requested unless there is a compelling medical necessity basis
- ☐ Any service request resulting in a member being seen outside of the state of Arizona requires prior authorization approval from Health Choice Arizona
- ☐ Expedited requests which do not meet the AHCCCS definition of "Expedited may be downgraded to a "Standard" level request by Health Choice Arizona
- ☐ Health Choice Arizona does not require prior authorization for emergency services
- ☐ Health Choice Arizona does not pay for experimental and/or investigational services

Time Frames for Health Plan Prior Authorization Review

[Defined by the AHCCCS Medical Policy Manual, Chapter 1000, Medical Management/Utilization Management: "Chapter Overview" 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 a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following receipt of the authorization request, with a possible extension* (see "*AHCCCS-required 14-day Extensions*" below) of up to 14 calendar 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. "

- ☐ **"Expedited": 72 hours**– Expedited means a request for which a provider indicates or a Contractor determines using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

  The provider must sign the prior authorization request to certify critical need. The Contractor 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."

"CRS": Children's Rehabilitative Services (OCSHCN - Office for Children with Special Health Care Needs; http://www.azdhs.gov/phs/ocshcn)

CRS provides family-centered medical treatment, rehabilitation, and related support services for children under age 21 with qualifying chronic and other specific conditions. CRS members receive care for their eligible conditions in multi-specialty interdisciplinary clinics. If you identify a child who may qualify for CRS please complete the CRS Application form and fax to AHCCCS CRS Enrollment Department number located at the top of the application. AHCCCS will notify you of the disposition of the application once eligibility is determined. If it is determined the member is eligible for CRS the member will disenroll from Health Choice Arizona and enroll with United Healthcare Community Plan for all their medical care. If a member who is eligible for CRS declines CRS services they may be financially responsible for all services related to their CRS condition.

Please refer to Exhibit 6.9A (AAC R9-22-1303 CRS Qualifying Medical Conditions list) for additional assistance in determining what general and specific types of diagnoses/conditions are often CRS-covered medical services. Please also refer to Chapter 16: Women and Children's Services and Exhibits 16.1 (16.2, Spanish) for CRS Application forms.

Prior Authorization Determinations

Prior authorization requests received with the correct and appropriate clinical documentation by Health Choice Arizona (and/or eviCore, on behalf of Health Choice Arizona) 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 that services have been authorized by Health Choice Arizona.

2. **Denied** - The information received did not meet all Health Choice Arizona requirements, and authorization is not granted. The requesting Provider and member will receive a denial notification letter.

3. **"14-day Extension"- <u>AHCCCS-required 14-day Extensions</u>**:

   a. In some instances where PA has been requested, the documentation received by Health Choice Arizona *may* suggest medical necessity exists for the service exists 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 in order for Health Choice Arizona to meet AHCCCS mandated Expedited or Standard PA time frames, Health Choice Arizona will issue an AHCCCS-required "*Notice of Extension for Service Authorization*" (NOA) to both the member and the requesting provider.

   This 14-day extension will afford both Health Choice Arizona and the requesting Provider 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 Extension Health Choice Arizona has not received the necessary additional information, the request will be denied, and both the Provider and member will be notified.

   Note: The Health Choice Arizona 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. **Reduction**: The information received met all Health Choice Arizona medical necessity requirements and 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. Health Choice Arizona Medical Directors and clinical staff are available to discuss the review determination with the attending physicians or other ordering providers.

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, and/or Non-Formulary (NF) medication requests, specific information which explains the medical necessity for an OON or NF service is required. A PA is required in order for any service to be covered at OON providers/facilities.

Pre Service Denials

Members will be notified of a denial of service request 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 a denial is issued, the health plan must inform the member of the denial of service and 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 in order 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 a denial of service will also be sent to the requesting Provider (or their designee). Provider denial letters are sent to the Physician or Facility who initiated the request the prior authorization and will contain varying degrees of detail in order to explain the basis for denial.

Special considerations and information regarding Medical Prior Authorizations

- ☐ The Primary Care Physician/Provider (PCP) should initiate the prior authorization request; Please refer to the Prior Authorization Grid.
- ☐ Health Choice Arizona members should be instructed not to self-refer to specialists without the express recommendation of their PCP.
- ☐ Health Choice Arizona 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 that 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.
- ☐ Contracted health professionals, hospitals, and other providers are required to comply with Health Choice Arizona Prior Authorization policies and procedures.

Retrospective ("RETRO") Authorizations

Health Choice Arizona requires Prior Authorization (PA) be obtained for some non- emergent/non-urgent services, as defined by this Chapter and the Health Choice Arizona PA Grid. Health Choice Arizona does not generally review requests for "retro" 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.

Any "Retro" Authorizations will be entered into the health plan claims and medical management information system and deemed "Cancelled" at the time they are processed. There are no defined AHCCCS time-frames or requirements for processing
"Retrospective" authorization requests where services have already been provided to the Health Choice Arizona member.

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.

Health Choice Arizona uses the following protocol to resolve informal appeals regarding authorizations:

1. The requesting provider may resubmit a new PA 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 Health Choice Arizona 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

Health Choice Arizona 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 or FAX. New and/or additional information is needed to constitute a new PA 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.

Provider Portal

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

- ☐ Checking claims status
- ☐ Checking member eligibility
- ☐ Checking Health Choice Arizona Prior Authorization Status

Hospital Services: Inpatient and Outpatient Services

All hospital admissions, including Acute, Observation, Rehabilitation, Long Term Care Skilled Nursing Facilities, and Hospice require prior authorization.

All facilities must notify Health Choice Arizona and obtain an authorization prior to, or at the time of ALL admissions.

In the event acute hospitalization services delivered are to evaluate and stabilize an Emergency Medical Condition, -the plan must be notified of emergent inpatient services 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 fax Health Choice Arizona 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.

Health Choice will request medical information and/or records to assist in making a utilization review determination. If the information is not received within a 24 hour period the request will be administratively denied for lack of medical information. For in-patient/concurrent reviews the request will be made up to two times 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 outpatient services listed on the prior authorization grid require a prior authorization. When authorization is obtained by the requesting provider, no plan notification is required from the provider, however, the facility/hospital must notify Health Choice by fax within one day of the admission.

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 Arizona will entertain Prior Authorization requests for "medical necessity exceptions" where the Provider believes a case must be performed in the Hospital Outpatient setting.

Obstetrical Package

Please see Chapter 16: Women and Children's Services, for information

Outpatient Laboratory Services

Health Choice Arizona has a statewide capitated contract with LabCorp of America to provide a full array of laboratory services. Please refer to the prior authorization grid regarding laboratory services that require prior authorization.

- Please visit **www.lapcorp.com** for service locations

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.

Health Choice Arizona has 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.

Health Choice Arizona contracts with **Nationwide Vision** to provide the following services:

1. Annual screening diabetic retinal exams
2. All exams/corrective lenses for EPSDT-aged members (members under age 21)
3. Dilated fundus examinations
4. Visual field testing
5. Glaucoma testing (members under age 21 with glaucoma should be CRS enrolled)
6. Evaluation and treatment of conjunctivitis
7. Evaluation of cataract (members under age 21 with Cataracts should be CRS enrolled)
8. Allergy and dry eye treatment

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

Durable Medical Equipment and Infusion/ Enteral Therapy

Preferred Homecare is the statewide contracted service provider for Health Choice Arizona. Requests for Durable Medical Equipment (DME) or Infusion/Enterals are to be sent directly to Preferred 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.

Contact Information for Preferred Home Care:

☐Main Office Phone Number:	(480) 446-9010
	(800) 636-2123
☐Main Fax Number	(480) 446-7695

Orthotics / Prosthetics

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

Effective 10/1/2014, AHCCCS has implemented new Orthotics and Prosthetic limitations. Please refer to the Health Choice Arizona PA Grid and/or the AHCCCS Medical Policy Manual Chapter 300, policy 310-P.

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.

Important notice to all Health Choice Arizona Providers

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