CHAPTER 6:

Authorizations and Notifications

Reviewed/Revised: 4/26/19, 1/1/20

6.0 MEDICAL AUTHORIZATION AND NOTIFICATIONS 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 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 in partnership with the requesting provider submitting a complete prior authorization request form and clinical documentation to facilitate an effective review process.

6.1 MEDICAL PRIOR AUTHORIZATION AND NOTIFICAITONS

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 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.

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 PA forms can be accessed on our Health Choice Arizona website: www.HealthChoiceAZ.com and are available through your Health Choice Arizona Provider Performance 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 have Health Choice Arizona primary insurance coverage. 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. 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.
5. Offices must clearly indicate on the Health Choice Arizona PA form if the request is "Expedited" (see below for details). All expedited PA request forms **MUST** be signed by the ordering physician, nurse practitioner, or physician assistant. 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" by Health Choice Arizona which may take up to 14 calendar days to complete.
6. 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- 8120
   - Health Choice Arizona Pharmacy PA Fax Line (877) 422-8130

   eviCore Health Solutions ("eviCore") - All "high-tech" radiology services (MRI, MRA, CT and PET), 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, or requests for multiple (recurring) units of an obstetrical test, MUST be conducted 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 payer 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

6.2 BEHAVIORAL HEALTH – SECURING SERVICES AND PRIOR AUTHORIZATION

DEFINITIONS PER AHCCCS

Behavioral Health Home

Contracted behavioral health provider that serves as an intake agency, provides or coordinates the provision of covered behavioral health services, and coordinates care with the primary care provider for adults and/or children with behavioral health needs.

Behavioral Health Professional

a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101,
b. A psychiatrist as defined in A.R.S. §36-501,
c. A psychologist as defined in A.R.S. §32-2061,
d. A physician,
e. A behavior analyst as defined in A.R.S. §32-2091,
f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
g. A registered nurse.

Specialty Provider

Behavioral Health service that is not available in the Behavioral Health Home.

Service Plan

A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Child and Family Team (CFT)

A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental

Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and Contract as necessary to be successful on behalf of the child.

Adult Recovery Team (ART)
A group of individuals that, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service planning, and service delivery. At a minimum, the team consists of the member's, guardian/designated representative (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the enrolled member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other members identified by the enrolled member.

6.3 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 PCP or medical provider has several options. (1) Contact the Health Choice Behavioral Member Services department at 877-923-1400 to determine the member's assigned behavioral health home. (2) Fax the referral form to 480-317-3358 or by email to HCH.CaseManagement@steward.org .

6.4 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 Health Choice Arizona 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.

6.5 REPORTING RESIDENTIAL SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION

Health Choice Arizona provides a web-based platform enabling health plans to communicate healthcare information directly with providers through the **Health Choice Arizona ICE Portal/My OOH Placements.**

All members admitted to , Substance Use Disorder Residential Facilities (CD RTC) and Home Care Training for the Home Care Client (HCTC) must be entered into "My Out of Home Placement" within two (2) business days of notification. Members discharged from HCTC must be entered within two (2) business days of notification.

- Definition of a discharge: Any time a member is discharged from a facility
- If a member is "transferred" to another facility or another HCTC, a new admission is required to be entered in "My Out of Home Placement".

Behavioral Health Homes should develop processes to validate accuracy of information. Health Choice Arizona will perform periodic audits to ensure the accuracy of data. MPS is 90% accuracy of admissions and discharge dates.

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

If Health Choice Arizona 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, Health Choice Arizona will enter into a single case agreement with that provider for a limited time.

Health Choice Arizona and its Behavioral Health Homes are not required to offer services outside of the contracted provider network if the service is available within the network.

For behavioral health services, Health Choice requires the following information in order to complete a **single case agreement**:

- Requested services (including covered service codes)
- Provider information (name, license, address, phone number) and AHCCCS ID. If the provider does not have an AHCCCS ID, they can be directed to the **AHCCCS Provider Registration website** for instructions on how to apply
- Copy of the service plan indicating needed services have been documented
- Reason for going to a non-contracted provider (i.e., specialty not available otherwise)

The process for securing services through a non-contracted provider or for non-contracted services by a contracted provider, like one on one supervision, for both Adult and Children's Services is as follows:

- Once the clinical team at the 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 single case agreement process can begin.
- Health Choice Arizona will contract directly with providers regardless of the level of care or the service utilizing a single case agreement.
- **Single Case Agreement Request Form and instructions** can be located on the Health Choice Arizona website under **Commonly Used Forms**.
- The single case agreement request can be emailed to HCIC_Contracts@steward.org.
- Non-contracted service requests approved by the Health Home and determined medically necessary for the member, must be communicated to HCIC_Contracts@steward.org with rate information and signed agreements. Notifications to both HCIC_Contracts@steward.org and HCIC_Contracts@steward.org are required before claims can be submitted so that the contracted rate can be manually adjusted before processing.
- Health Choice Arizona will review the request and begin the negotiation process with the provider so that prior authorization can occur (if required). (Please refer to the remainder of this policy regarding prior authorization requirements.)
- Once the single case agreement has been negotiated and executed, the provider will be given the signed copy along with the rate schedule noting the codes and rates billable by the provider.

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

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 Health Choice Arizona's policies. Both referring and receiving providers must comply with Health Choice Arizona policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, 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.

6.7 EMERGENCY SITUATIONS

Prior authorization is never applied in an emergency situation. A retrospective review may be conducted after the person's immediate behavioral health needs have been met. If upon review of the circumstances, the behavioral 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.

6.8 BEHAVIORAL HEALTH SERVICES THAT REQUIRE PRIOR AUTHORIZATION AND CRITERIA

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

- Non-emergency admission to and continued stay in an Behavioral Health Hospital or Sub-Acute Facility
- Admission to and continued stay in a Behavioral Health Inpatient Facility (Level I) for persons under the age of 21
- Behavioral Health Residential Facilities (BHRF) *with exception of Substance Use Disorder Facilities and respite.
- Electroconvulsive Therapy (ECT)
- Some medications and prescribing practices

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

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, Health Choice Arizona 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

Notice must be provided in accordance with Chapter 15 of the Health Choice Arizona Provider Manual –Claim Disputes, Member Appeals and Member Grievances

Requesting Authorization for a Behavioral Health Service

Health Choice Arizona has different processes for requesting a prior authorization dependent on the service requested as below.

Providers can also call after-hours for assistance at (877) 923-1400. Authorization decisions require complete forms and supporting documents to be provided by the member's Behavioral Health Home clinical team.

The following documentation is required in order to obtain prior authorization:

Inpatient Psychiatric Acute Hospital or Sub-Acute Facility

- For non-emergency admissions, submit the completed **Certificate of Need (CON)** and the Health Choice Arizona **Prior Authorization and Continued Stay Request Form for Psychiatric Hospitals and Sub-Acute Facilities** prior to admission. Authorization decisions are made within one business day. Length of the authorization is based on medical necessity.
- For all continued stay requests, submit the **Prior Authorization and Continued Stay Request Form for Psychiatric Hospitals and Sub-Acute Facilities** within 24 hours of an emergency admission (include the completed CON) or prior to the end of the initial authorization. Length of the authorization is based on medical necessity.
- Fax the form to the UM Department at (480) 760-4732.

Behavioral Health Inpatient Facility for person's under the age of 21.

- Behavioral Health Inpatient Authorizations are requested from the member's Behavioral Health Home (CFT)
- For non-emergency admissions, submit the completed **Certificate of Need (CON) a**nd the **Health Care of AZ Prior Authorization and Continued Stay Request Form for Behavioral Health Inpatient Facilities Authorization for Persons Under Age 21** prior to admission. Authorization decisions can be expedited or standard. The initial authorization request is valid for up to 30 days and the maximum number of days authorized may be 30 days.
- For all continued stay requests, submit the **Recertification of Need (RON)** and the Prior **Authorization and Continued Stay Request Form for Behavioral Health Inpatient Facilities Authorization for Persons Under Age 21** prior to the end of the previous authorization. Length of the authorization is up to 30 days.
- Email the applicable form(s) listed above to HCH.HCICauthorization@steward.org or fax to (480) 760-4732.

Behavioral Health Residential Facilities (BHRF)

- The requestor submits the completed **Health Care BHRF Prior Authorization Request Form** with supporting documentation prior to admission to HCH.HCICauthorization@steward.org **or 480-760-4732.**
- **For all continued stay request, the Behavioral Health Residential facility submits Prior Authorization and Continued Stay Request Form** with supporting documentation to HCH.HCICauthorization@steward.org or (480) 760-4732 seven days before to last authorized day.
- Initial and continued authorization is up to 60 days**.**

Electro-Convulsive Therapy (ECT)

- Submit the **ECT Prior Authorization Form** with clinical documents supporting the medical necessity. Authorization decisions can be expedited or standard. The initial authorization request is valid for up to 15 days and the maximum number of sessions authorized is based on medical necessity.

- Fax the form to the Behavioral Health Arizona UM Department at (480) 760-4732.

Certification of Need (CON) and Recertification of Need (RON)

A **Certificate of Need (CON)** is a certification made by a physician that inpatient services are or were needed at the time of the person's admission Although a CON must be submitted prior to a person's admission (except in an emergency), a CON is not an authorization tool designed to approve or deny an inpatient service, rather it is a federally required attestation by a physician that inpatient services are or were needed at the time of the person's admission. The decision to authorize a service that requires prior authorization is determined through the application of admission and continued stay authorization criteria.

In the event of an emergency, the CON must be completed:

- For persons age 21 or older, within 72 hours of admission; and
- For persons under the age of 21, within 14 days of admission.

A **Recertification of Need (RON)** is a recertification made by a physician, nurse practitioner or physician assistant that inpatient services are still needed for a person. A RON must be completed at least every 60 days for a person who is receiving services in an inpatient facility. An exception to the 60-day timeframe exists for inpatient services provided to persons under the age of 21. The treatment plan (individual plan of care) for persons under the age of 21 in an inpatient facility must be completed and reviewed every 30 days. The completion and review of the treatment plan in this circumstance meets the requirement for the recertification of need.

The following documentation is needed on a CON and RON:

- Proper treatment of the person's behavioral health condition requires services on an inpatient basis under the direction of a physician.
- The service can reasonably be expected to improve the person's condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of the person; and
- For CONs, a dated signature by a physician;
- For RONs, a dated signature by a physician, nurse practitioner or physician assistant.

Additional CON requirements include:

- If a person becomes eligible for Title XIX or Title XXI services while receiving inpatient services, the CON must be completed and submitted to Health Choice Arizona prior to the authorization of payment.
- For persons under the age of 21 receiving inpatient psychiatric services: Federal rules set forth additional requirements for completing CONs when person under the age of 21 are admitted to, or are receiving services in an inpatient facility. These requirements include the following:
    - For an individual who is Title XIX/XXI eligible when admitted, the CON must be completed by the clinical team that is independent of the facility and must include a physician who has knowledge of the person's situation and who is competent in the diagnosis and treatment of mental illness, preferably child psychiatry;
    - For emergency admissions, the CON must be completed by the team responsible

for the treatment plan within 14 days of admission. This team is defined in 42 CFR §441.156 as "an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility"; and

- For persons who are admitted and then become Title XIX or Title XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period of time for which claims for payment are made.

Authorization Criteria

For services in psychiatric hospitals, sub-acute facilities, and Behavioral Health Inpatient Facilities, and its providers use the following criteria:

- **InterQual Adult and Geriatric Psychiatric Inpatient Criteria**
- **InterQual Child and Adolescent Psychiatric Inpatient Criteria**
- **Behavioral Health Inpatient Facility Admission and Continued Authorization Criteria for Persons Under the Age of 21**
- **InterQual ECT (Electroconvulsive Therapy) Acute/Short Term and Continuation/Maintenance Clinical Criteria**
- **HCA Behavioral Health Residential Criteria**
- **Psychotropic Medications**

Denials for Level I Behavioral Health Inpatient Facility for Persons Under the Age of 21

Prior to denials for Behavioral Health Inpatient Facility for persons under the age of 21, Health Choice Arizona Medical Directors or physician designee will talk with the treating psychiatrist/ psychiatric nurse practitioner most familiar with the child in order to gather any additional information that could be helpful in making the determination. If a psychiatrist or psychiatric nurse practitioner has not yet been involved, an evaluation should be arranged in order for Medical Director or designee to obtain the professional opinion of a behavioral health clinician.

In addition, if a denial is issued for admission to a Behavioral Health Inpatient Facility, Health Choice Arizona will provide a clearly outlined alternative plan at the time of the denial. This may require development of a Child and Family Team (CFT), if one has not already been established, or consultation with the CFT. It is expected that the alternative treatment plan will adequately address the behavioral health treatment needs of the child and will provide specific information detailing what services will be provided, where these services will be provided, and when these services will be available and what specific behaviors will be addressed by these services. It is also expected that the alternative treatment plan will include what crisis situations can be anticipated and how the crises will be addressed.

To obtain additional information on how to access or obtain practice guidelines and coverage criteria for authorization decisions, please contact Health Choice Arizona Behavioral Member Services 877-923-1400 or check the website at www.HealthChoiceAZ.com.

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)*:* 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 consecutive days in one calendar month, and only when the service provided in the IMD meet the requirements for in lieu of services at 42 CFR 438.3(e)(2)(i) through (iii). For stays that exceed 15 consecutive days in one calendar month, whether or not pays for any or all of the stay, AHCCCS shall recoup the capitation payment made to the Contractor for that member for the month in which the stay has days in excess of 15 days. [42 CFR 438.6(e)].

6.9 COVERAGE AND PAYMENT OF EMERGENCY BEHAVIORAL HEALTH SERVICES AND POST-STABILIZATION SERVICES

Emergency behavioral 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 Health Choice Arizona.

Payment must not be denied when:

- Health Choice Arizona or behavioral health provider instructs a person to seek emergency behavioral health services;
- A person has had an emergency behavioral health condition, including cases in which the absence of medical attention would have resulted in:
- Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
- Emergency behavioral health conditions must not be limited to a list of diagnoses or symptoms;
- Health Choice Arizona may not refuse to cover emergency behavioral health services based on the failure of a provider to notify Health Choice Arizona of a person's screening and treatment within 10 calendar days of presentation for emergency services.
- A person who has an emergency behavioral 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 actually treating the person, is responsible for determining when the person is sufficiently stabilized for transfer or discharge, and such determination is binding Health Choice Arizona.

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. Health Choice Arizona is 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 Health Choice Arizona for the following situations as per **R9-22-210**:

- Post-stabilization care services that were prior authorized by Health Choice Arizona;
- Post-stabilization care services that were not prior authorized by Health Choice Arizona or because Health Choice Arizona 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
- Health Choice Arizona and the treating physician cannot reach agreement concerning the member's care and a Health Choice Arizona physician advisor is not available for consultation. In this situation, Health Choice Arizona must 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:
    - Health Choice Arizona physician with privileges at the treating hospital assumes responsibility for the person's care;
    - Health Choice Arizona physician assumes responsibility for the person's care through transfer;
    - Health Choice Arizona and the treating physician reach an agreement concerning the person's care; or
    - The person is discharged.

6.10 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": up to 72 hours**– Expedited means a request for which a provider indicates or a Contractor determines that 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. If the due date for an expedited authorization decision falls on a weekend or legal holiday as defined by the State of

Arizona, the expedited decision must be made on the day preceding the weekend or holiday.

The ordering provider must sign the prior authorization request form 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."

6.11 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-** 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*" (NOE) 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. **Modified**: The information received met Health Choice Arizona 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 Health Choice Arizona Medical Director if request is made within 72 hours of receiving the denial notification from Health Choice.

6.12 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.

6.13 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 for 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 (see 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, except for Diabetic Pump Supplies which are valid for 365 days.
- Contracted health professionals, hospitals, and other providers are required to comply with Health Choice Arizona Prior Authorization policies and procedures.

6.14 INFORMAL RESOLUTIONS OF DENIALS

Health Choice Arizona uses the following protocol to resolve 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 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 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.

6.15 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
- Out of state services
- Late notifications of non-emergency services that are required to be secured by an Health Choice Arizona behavioral health home clinical team, but were not obtained, including behavioral health and substance use residential treatment and HCTC
- Outlier claims
- Services that were provided in an emergency by a non-contracted provider
- Provider-Preventable Conditions

Health Choice Arizona Utilization Review Nurses, in coordination with the Health Choice Arizona Medical Directors, analyze member cases where services have been provided and concurrent review was not able to be conducted. Some of the factors considered are 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.

Health Choice Arizona utilizes Health Choice Arizona clinical guidelines, InterQual Level of Care Criteria guidelines, and NCD/LCD as an adjunct for all retrospective reviews. The Retrospective 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.

Health Choice Arizona 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.

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.

6.16 PROVIDER-PREVENTABLE CONDITIONS

Health Choice Arizona reviews 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 CareAcquired 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, with the exception of 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 that 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 that the HAC or OPPC was a result of mistake or error by a hospital or medical professional, Health Choice Arizona conducts a quality of care investigation and reports the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

6.17 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 Prior Authorization Status
- Submit prior authorization request on line for Health Choice members

6.18 HOSPITAL SERVICES: INPATIENT AND OUTPATIENT SERVICES

All non-emergency hospital admissions, including Acute, Observation, Rehabilitation, Long Term Care Skilled Nursing Facilities, Level I Behavioral Health Inpatient Facility for <21yo, 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 is required to evaluate and stabilize an Emergency Medical Condition, Health Choice Arizona **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 via 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 Arizona will request medical information and/or records to assist in making a determination about 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 - Health Choice Arizona will consider Prior Authorization requests for "medical necessity exceptions" where the Provider believes a case must be performed in the hospital outpatient setting.

6.19 PSYCHIATRIC INPATIENT, BEHAVIORAL HEALTH INPATIENT FACILITY FOR PERSONS UNDER 21 AND ELECTROCONVULSIVE THERAPY

All requests for behavioral health hospitalizations are made by faxing to 1-855-408-3401 or secure email to HCH.HCICauthorization@steward.org.

- Authorization is NOT a guarantee of payment for services.
- All request forms must be submitted with request and all required supporting documents.
- 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.
- 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 authorization lengths are based on medical necessity.
- Continued stay reviews are completed by Medical Management Specialist prior to the end of the current authorization.
    - Behavioral Heath Inpatient Facility (BHIF) requests for continued stay must be submitted seven days prior to the expiration of the current authorization
    - ECT requests must be submitted 7 days prior to the last authorized treatment. Authorizations are up to 15 treatments within five weeks for continued/maintenance or up to 20 treatments over 1 year.
- Reviews not meeting medical necessity guidelines are referred to Medical Director or the physician designee for review.
- Review of authorization requests includes but is not limited to:
    - Necessity of admission and appropriateness of the service setting
    - Quality of care
    - Length of stay
    - Whether services meet the member's needs

- Discharge needs
- Utilization pattern analysis

6.20 PSYCHIATRIC INPATIENT, RESIDENTIAL AND HCTC FACILITIES DISCHARGE NOTIFICATIONS

In order to identify members with longer than expected lengths of stays or unexpected readmissions to higher levels of care, to track length of stay accurately and to flag the member for a discharge follow up call by an HCIC Member Services Representative:

- Behavioral Health Inpatient Facilities, Behavioral Health Residential Facilities and HCTC providers must report all admissions, transfers and discharges by completing and **submitting Notification of Admission, Discharge and Transfer Form for BHIF, BHRF, HCTC** within 5 days of the occurrence to *HCH.HCICMMReporting@steward.org*.
- Inpatient Psychiatric Hospitals and Sub-Acute Facilities submit a discharge notification or the member's discharge summary within 1 business day of discharge to *HCH.HCICMMReporting@steward.org .*
- CD residential facilities must report all admissions and discharges Medical Management unit by entering the change into HCIC ICE portal "My CDR Placement" within 5 days of the occurrence.

6.21 OBSTETRIC PACKAGE

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

6.22 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

6.23 OPTHALMOLOGY AND OPTOMETY - *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:

- 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.

6.24 DURABLE MEDICAL EQUIPMENT AND INFUSION / ENTERAL THERAPY

Preferred Homecare is the statewide contracted service provider for Health Choice Arizona Durable Medical Equipment (DME). Requests for Durable Medical Equipment (DME) are to be sent directly to Preferred Home Care 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 or (800) 636-2123
- Main Fax Number: (480) 446-7695

Coram Infusion / Enteral Therapy is the statewide contracted service provider for Health Choice Arizona Infusion/Enteral Therapy services. Request for Infusion/Enterals are to be sent to directly to Coram Infusion 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 Coram Infusion

- Main Office Phone Number: (480) 240-3200
- Main Fax Number: (480) 505-0455

6.25 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.

6.26 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.

6.27 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.

6.28 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 with regard to 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 HCIC receives a PASRR Level II request from AHCCCS, Health Choice Arizona 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).

6.29 DENTAL AUTHORIZATIONS AND NOTIFICATIONS

See Chapter 20