

# The Basics of Medicaid Precertification



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**PA/UM Department**

# Medicaid Precertification Basics

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

# 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.**

# **Core PA/UM Rules**

- ▶ **Initial PAs should have all required information upon submittal. When submitted, case is pended (suspended in HP system).**
- ▶ **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.**

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

- ▶ PA/UM routinely processes only one reconsideration on an 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.
- ▶ For an alphabetical list of Provider Manuals, go to [www.mmis.georgia.gov](http://www.mmis.georgia.gov) under Provider Information Tab and select from drop down list 'Provider Manuals.'

# **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?**

- ▶ **Emergency admissions** need precertification within 30 days of the admit date.
- ▶ **All elective inpatient stays** including surgical procedures need precertification approval prior to admit date.
- ▶ **Outpatient procedure CPT code 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 if authorization is required.

# 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 GMCF does not do reviews on CMO members nor handle inquiries on CMO submissions



# Who Is Responsible for Precertification?

- ▶ The physician, dentist or therapist is responsible for obtaining authorization of their services. 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 medical providers to assure that 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.

# Types of Certification

- ▶ **Precertification:** Inpatient and outpatient procedure codes listed in Physician Services Manual Appendix “O.” If procedure not performed within 90 days, contact Alliant GMCF to extend the expiration date. Usually processed within 1 full business day after receipt of a complete request.
- ▶ **Prior Approval:** Procedure codes listed in Physician Services Manual on Appendix “E.” All transplants, out-of- state cases and some DME Radiology and Outpatient Hospital Therapy codes are prior approvals. Alliant GMCF has 10 business days to process prior approvals and these are not done by phone.

# Types of Certification (Cont'd)

- ▶ **Re-certification:** Inpatient precert expires on day 90 of authorization period. Call or fax a request to extend the 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 and any subsequent care after 90 days will not be covered or reimbursed.
- ▶ **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.

# Precert Process

- ▶ **Precert Nurses** – Initial review by nurses using InterQual criteria. If approved by the nurse a precert/tracking number is issued. If the cases do not meet criteria, they are referred for medical review to the Referral Coordinator. **Please note** – no additional information can be added once 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.



# 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 /reconsiderations on initial denials must be written and submitted via the Provider Workspace Reconsideration link.

# Appeal/Reconsideration Process (cont'd)

- ▶ **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. If denied, then a final denial notice is issued.



- **DCH Administrative Review** – A provider that feels a final denial has been unjustly issued by Alliant GMCF, 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 directly to DCH Customer Service and Resolution within 30 days of the date on the Final Denial Notice. 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.

# Need to Know Information

- ▶ **Readmissions:** within 3 full days of last hospital inpatient 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. Hospital and facility based PAs should have the 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. Request recertification with current clinical between days 87-90 of authorization period. After 90<sup>th</sup> day, request is considered untimely.

# 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 after date of admit/procedure date.
- ▶ **Technical Denials** are for policy violations like untimely submissions for elective care done without prior approval, emergent cases not submitted within 30 days or failure to submit DCH required items.
- ▶ **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 Physician Services Manual Appendix E , L or O.



# Need to Know Information (Cont'd)

- ▶ **Upgrades:** If the member fails observation and needs to be upgraded to inpatient, mark request as 'urgent' inpatient. 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 or Web* change request link in affected PA. A change request received after 30 days will be considered untimely and given a Technical Denial with instructions for reconsideration.
- ▶ **Be careful with initial date entry.** Asking for a change to a previous year or month may cause a claims edit.

# 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 setting do not need a precert. Transfers between units within same hospital are not considered new admissions and do not need a new authorization from Alliant GMCF.

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

# Transfers (Cont'd)

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

- ▶ 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.

# 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?  
(Sending back may be considered a contractual service agreement).
- 
- ▶ **Social transfers** or those transfers done at the request of the beneficiary, 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 DCH 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-TDs (*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 via. Web portal Reconsideration Request Link and include **the reason the case did not comply with policy**.
- ▶ **Attachments** may be submitted at the time of reconsideration if additional documentation is needed for justification.

# 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 Web portal, contact Alliant GMCF via phone or Contact Us to verify information and status of non-approval.
- ▶ Admission before the screening process is completed will result in a premature admit status and may cause payment withholding or fines.

# 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 a designated DCH contractor. This agency issues their own determination and authorization number.
- ▶ ***Level II screenings can take several business days to process and the patient must stay in their current setting until the Level II process is complete.***
- ▶ A referred Level 1 request sent for Level II processing will remain in a pended status and cannot be used for billing.



# Swing Bed

- ▶ **Must submit request on day of Swing Bed unit admission.**
- ▶ **Submission of DMA 6 or 6A form is via Web portal only.**
- ▶ **Requests received after admit date will have a payment date set as date the request was submitted. Weekend/Holiday initial 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 to justify continued stay.**

# **Radiology Reviews**

**The Georgia Legislature mandated review of high cost radiology and imaging procedures designated on Physician Services Manual Appendix L list including:**

- ▶ **PET Scans**
- ▶ **CT of head, abdomen, pelvis, chest**
- ▶ **MRI Brain, neck, chest, heart, thorax, lumbar, abdomen, pelvis, selected extremities and joints**
- ▶ **MRI angio, myocardial imaging and cardiac echo**
- ▶ **Obstetrical Ultrasounds**

# 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.

Radiology codes needing review are primarily listed on Physician Services Appendix L but also check Appendix E/O for some radiation procedures.

## **Radiology (Cont'd)**

- ▶ Radiology requests may be submitted only through the designated Medicaid Web Portal.
- ▶ Radiology inquiries can be handled via Contact Us in the Provider Workspace.
- ▶ To register for Web access, go to [www.mmis.georgia.gov](http://www.mmis.georgia.gov) or call HP Customer Service.
- ▶ Providers may view the PA request status via the Web.
- ▶ Written notification of review outcome is sent to provider at address associated with submitted provider ID.

# 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.

# **Radiology PA Process (Cont'd)**

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

# 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.
- ▶ Radiology outpatient exam done within 3 days of patient upgraded to inpt at same facility with a related issue, the outpt PA should be withdrawn and billed with the inpatient claim.

# **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 GMCF ONLY by withdrawing the non-imaging CPT. System sees withdrawal as a denial.



# Durable Medical Equipment (DME)

- ▶ The DME Services Manual can be found on the Medicaid Web portal at [www.mmis.georgia.gov](http://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. Check provider notices-also known as 'Banner Messages' via web portal.
- ▶ DME PAs are submitted via the Web portal only.

# 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.

# **DME PA Process (Cont'd)**

- ▶ **Providers have 30 calendar days to submit more details to an initial denial by using web portal reconsideration request link. The first information received will be worked as the reconsideration, so make sure all supportive information for reconsideration is submitted at the same time.**
- ▶ **Alliant GMCF does one reconsideration review based on specific clinical facts, DCH policy and InterQual. A continued incomplete request will result in a final denial.**

# **DME PA Process (Cont'd)**

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

# 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](http://www.mmis.georgia.gov)

# **Hospital Outpatient Therapy (Cont'd)**

- ▶ **Submit Hospital Outpatient Therapy PAs via GAMMIS 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 the 10<sup>th</sup> business day. So if you want to start therapy on 1<sup>st</sup> of month, submit PA request by 19<sup>th</sup> or 20<sup>th</sup> of preceding month.**

# Hospital Outpatient Therapy (Cont'd)

## ► Common denial reasons to avoid:

- Clinical situation is not recent/acute
- MD certification is missing, not signed or not dated within 30 days of requested start date
- Justification of emergent/urgent care is not documented
- Incorrect 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
- A modifier is used when modifiers are not required. This causes errors and potential delays

# Dental Authorizations

- ▶ **Health Check Dental** authorizations, are for members under the age of 21 up to the last day of the 21<sup>st</sup> birthday month.
- ▶ **Adult Dental** authorization are for members over age 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. Digital or scanned X-rays may also be attached to the PA via web portal once request has been submitted and pending request ID has been assigned. Instructions for attaching documents are available under 'Provider Education' tab found on the Provider Workspace
- ▶ 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 Manual and are limited to those cases that cannot be handled in the dental office setting. All CDT codes/units rendered in the hospital require precert

# Contact Alliant GMCF For Precertification

- ▶ All PAs may be submitted via Web portal at [www.mmis.georgia.gov](http://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.
- ▶ A 9-digit Medicaid Provider ID with ending letter must be entered 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.
- ▶ The Web portal Contact Us link may be used for all PA inquiries.

# **Contact Alliant GMCF 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. Selecting '0' option will only delay getting to the correct review department
- ▶ Callers supplying a provider ID who have questions about an existing PA will be asked to enter PA number or Request ID (12 digit tracking number) and call will be routed to the appropriate review department.

**Thank you...**

**Questions?**