The Basics of Medicaid Precertification

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Leigh Hamilton, RN BSN
Manager, PA/UM

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Medicaid Precertification Basics

- Conditions of reimbursement
- What needs precertification?
- Who is responsible?
- Types and time frames
- How do we do it?

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Conditions of Reimbursement

"The purpose of the program is to ensure medically necessary quality health care services are provided to eligible Medicaid members in the most cost-effective and safe setting."

- Medically Necessary – Severity of Illness/Intensity of Service
- Eligible Medicaid Member
- Most Cost-effective, Safe Setting
- PA/UM Reviews include: Hospital and ASC-based stays, Radiology and Imaging procedures, Injectable meds, DME, Transportation, short-term Hospital Outpatient PT/OT/ST, Dental, Hearing, Vision, Orthotics & Prosthetics, Additional Office Visits, Transplants and Out-of-State requests

Precertification/Prior Approval Does Not guarantee reimbursement.

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Core PA/UM Rules

- Initial PAs should have all required information upon submittal.
- Initial approvals require compliance with federal and state guidelines and have medical information to support the need for care and to ensure that care is done in least costly, safe setting.
- DCH policy denials may be done by an initial reviewer and are based on applicable DCH Provider Manuals.

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Core PA/UM Rules *(Cont'd)*

- PA/UM routinely processes only one reconsideration on a initially denied case. Be sure all the facts and documentation needed to address the denial reason(s) are submitted at the same time.
- A description of PA requirements is found in sections 800 & 900 and appendices of the various Provider Manuals.
- Provider Manuals can be viewed at www.mmis.georgia.gov under Provider Manuals. They are listed alphabetically.

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Core PA/UM Rules *(Cont'd)*

To view procedure decision rationale:

- If a procedure is denied, hold the mouse pointer over the denial reason code at the end of a procedure line to display the specific denial code description and denial rationale for that procedure line.
- If the procedure is approved, and the reviewer added approval comments, hold the mouse pointer over the word 'Approved' and the reviewer comments display.

What Hospital-based Care Needs Precertification?

- **Inpatient admissions, including psychiatric admits.**
- **Emergency admissions** need precertification within 30 days of the admit date. Admit date is day one.
- **All elective inpatient stays** including surgical procedures need precertification approval **prior** to admit date.
- **Outpatient procedures, if CPT code is listed on Physician Services Manual *Appendix E or O.***
- **Emergent procedures done during an observation stay**, have 30 days from the date of the procedure to submit a request.

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Is Anything Exempt from Hospital Precertification?

- Observation setting or emergency outpatient services **NOT** listed on either *Appendix E (Prior Approval), L (Imaging) or O (Precertification)*
- Members with both Medicare A and B as primary
- Uncomplicated Cesarean or vaginal hospital deliveries
- Newborns remaining at birth hospital under 31 days old
- Alliant does not do reviews on CMO members

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Who Is Responsible for Precertification?

- The attending Medicaid physician is responsible for obtaining authorization services. Services needing review and done without authorization are not reimbursable. The physician's failure to get approval will be imputed to the hospital and will result in denial of payment, per the Hospital Services Manual.
- Many hospitals coordinate with their physicians to assure that any necessary authorization has been obtained.

Note: If the attending physician is not a Medicaid provider or the member has only Medicare Part A or only Part B, we strongly recommend that the hospital request a review.

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Types of Certification

- **Precertification:** Inpatient stays and outpatient procedure codes listed in Physician Services Manual Appendix “O.” If you cannot perform the procedure within 90 days, contact Alliant to extend the expiration date. Initial requests are usually processed within one (1) full business day.

- **Prior Approval**: All procedure codes listed in Physician Services Manual on Appendix “E.” All transplants and Out-of-State cases and some DME Radiology and Outpatient Hospital Therapy codes are prior approvals. Alliant has 10 business days to process prior approvals and these are not done by phone.

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Types of Certification *(Cont'd)*

- **Re-certification**: Inpatient precert expires on day 90 of authorization period. This must be submitted via the Recertification link on the Medical Review Portal. Submissions must be made to the appropriate precert on day 87, 88, 89 up to day 90 with current clinical status to extend the precert another 90 days. Submission after day 90 is untimely.

- **Retro-eligibility**: This occurs when a patient does not have Medicaid at the time of service but receives coverage for that service at a later date. Submit request within 6 months from the month retro-eligibility is effective. Submission after this time frame is considered untimely.

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Sample Page of Appendix E and O

- Physician Services Provider Manual (Part II) Appendix E and O list CPT codes that require review. Only submit CPT codes that require review to avoid claims edits. **Appendices are updated at the beginning of every quarter.**
- **Example of Appendix E: Prior Approval.** Written description.

  Laparoscopy/Hysteroscopy

  58552 - with removal of tube(s) and/or ovary(s)

  58553 - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater
- **Example of Appendix O: Precertification.** No written description.

  11310 11312

  11311 11313

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Precert Process

- ***Precert Nurses*** – Cases are reviewed by nurses using InterQual criteria, they are approved by the nurse and a precert/tracking number is issued. If the cases do not meet criteria, they are referred to the Referral Coordinator. Please note – no additional information can be added to a case after it's been referred for physician review.

- ***Referral Coordinators*** – This is the second review of the clinical information by a nurse. The Referral Coordinator reviews the request and either approves the case or refers it to a Physician Consultant.

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Precert Process *(Cont'd)*

- ***Physician-Peer Consultants*** – Peer Consultants review the clinical material provided.
- They are not bound by InterQual criteria guidelines and use medical judgment to approve or deny the request based on the information provided.
- If the consultant approves the case, an approval number and notification are issued. If the consultant denies a case, the provider is notified of the denial reason and given tracking number.
- Appeals /reconsideration on physician denials are best done via the Provider Workspace Reconsideration link.

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Appeal/Reconsideration Process

- ***Second Peer Consultant*** – When the appeal/reconsideration is received, the Referral Coordinator reviews the additional data and approves the case or refers it to a Peer Consultant. The Peer Consultant is Board Certified in the appropriate specialty. The consultant reviews all initial and additional information submitted and may approve or deny it.
- **DCH Administrative Review** – A provider that feels a case has been unjustly denied by Alliant, may request an Administrative Review per DCH Policy Manual Part 1 Chapter 500 and 402.6 for UR denials. The Administrative Review must be requested within 30 days of the date on the Final Denial Letter. Administrative Review process must be completed for the provider to be entitled to a hearing and are limited to issues addressed in the Administrative Review process. **(should be submitted via Admin Review Link on Med Review Portal)**

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Need to Know Information

- **Readmissions** within 3 days with the same or a related diagnosis are to be combined and should be billed using the original precert number.
- **Submission/Appeal/Reconsideration:** Admitting physician and facility need to coordinate submission of initial request and appeals. All hospital and facility based PAs should have the requesting / admitting physician name and ID on the request and facility name /REF number.
- **Authorization Period** is generally effective for 90 days. Some review types like dental or DME have different effective/end date rules.
- Recertification is required for inpatient stays over 90 days. Submit recertification with current clinical between days 87-90. After 90th day, request is considered untimely.

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Need to Know Information *(Cont'd)*

- **Admission Type**: Planned/elective care require precert before services are rendered. Emergent/urgent care must be submitted within 30 days from the admission/procedure date. Submission time frame starts on date of admit/procedure.
- **Technical Denials** are for policy violations like untimely submissions for elective procedures performed without precert/prior approval and emergent cases not submitted within the 30-day time frame.
- **Observation vs. Inpatient**: When the need for inpatient stay is questionable, observation is a good option. Observation can be up to 24-48 hours. Over 48 hours observation stay may be needed and, if ordered, will be subject to prepayment review at the time claims are submitted. Medical observation stays, regardless of time, do not require a precert unless a procedure is performed that is listed on Appendix E and O.

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Need to Know Information *(Cont'd)*

- **Upgrades**: If the member fails observation and needs to be upgraded to inpatient, the admit date is the inpatient MD order date.
- **Changes to existing cases**: Submit request for a change within 30 days of issuance or within 30 days of the procedure *via phone, fax or Web* change request menu in affected PA. A change request received after 30 days will be considered untimely and given a Technical Denial.
- Alliant is unable to change year in PA requests, so be careful with date entry.

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Hospital Stay Transfers

Transfer: Applies only to those patients who are inpatient and transferring to another inpatient setting, requiring two precert numbers – one for each facility. ER-to-ER transfers are not precerted.

Transfers between units within a hospital are not considered new admissions and do not need Alliant review.

Transfers ***are*** approved for the following events:

- Upgrade of care
- The member needs a service or treatment that the current facility is unable to provide
- Back transfer to original/lower level of care facility for continued inpatient setting

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Transfers *(Cont'd)*

Generally, the accepting facility is responsible for obtaining the new precert number.

- A transfer to another facility for an inpatient or outpatient procedure is not always precerted; (refer to the Hospital Policy Manual, section 903.2). In some instances, there may be a contractual agreement between the facilities for these services.
- Contractual services may apply when a back transfer is made to original sending facility and medical services are continued at the same level or lower level of care. In this case, the transfer may be considered inappropriate and therefore not a covered service.

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Transfers *(Cont'd)*

Be prepared to answer the following questions in relation to transfers:

- Which services can the new facility provide that the current facility cannot provide?
- What makes the care at the new facility medically necessary?
- Will the accepting facility keep the member or does the accepting facility plan to send the member back to the first facility?

- Social transfers or those transfers done at the request of the beneficiary or family, or for the physician's convenience, are **NOT** covered.
- If a transfer is deemed non-covered, **the accepting facility will not be paid.**

Technical Denials (TDs)

- TDs are issued when cases do not comply with policy. The most common denial reason is case was not submitted within the required time lines (*untimely*).
- Timelines to know:
  - **Urgent/Emergent:** 30 days
  - **Elective:** before the procedure or admission
  - **Retro-eligible:** within 6 months of eligibility date
  - **Changes:** within 30 days of PA submission or admission/procedure date
  - **Medicare Exhaust:** within 3 months of exhaust notice

Technical Denials *(Cont'd)*

- TDs are NOT based on medical necessity, but happen when a DCH policy is violated. However, cases will be medically approved or referred to consultant **ONLY** if the TD is overturned. So Reconsideration should address the policy problem.
- Once a TD is issued, you have 30 days to appeal in writing. Appeals/Reconsiderations need to include the PA tracking number and **the reason the case did not comply with policy**.
- Appeals/Reconsiderations are best submitted via the Provider Workspace on the Web in the case. Additional documentation can also be attached directly to same case to save you time.

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PASRR

- ***ALL*** nursing home admissions with an anticipated stay for more than 30 days require a mental health screening (**Level 1**). Level 1 screenings must be completed and approved before admission.
- **If you do not get an immediate approval via Medical Review Portal, contact Alliant the next business day to verify information and status of request. This can be done via contact us link or phone call.**
- Admission before the screening process is complete will result in a premature admit status and may cause payment withholding or fines.

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PASRR Level II

- If the patient has a mental illness or a history of mental illness/mental retardation, they may require a Level II.
- Level II screenings are performed by Beacon or other contracted agency as designated by DCH. These agencies issue their own determination.
- ***Level II screenings can take up to 5 business days to process and the patient must stay in their current setting until the Level Two process is complete.***
- If the physician is considering nursing home placement, submit Level 1 request early to avoid discharge delays.

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Swing Bed

- Must submit request on day of admission.
- Submission of DMA 6 or 6A form is via Web portal only.
  - ***No phone or fax submissions accepted.***
- Requests received after admit date will have a payment date set as date the request was submitted. Weekend admits may be submitted by next business day.
- Initial stay is given 14 days. Subsequent continued stay requests are given 30 days.
- Continued stay requests should be submitted on day of previous PA expiration date or day after. Include the discharge plan for transition home or to a nursing facility.

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Radiology Reviews

The Georgia Legislature 2006 budget mandated review of high cost radiology and imaging procedures including:

- PET Brain
- PET Whole Body
- CT Head
- CT Pelvis/Abdomen
- MRI Brain
- MRI Lumbar Spine
- Obstetrical Ultrasounds

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Two PA Types for Radiology

1. **Radiology – Physician Office:** Use this PA type for radiology services provided in a doctor's office or free standing radiology center.
2. **Radiology – Facility Setting:** Use this PA type for radiology services provided in an outpatient hospital or ambulatory surgical center.

Note: Radiology codes needing review are primarily listed in Physician Services Appendix L Radiology Services requiring Prior Authorization.

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Radiology *(Cont'd)*

- Radiology requests may be submitted only through the GA MMIS Web Portal. Faxed, mailed or phoned requests are not permitted.
- Radiology inquiries can be handled via Contact Us in the Provider Workspace.
- To register for Web access, go to www.mmis.georgia.gov or call HP Customer Service.
- Providers may view the PA request status via the Web.

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Radiology PA Process

- When submitted, the case is pended (*suspended in HP system*).
- Radiology is a Prior Approval review. Cases are reviewed by nurses utilizing InterQual criteria and DCH policy guidelines with a 10 business day turn around.
- Written notification of review outcome is sent to the providers.

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Radiology PA Process *(Cont'd)*

- If denied, providers may submit a request for reconsideration via Web portal's Provider Workspace Reconsideration link.
- You have 30 days to request a precert for emergent procedures. Providers may give emergency imaging care without PA approval, and request approval within 30 days. Day of care is day one.
- A precert is required before performing elective procedures.

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Radiology Exceptions

- The following OB Ultrasound codes can be done once during a pregnancy without a PA -76805, 76810 and 76817.
- Radiology outpatient CPTs that require a PA do not require a PA if done during an inpatient hospital admission.
- ER (*Emergency*) imaging procedures that need a PA must be submitted within 30 calendar days.

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Radiology Exceptions *(Cont'd)*

- Required Precert codes are listed primarily in the Physician Services Manual on Appendix L.
- Refer to Appendices E, L and O for detailed information regarding specific procedures that require prior approval before services are rendered.
- Radiology Reviews are processed using the rules in the Physician and/or Hospital Manuals available online at www.mmis.georgia.gov.

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Radiology Entry Restrictions

- Only radiology codes may be approved on a radiology PA request form and submitted via Web portal under specified radiology review type – facility or office setting.
- The PA system will not permit processing of outpatient radiology procedure codes requiring PA to be handled in any other PA review type.
- Radiology PAs with CPTs for non-imaging codes can be processed at Alliant ONLY by withdrawing the non-imaging CPT. System sees withdrawal as a denial.

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Durable Medical Equipment (DME)

- The DME Services Manual can be found on the Web portal at www.mmis.georgia.gov.
- The manual is updated by the Department of Community Health (DCH) quarterly.
- Providers need to be aware of the changes DCH makes and their effective date.
- DME PAs are submitted via the Web Portal only. No phone submissions allowed.

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DME PA Process

- There is a 30 calendar day turnaround time for PA decision. Countdown starts the day we get all required information.
- The date of service or start date cannot be more than 90 days from the PA submission date.
- Incomplete cases are denied for missing information.

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DME PA Process *(Cont'd)*

- Providers have 30 calendar days to submit more details by fax or Web as reconsideration to an initial denial. The first information received will be worked as the reconsideration, so make sure all information critical for the reconsideration is submitted at the same time.

- As with all its reviews, Alliant does one reconsideration review, based on specific clinical facts, DCH policy and InterQual. So be sure everything to be considered is included in the reconsideration.

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DME PA Process *(Cont'd)*

- DME can only be approved for use in the member's home and is not reimbursed and should not be requested for members in a nursing home.
- The Schedule of Maximum Allowable Payments for DME Services, also called the Fee Schedule, can also be found on the Web portal under "Fee Schedules." The schedule is updated quarterly and:
  - Includes maximum allowed units and payments for CPTs & HCPCS codes
  - Indicates whether the item requires a prior approval since many items in this schedule do not.
- NU indicates purchase; RR indicates rental

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Hospital Outpatient Therapy

- Hospital Outpatient Therapy PAs are for: Acute Conditions. *Exceptions*: wheelchair evaluations, some swallowing studies and some hearing evaluations.
- Medicaid Policies for Hospital Outpatient Services can be found in Section 903.5 of the Hospital Services Manual cited below.
- Rehabilitation defined by federal regulation is not covered in the Hospital program. However, short-term rehabilitation services, e.g., physical therapy, occupational therapy and speech therapy are covered immediately following and in treatment of acute illness, injury or impairment.

View entire section at: www.mmis.georgia.gov

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Hospital Outpatient Therapy *(Cont'd)*

- Hospital Outpatient Therapy PAs must be submitted via the Web portal with acute condition diagnosis and date of onset clearly documented in the request. Supporting documents may also be attached during submittal.
- Indicate the frequency and duration of each therapy code in the online request. If audited, providers are expected to have a corresponding medical order for therapy.
- Expect an initial decision by the10th business day. So if you want to start therapy on 1st of month, submit PA request by 19th or 20th of preceding month.

Hospital Outpatient Therapy *(Cont'd)*

- **Common denial reasons to avoid**
  - Member is covered by a CMO
  - Not recent/acute clinical situation
  - MD certification missing, not signed or not dated within 30 days of requested start date
  - If care is emergency, describe the emergency
  - The correct number of units is requested. Check the total number of units per CPT per line. Make sure the total reflects one visit = one unit/day
  - Modifiers are not required and entering modifiers causes errors and potential delays

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Dental Authorizations

- Health Check Dental authorizations, which include orthodontics and incorporate codes for pregnant women, are for members under the age of 21.
- Authorizations for pregnant members over the age of 21 are submitted as Adult Dental and require the DMA 635 form as attestation of pregnancy.
- Specific criteria for units and combination of codes can be found in the Dental Services Manual. Appendix B is the Maximum Allowable Payment for Dental Services.

Dental Authorizations *(Cont'd)*

- Authorization requests should be entered via the Web portal or can be sent by fax. No phone requests are accepted. Scanned X-rays can be attached via Web portal or mailed hard copy to:

  Alliant
  PA/Dental Department
  P.O. Box 105329
  Atlanta, Georgia 30348

- Turnaround time for Dental Authorization review is 30 days after all required information has been received.
- Hospital dental care guidelines are found under Section 805.1 in the Dental Policy and are limited to those cases that cannot be handled in the dental office setting.

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Contact Alliant for Precertification

- All PAs may be submitted via Medical Review Portal at www.mmis.georgia.gov.
- A few review types may be done by phone. Contact HP Customer Service at 800-766-4456 to access precertification department.
- Must enter 9-digit Medicaid Provider ID with ending letter to access precertification department. Callers without a correct ID will be sent to the general inquiry queue which may delay reaching the correct review department.
- May use Web portal Contact Us link for all PA inquiries.

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Contact Alliant for Precertification *(Cont'd)*

- Callers with a valid provider ID wanting to start a new PA will be given several options to select the correct review department.
- Callers supplying a provider ID who have questions about an existing PA will be asked to enter PA number and call will be routed to the appropriate review department.

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Thank you…

Questions?

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