SECTION F
REFERRAL AND PRIOR AUTHORIZATION PROCESS

At times Phoenix Health Plan (PHP) members may require services that go beyond the scope of their Primary Care Provider (PCP). When this occurs, the PCP refers the member to an appropriate Specialty Care Provider. Our prior authorization guideline is available on our website www.phoenixhealthplan.com. You may also contact network management for a copy to be faxed or mailed to your practice.

Authorizations for consults and follow-up visits are valid for 120 days as long as the member retains AHCCCS eligibility with PHP

If you are unable to schedule the consult with the member within the appropriate timeframes referenced above, please contact the prior authorization department and request to have the authorization extended prior to rendering the service.

STANDARD AUTHORIZATION REQUESTS

A routine request is non-urgent and will be responded to within 14 days upon receipt of a request. Please supply all supportive documentation to assist in rapid processing of your request.

When requesting multiple services for member(s), submit each request separately. Bundled requests cause delays in processing as the submission requires unbundling. Determinations will be faxed to the requesting provider within 1 business day of rendering a determination.

EXPEDITED AUTHORIZATION REQUESTS

PHP's goal is to process expedited requests within 3 days or sooner of receipt of all supportive documentation. Determinations will be faxed to the requesting provider within 1 business day of rendering a determination. AHCCCS defines an "expedited" request as "when using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum functioning.". Please remember not to use "expedited" for the convenience of the member or physician. In cases when the request does not meet the "expedited" criteria, but is time sensitive, PHP will attempt to process the request in the timeframe requested."

COORDINATION OF BENEFITS

Prior authorization requirements apply to all members. All members are required to see contracted providers. If the member has primary coverage other than PHP and the physician is not a contracted provider, services will be denied unless prior authorized.

PHARMACY PRIOR AUTHORIZATION AND FORMULARY EXCEPTION PROCESS

Some formulary drugs and all non-formulary drugs require prior authorization approval for coverage. In addition, some formulary drugs may require step therapy (ST) or have quantity limitations (QL) imposed.

- Any physician may request a prior authorization, formulary exception or an exception to a utilization management edit by completing a Pharmacy Prior Authorization and Formulary Exception form.
- Pharmacy forms can be found on our website at www.phoenixhealthplan.com.
- Fax completed forms and supporting documentation to 602-674-6652 or 1-888-887-9982.
- Completed request forms and supporting medical or laboratory documentation should be submitted at the same time.

Pharmacy prior authorization requests sent to other fax numbers may result in a delayed review and decision on your request. All prior authorization and formulary exception requests will be reviewed to

determine if first line formulary drugs have been consistently used for a sufficient length of time. Samples do not constitute an adequate trial. Failures due to a severe adverse drug event must be submitted with supporting documentation (such as resulting CPK, LFT elevations) and an FDA MedWatch 3500 form describing the adverse event, outcome and intervention required. For further assistance please call the PHP prior authorization department.

REFERRAL PROCESS FROM PCP TO SPECIALIST

- PCP selects a contracted Specialist.
- Refer to prior authorization guideline to determine if an authorization is required for that specialty.
- If prior authorization is NOT required for the referral, the provider may fax their own referral form or script along with pertinent documentation, contact name and phone number directly to the contracted Specialist and notify the member that they may schedule an appointment.
- If prior authorization is required, fax the completed prior authorization form to the prior authorization department. Please include ICD-9 and CPT code(s), pertinent documentation, a contact name and phone and fax numbers with area code.
    - If the request is approved, an authorization is issued for a consult and same day treatment.
    - Once authorization is obtained, fax the prior authorization form with the authorization number to the contracted Specialist and notify the member that they may schedule an appointment.

NOTE: It is the responsibility of the Specialist to verify member eligibility at each appointment, prior to rendering services. Claims will not be reimbursed if a member is not eligible on the date of service.

- Specialists must refer to the prior authorization guideline to determine what services may be rendered without obtaining prior authorization.
- If follow-up visits are needed, refer to the prior authorization guideline to determine if an authorization is required for additional visits to the selected specialty.
- If prior authorization is NOT required, the Specialist may proceed with scheduling follow-up visits to see the member.
- If prior authorization is required, the Specialist or PCP must request a prior authorization using the Prior Authorization Form. A legible consult note or clearly written documentation must also be attached to support the request, along with appropriate ICD-9 and CPT code(s) and a contact name and phone number with area code.
- The Specialist or PCP may request an authorization for the entire treatment plan as long as the consultation notes have been submitted.
- If surgery or a special procedure is required, the Specialist or PCP must request a prior authorization using the prior authorization form. A legible consult note or clearly written documentation must also be attached to support the request, along with appropriate ICD-9 and CPT code(s), the name of the contracted facility where services will be rendered and a contact name and phone number with area code.

- Prior authorization requests for surgery must be completed at least 14 prior to the date of the surgery unless it is an emergent situation.
- Authorizations for surgery are valid for 120 days, after which time the authorization must be extended.
- Copies of the consultation and any follow-up notes must be provided to the member's PCP.

REFERRAL PROCESS FROM SPECIALIST TO SPECIALIST

Should a Specialist need to refer a member to another Specialist, it is not necessary for the member to be physically referred back to the PCP as long as the PCP has been informed of the impending referral. The referring Specialist must refer to the prior authorization guideline to determine if an authorization is required for the needed specialty. If a prior authorization is required, the prior authorization form should be completed and faxed as outlined above.

REFERRAL PROCESS FOR ANCILLARY PROVIDERS

The referring provider should follow the instructions for "Referral from Primary Care Provider to Specialty Care Provider" in the role of the referring provider, taking note of the following:

Durable Medical Equipment

Covered durable medical equipment (DME) must be medically necessary and prescribed by a PCP or Specialist. DME can be obtained by contacting the contracted DME provider directly. If additional assistance is needed, please contact the prior authorization department.

Please include the following information when faxing a request for DME:

- Amount, type and size of equipment desired including HCPC code
- Member information
    - Name
    - AHCCCS identification number
    - Weight
    - Address
    - Phone number
    - Diagnoses
    - Completed and Signed Certificate of Medical Necessity

The following limitations shall apply:

- Reasonable repairs or adjustments of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of repair is less than the cost of rental or purchase of another unit. The equipment must be considered medically necessary by PHP.

- The rental of such equipment shall terminate no later than the end of the month in which the member no longer needs the medical equipment as certified by the authorized provider. Or when the member is no longer eligible or enrolled with PHP (except during transitions of care as specified by the health plan medical director).

Notes:

- SVN machines, standard wheelchairs, standard walkers, and crutches can be obtained by directly calling the contracted DME provider without an authorization.

- For other DME items, fax a completed service request form, documentation to support request, and prescription to the DME provider. **A completed and signed Certificate of Medical Necessity is required** for certain items such as oxygen and semi-electric wheelchairs.

- View the PHP Prior Authorization Guidelines to determine if DME requires prior authorization.

Home Health Care and Infusion Care

- Select a contracted provider from the online referral directory.
- Call the intake department at a contracted home health care agency.
- The case manager may be contacted with questions regarding the process.

Orthotics and Prosthetics

Orthotic and prosthetic services are covered when medically indicated and prescribed by a contracted provider. When referring a member for orthotic/prosthetic services, the provider's office must submit a prior authorization form along with supporting documentation and appropriate HCPC code. Once approved, the orthotic/prosthetic provider will contact the member for fitting and delivery.

Outpatient Laboratory Services

- Complete laboratory requisition and direct member to the contracted laboratory drawing site.
- If drawing specimen in-office, contact the contracted laboratory for pick up.
- Laboratory Services must be done at a contracted lab facility with the exception of the following codes that fee-for-service PCPs and Specialists may perform in office.

In-Office Lab Test List (Fee-For-Service Provider):

Code	Description
36410	Blood draw
36415	Blood draw
81000	Urinalysis w/microscopy
81002	Urinalysis w/o microscopy, non-automated
81003	Urinalysis w/o microscopy; automated
81025	Urine pregnancy test
82962	Glucose, blood by Glucose Monitoring Device
85013	Spun Hematocrit
85007	Blood Count;Blood Smear; Microscopic exam with Manual Differential WBC Count (For Oncologist Only)
85008	Blood Count; Blood Smear; Microscopic exam without Manual Differential WBC Count (For Oncologist Only)
85025	Automated Hemogram (For Oncologist Only)
85027	Hemogram and Platelet Count (For Oncologist Only)
85044	Reticulocyte Count (For Oncologist Only)
86403	Strep Quick Test (particle agglutination; screen, each antibody)
86490	Cocci Intradermal Test
86580	TB Intradermal Test
87210	Wet Mount
87804	Influenza Assay w/ Direct Optical Observation

87880	Streptococcus, group A
89050	Body Fluid Cell Count (For Oncologist Only)

In-Office Lab Test List (Capitated PCPs)

Capitated PCPs will be reimbursed fee-for-service (FFS) for the following lab codes:

36410	Blood draw
36415	Blood draw
81025	Urine pregnancy test
86403	Strep Quick Test (particle agglutination; screen, each antibody)
86490	Cocci Intradermal Test
86580	TB Intradermal Test
87880	Streptococcus

Radiology Services

- MRI, MRA and PET scans require prior authorization in all counties.
- CT scans require prior authorization
- Radiological services performed in outpatient hospital require prior authorization in Maricopa County.

- Select contracted site for service from the online referral directory.
- Call a contracted provider to schedule an appointment date and time.
- It is the responsibility of the imaging service provider to verify member eligibility with the member services department, prior to rendering services.

Outpatient Rehabilitation Services (OT/ST/PT)

- PT and OT may be referred for an initial evaluation without prior authorization. Following the initial evaluation, the physical therapy provider is responsible for obtaining prior authorization for the treatment plan.

- ST is covered for members under 21 years of age require prior authorization for the initial evaluation and subsequent visits.

- Outpatient occupational therapy (OT) and speech therapy (ST) for members 21 years and older is not an AHCCCS covered benefit.

Skilled Nursing Facility (SNF) Admission

All admissions to SNF's require a prior authorization. If no prior authorization is obtained, the SNF stay will be denied for payment purposes. To obtain prior approval for the SNF admission you will need to contact our Concurrent Review Nurse working out of the discharging hospital. Our Concurrent Review Nurse will give you a verbal authorization for level of care and number of days authorized. To receive your prior authorization number, fax the face sheet to our prior authorization coordinator at 602-674-6650 within 24 hours of admission. You will then receive a prior authorization number via a returned fax.

HOSPITAL ADMISSIONS

Emergency Department

Emergency room visits do not require a fax notification to the health plan. If the member is admitted as an inpatient or admitted for observation, fax notification is required within twenty-four (24) hours.

Information must include:

- Member Name
- Member I.D. Number
- Date of Birth
- Type of Service
- Facility's Name
- Diagnosis
- Pertinent health status information

Inpatient Admissions through the Emergency Department

Should the member require admission to the hospital, the member's PCP or hospitalist must be called and the call documented on the ER record.

Hospital admissions notifications must be faxed within 24 hours of admission.

Elective Inpatient and Outpatient Admissions

Elective and emergency hospital admissions that are initiated by any provider will be subject to facility's admission screening procedures. The facility is required to fax notification for admission to 602.674.6650 within twenty-four (24) hours. The contracted provider must use the hospital's reference number for an emergency hospital admission.

An elective hospital admission initiated by the PCP or Specialist requires prior authorization prior to the scheduling of the admission at a contracted facility. Prior authorization forms should be faxed to the prior authorization department. The prior authorization department will fax the authorization to the requesting provider upon approval. PHP also requires a fax notification from the facility for notification of the inpatient admission of a member.

Observation

Observation status should generally not exceed 23 hours and 59 minutes. This time limit may only be exceeded if medically necessary to evaluate the medical condition and/or treatment of a recipient.

Extensions of the time limit for an additional 24 hours MUST be prior authorized concurrently by a PHP Concurrent Review Nurse or a PHP Medical Director, using standardized criteria.

Please call 602-824-3783 or 602-824-3863 during normal business hours for direction to your Concurrent Review Nurse. After-hours, please call the on-call nurse at 602-824-3700; option 2.