

4 Obtaining Prior Authorization

Prior authorization serves as a cost-monitoring, utilization review measure and quality assurance mechanism for the Alabama Medicaid program. Federal regulations permit the Alabama Medicaid Agency to require prior authorization (PA) for any service where it is anticipated or known that the service could either be abused by providers or recipients, or easily result in excessive, uncontrollable Medicaid costs.

This chapter describes the following:

- Identifying services requiring prior authorization
- Submitting a prior authorization request
- Submitting prior authorization supporting documentation
- Receiving approval or denial of the request
- Using AVRS to review approved prior authorizations
- Submitting claims for prior authorized services

Added: [Submitting prior authorization supporting documentation](#)

4.1 Identifying Services Requiring Prior Authorization

The Alabama Medicaid Agency is responsible for identifying services that require prior approval. Prior authorization is generally limited to specified non-emergency services. The following criteria may further limit or further define the conditions under which a particular service is authorized:

- Benefit limits (number of units or services billable for a recipient during a given amount of time)
- Age (whether the procedure, product, or service is generally provided to a recipient based on age)
- Sex (whether the procedure, product, or service is generally provided to a recipient based on gender)

To determine whether a procedure or service requires prior authorization, access the Automated Voice Response System (AVRS). Refer to Section L.6, Accessing Pricing Information, of the AVRS Quick Reference Guide (Appendix L) for more information.

For all Magnetic Resonance Imaging (MRI) scans, Magnetic Resonance Angiogram (MRA) scans, Computed Tomography (CT) scans, Computed Tomography Angiogram (CTA) scans, and Positron Emission Tomography (PET) scans performed on or after March 2, 2009, providers will be required to request prior authorization from eviCore (Formerly MedSolution). Scans performed as an inpatient hospital service, as an emergency room service, or for Medicaid recipients who are also covered by Medicare are exempt from the PA requirement. Refer to Chapter 22, Independent Radiology, for the diagnostic imaging procedure codes that require prior authorization, and to section 22.3 Prior Authorization and Referral Radiology Services for additional information.

Prior authorization requests for outpatient diagnostic imaging procedures may be made to eviCore (formerly MedSolutions) by phone at (888) 693-3211 or by fax at (888) 693-3210 during normal business hours 7:00 a.m. to 8:00 p.m. C.T. Requests can also be submitted through MedSolutions' secure website at www.MedSolutionsOnline.com.

The program services chapters in Part II of this manual may also provide program-specific prior authorization information.

NOTE:

When a recipient has third party insurance and Medicaid, prior authorization must be obtained from Medicaid if an item ordinarily requires prior authorization. This policy does not apply to Medicare/Medicaid recipients.

NOTE:

For SOBRA adult recipients who now have full Medicaid benefits, retroactive to November 1, 2015, providers may submit a PA for a date of service on or after November 1, 2015 if the procedure code requires a PA. For dates of service from November 1, 2015 to April 30, 2016, the PA must be received by HPE by June 30, 2016 for review. All other PAs for a date of service May 1, 2016 and after must be submitted timely, prior to rendering the service, and adhere to the normal submission guidelines in this Chapter and other applicable Chapters, such as Chapter 14, Durable Medical Equipment

4.2 Submitting a Prior Authorization Request

To receive approval for a PA request, you must submit a complete request using one of the approved submission forms. This section describes how to submit online and paper PA requests, and includes the following sections:

- Submitting PAs (278 Health Care Services Review-Request for Review and Response) using Provider Electronic Solutions
- Submitting Paper PA Requests
- Submitting PAs using the Web Portal

NOTE:

PAs are approved only for eligible recipients. It is therefore recommended that provider verify recipient eligibility prior to submitting a PA request. Refer to Chapter 3, Verifying Recipient Eligibility, for more information.

In the case of a retroactive request (retroactive eligibility), the recipient must have been eligible on the date of service requested. The provider must submit the PA request within 90 calendar days of the retroactive eligibility award (issue) date. If a retroactive PA request is submitted and does not reference retroactive eligibility, the request will be denied.

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital or ambulatory surgical center **prior to rendering the service**, unless it is a medical emergency, as explained below.

Deleted: Providers will soon...after implementation November 15, 2016.

If a medical emergency is referenced, the provider must submit the PA request **within 30 days** of the date of service. Supporting documentation must provide evidence that the service was not scheduled and that delays greater than 72 hours would have resulted in serious injury or harm.

Prior authorizations must be received by the fiscal agent within 30 days of dispensing equipment, or for laboratory procedures within 30 days of the date of service.

A Letter of Medical Necessity (LMN) with sufficient information to meet criteria may be submitted. However, medical records may be requested to justify the medical necessity of the requested item or service by the Agency or its designated PA reviewer.

Medical records must be submitted to justify the medical necessity of the requested item or service. Checklists are not sufficient documentation to meet criteria.

Prior authorization requests that are received by HPE and rejected due to incorrect information will not be considered received timely unless resubmitted correctly within 30 days of the dispensed date.

Providers shall verify that procedure codes requested on a PA are not subject to NCCI edits, whether procedure to procedure (PTP), or medically unlikely (MUE) edits. An approved PA may not override an NCCI edit.

Providers shall review NCCI edits on the CMS site at, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>, prior to submitting a PA.

Deleted: Beginning December 1, 1999, you

Added: Providers
Added: HPE will mail...from the internet

4.2.1 Submitting PAs Using Provider Electronic Solutions

Providers can submit electronic PA requests using HPE Provider Electronic Solutions software available at no charge. HPE will mail the software to the provider at no cost, or the provider may download the software from the Internet.

http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.10_Provider_Electronic_Solutions.aspx

Refer to Chapter 15 of the *Provider Electronic Solutions Manual* for specific information. This chapter provides instructions for submitting electronic 278 requests

The electronic 278 Health Care Services Review- Request for Review and Response claim is not limited to the use of the Provider Electronic Software. Providers may use other vendor's software to submit a 278 electronic claim.

Deleted: If you already...for contact information-

Deleted: can be located...by the system-

Deleted: Please be aware...Electronic Solutions Manual-

Deleted: The submission process...it occurs today-

Added: with your PA...using the Web Portal.

Deleted: and attach the response to your attachments

Deleted: It is also...Montgomery, AL 36124

NOTE:

Please include a copy of the Prior Authorization response, which is received after your submission, with your PA supporting documentation. For details, refer to section 4.3 PA Requests Requiring Supporting Documentation on submitting PA supporting documentation using the Web Portal.

4.2.2 Submitting Paper PA Requests

In the absence of electronic applications, providers may submit requests for prior authorization using the Alabama Prior Review and Authorization Request Form (Form 342). No other form or substitute will be accepted. Completed requests should be sent to the following address:

**HPE Prior Authorization Unit
P.O. Box 244032
Montgomery, AL 36124-4032**

For a hardcopy request, the provider or authorized representative must personally sign the form in the appropriate area to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of the patient. For electronic signatures, provider certification shall be in accordance with the electronic signature policy in the Administrative Code, Chapter 1, Rule No. 560-X-1-.18 Provider/Recipient Signature Requirements.

4.2.3 Submitting PA Requests Using the Web Portal

Providers may also submit PA requests through the interactive web portal. Please use this link for the Alabama Medicaid Agency AMMIS Interactive Services Website User Manual: http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx

See Section 13 of the AMMIS Interactive Services Website User Manual, Prior Authorization, for information about this process.

4.3 PA Requests Requiring Supporting Documentation

If supporting documentation is required for PA review, the required attachments must be sent to HPE within 48 hours to be scanned into the system to prevent a delay in review and/or a denial for “no documentation” to support the PA request. Do not fax this information to the Alabama Medicaid Agency unless a request is made for specific information by the Agency reviewer. Attachments scanned can be located in the system and are linked by the PA number on the Prior Authorization response returned by the system.

This section describes how to submit PA supporting documentation using the Web Portal, and includes the following sections:

- Submitting PA Supporting Documentation Using the Web Portal
- Instructions for Submitting PA Supporting Documentation using the Web Portal

4.3.1 Submitting PA Supporting Documentation Using the Web Portal

Providers will be able to upload or fax PA supporting documentation via the Forms menu of the Alabama Medicaid Interactive Web Portal starting:

- July 18, 2016 for Medical PA support documentation
- August 11, 2016 for Dental PA supporting documentation

A form will allow providers the ability to upload Medical or Dental PA supporting documents in PDF format or create a fax barcode coversheet from the Web Portal. Providers may submit additional documentation via fax at a later time and have that documentation combined with the original document through the use of the same barcode coversheet.

Added:
Providers will
be
able...same
barcode
coversheet.

NOTE:

Fax the required documentation with the provided barcode coversheet on top of the documentation to 334-215-7416

The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. **DO NOT** place anything on the bar code on the cover sheet or alter it in any manner.

Do not fax double sided pages.

Do not fax multiple sets of records at the same time. Each fax should be sent separately.

The bar code cover sheet is unique to this transaction. To submit documentation for another recipient, please complete the process for that unique recipient transaction.

Added: Do not fax...unique recipient transaction.

NOTE:

Medical and Dental PA supporting documentation will continue to be accepted in paper format until November 15, 2016. After that date, supporting documents received will be returned to the provider.

Added: NOTE

NOTE:

Please note the submission process for paper/original Dental X-Ray/Radiograph images will remain as it occurs today. Refer to Chapter 13 (Dentist) of this manual for details.

Added: NOTE

NOTE:

Please note the submission process for paper/original Photos, Radiographs, and X-Ray images will remain as it occurs today for the following PA requests:

15-04 – Reduction mammoplasty

15-06 – Reconstruction vs. Cosmetic Procedures

15-07 – Blepharoplasty

15-08 - Abdominoplasty

Added: NOTE

4.3.2 Instructions for Submitting PA Supporting Documentation Using the Web Portal

Added:
[Instructions for Submitting PA Supporting Documentation Using the Web Portal](#)

Please use this link for the Alabama Medicaid Agency AMMIS Interactive Services Website User Manual:

http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx

See Section 13.6.1 of the AMMIS Interactive Services Website User Manual, Forms Panel, for information about this process.

4.4 Completing the Alabama Prior Review and Authorization Request Form

Providers use the Alabama Prior Review and Authorization Request Form to submit Medical PAs on paper. This form is available through the Medicaid Agency at the following website link:

http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.1_Billing_Forms.aspx

4.4.1 Blank Alabama Prior Review and Authorization Request Form

You may fill in the blanks on the computer. Print the form and add signature and date. Mail completed form to HPE at the address below. Information that is typed in will not be saved in the form once the document is closed.

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|-----------------------------------|-------------------------------------|---|---------------------------------------|---|--|-------------------------------------|------------------------------------|--------------------------------------|--------------------------------------|---|---|---------------------------------------|---|---|---|--|--|
| (Required if Medicaid Provider) PMP <input type="checkbox"/> Requesting Provider NPI # _____ Phone with Area Code _____ Name _____ | Recipient Medicaid # _____ Name _____ Address _____ City/State/Zip _____ EPSDT Screening Date _____ DOB _____ Prescription Date CCYYMMDD _____ | | | | | | | | | | | | | | | | | | | | | |
| Rendering Provider NPI # _____ Phone with Area Code _____ Fax with Area Code _____ Name _____ Address _____ City/State/Zip _____ Ambulance Transport Code _____ Ambulance Transport Reason Code _____ DME Equipment: <input type="checkbox"/> New <input type="checkbox"/> Used | First Diagnosis _____ Second Diagnosis _____ Assignment/Service Code _____ Patient Condition _____ Prognosis Code _____ <table style="width:100%; font-size: small;"> <tr> <td><input type="checkbox"/> Medical Care</td> <td><input type="checkbox"/> Home Health Visits</td> <td><input type="checkbox"/> Occupational Therapy</td> </tr> <tr> <td><input type="checkbox"/> Surgical</td> <td><input type="checkbox"/> LTC Waiver</td> <td><input type="checkbox"/> Physical Therapy</td> </tr> <tr> <td><input type="checkbox"/> DME-Purchase</td> <td><input type="checkbox"/> Medically-Related Transportation</td> <td></td> </tr> <tr> <td><input type="checkbox"/> DME-Rental</td> <td><input type="checkbox"/> Maternity</td> <td><input type="checkbox"/> Psychiatric</td> </tr> <tr> <td><input type="checkbox"/> Dental Care</td> <td><input type="checkbox"/> Inhalation Therapy</td> <td><input type="checkbox"/> Speech Therapy</td> </tr> <tr> <td><input type="checkbox"/> Oral Surgery</td> <td><input type="checkbox"/> Private Duty Nursing</td> <td><input type="checkbox"/> Vision-Optometry</td> </tr> <tr> <td><input type="checkbox"/> Home Health Care</td> <td><input type="checkbox"/> Prosthetic Device</td> <td><input type="checkbox"/> Case Management</td> </tr> </table> | <input type="checkbox"/> Medical Care | <input type="checkbox"/> Home Health Visits | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Surgical | <input type="checkbox"/> LTC Waiver | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> DME-Purchase | <input type="checkbox"/> Medically-Related Transportation | | <input type="checkbox"/> DME-Rental | <input type="checkbox"/> Maternity | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Dental Care | <input type="checkbox"/> Inhalation Therapy | <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Private Duty Nursing | <input type="checkbox"/> Vision-Optometry | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Prosthetic Device | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Home Health Visits | <input type="checkbox"/> Occupational Therapy | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Surgical | <input type="checkbox"/> LTC Waiver | <input type="checkbox"/> Physical Therapy | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> DME-Purchase | <input type="checkbox"/> Medically-Related Transportation | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> DME-Rental | <input type="checkbox"/> Maternity | <input type="checkbox"/> Psychiatric | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Dental Care | <input type="checkbox"/> Inhalation Therapy | <input type="checkbox"/> Speech Therapy | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Private Duty Nursing | <input type="checkbox"/> Vision-Optometry | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Prosthetic Device | <input type="checkbox"/> Case Management | | | | | | | | | | | | | | | | | | | | |

| Line Item | DATES OF SERVICE | | PLACE OF SERVICE | PROCEDURE CODE* | MODIFIER 1 | UNITS | COST/ DOLLARS |
|-----------|------------------|---------------|------------------|-----------------|------------|-------|---------------|
| | START CCYYMMDD | STOP CCYYMMDD | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

***If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider _____ Date _____

FORWARD TO: HPE, P.O. Box 244036 Montgomery, Alabama 36124-4032

Form 342 The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2016 American Medical Association and © 2016 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply. Alabama Medicaid Agency www.medicaid.alabama.gov

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2016 American Medical Association and © 2016 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

4.4.2 Instructions for completing the Alabama Prior Review and Authorization Request Form

Section 1: Requesting Provider Information (Required)

| | |
|------------------|--|
| PMP | Check if the patient has been assigned to a Primary medical provider (PMP) under the Primary Care Case Management (PCCM) program, known as Patient 1 st . |
| License # or NPI | Enter the license number or the National Provider Identifier (NPI) of the physician requesting or prescribing services. |
| Phone | Enter the current area code and telephone number for the requesting physician. |
| Name | Enter the name of the prescribing physician. |

Section 2: Rendering Provider Information (Required)

| | |
|---------------------------------|---|
| Rendering Provider NPI Number | Enter the National Provider Identifier of the provider rendering services. |
| Phone | Enter the current area code and telephone number for the provider rendering services. |
| Fax | Enter the current area code and fax number for the provider rendering services. |
| Name | Enter the name of the provider rendering services. |
| Address | Enter the physical address of the provider rendering services. |
| City/State/Zip | Enter the city, state, and zip code for the address of the provider rendering services. |
| Ambulance Transport Code | Enter code to specify the type of ambulance transportation. Refer to "Ambulance Transport Codes" in the section below for appropriate codes. Used for ambulance services only. |
| Ambulance Transport Reason Code | Enter code to specify the reason for ambulance transportation. Refer to "Ambulance Transport Reason Codes" in the section below for appropriate codes. Used for ambulance services only. |
| DME Equipment | Enter a check mark indicating if the DME Equipment is New or Used. |

Section 3: Recipient Information (Required)

| | |
|---------------------------|--|
| Recipient Medicaid Number | Enter the 13-digit RID number. |
| Name | Enter the recipient's full name as it appears on the Medicaid eligibility transaction. |
| Address | Enter the recipient's current address. |
| City/State/Zip | Enter the city, state, and zip code for the address of the recipient. |

Section 4: Other Information

| | |
|-------------------------------|---|
| EPSDT Screening Date CCYYMMDD | Required field for all requests. Enter the date of the last EPSDT screening. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001. |
| DOB | Enter the date of birth of recipient. |
| Prescription Date CCYYMMDD | Required field for all requests. Enter the date of the prescription from the attending physician. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001. |
| First Diagnosis | Required field for all requests. Enter the primary diagnosis code. |
| Second Diagnosis | Enter the secondary diagnosis code. |
| Service Type | Required field for all requests. Outpatient hospitals requesting physical therapy must use Service type 01 (medical) and not Service Type AE (physical therapy.). |

| | |
|-------------------|--|
| Patient Condition | Enter the code that best describes the patient's condition. Refer to "Patient Condition Codes" in the section below for appropriate codes. Used for non-emergency ground transport, > 100 miles, ambulance services and DME providers only. |
| Prognosis Code | Required field for Service Types: 42, 44, and 74. |

Section 5: Procedure Information (Required)

| | |
|----------------------------------|--|
| Dates of Service | Enter the line item (1, 2, 3, etc.) along with start and stop dates requested. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001. |
| Place of Service | Enter a valid place of service (POS) code. |
| Procedure Code* | Enter the five-digit procedure code requiring prior authorization. If this PA is for inpatient stay, a procedure code is not required. |
| Modifier 1 | Enter modifier, if applicable. |
| Units | Enter total number of units. |
| Cost/Dollars | Enter price in dollars. |
| Clinical Statement | Provide a clinical statement including the current prognosis and the rehabilitation potential as a result of this item or service. Be very specific. |
| Signature of requesting provider | After reading the provider certification, the provider signs the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file. |
| Date | Enter the date of the signature. |

NOTE:
Additional information may be required depending on the type of request.

Procedure Code Modifiers

Procedure code modifiers are not available with the current electronic 278 Health Care Services Review – Request for Review transaction. If procedure code modifiers are necessary for a claim to process correctly, providers may submit a paper PA form.

Ambulance Transport Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the type of trip for ambulance service requests.

| <i>Code</i> | <i>Description</i> |
|-------------|--------------------|
| I | Initial Trip |
| R | Return Trip |
| T | Transfer Trip |
| X | Round Trip |

Ambulance Transport Reason Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the reason for the ambulance transport request.

| <i>Code</i> | <i>Description</i> |
|-------------|---|
| A | Patient was transported to nearest facility for care of symptoms. |
| B | Patient was transported for the benefit of a preferred physician. |
| C | Patient was transported for the nearness of family member. |

| <i>Code</i> | <i>Description</i> |
|-------------|--|
| D | Patient was transported for the care of a specialist or for availability of specialized equipment. |
| E | Patient transferred to rehabilitation facility. |
| F | Patient transferred to residential facility. |

Patient Condition Codes

The table below lists condition codes which may be used in different programs. Some codes may not be appropriate for all provider types. Please refer to the provider specific chapter of the Alabama Medicaid Provider Manual for acceptable patient condition codes. **(Used for non-emergency ground transport, > 100 miles, for ambulance services.)**

| <i>Code</i> | <i>Description</i> |
|-------------|---|
| 01 | Patient was admitted to a hospital |
| 02 | Patient was bed confined before the ambulance service |
| 03 | Patient was bed confined after the ambulance service |
| 04 | Patient was moved by stretcher |
| 05 | Patient was unconscious or in shock |
| 06 | Patient was transported in an emergency situation |
| 07 | Patient had to be physically restrained |
| 08 | Patient had visible hemorrhaging |
| 09 | Ambulance service was medically necessary |
| 10 | Patient is ambulatory |
| 11 | Ambulation is impaired and walking aid is used for therapy or mobility |
| 12 | Patient is confined to a bed or chair |
| 13 | Patient is confined to a room or an area without bathroom facilities |
| 14 | Ambulation is impaired and walking aid is used for mobility |
| 15 | Patient condition requires positioning of the body or attachments which would not be feasible with the use of an ordinary bed |
| 16 | Patient needs a trapeze bar to sit up due to respiratory condition or change body positions for other medical reasons |
| 17 | Patient's ability to breathe is severely impaired |
| 18 | Patient condition requires frequent and/or immediate changes in body positions |
| 19 | Patient can operate controls |
| 20 | Side rails are to be attached to a hospital bed owned by the beneficiary |
| 21 | Patient owns equipment |
| 22 | Mattress or side rails are being used with prescribed medically necessary hospital bed owned by the beneficiary |
| 23 | Patient needs lift to get in or out of bed or to assist in transfer from bed to wheelchair |
| 24 | Patient has an orthopedic impairment requiring traction equipment which prevents ambulation during period of use |
| 25 | Item has been prescribed as part of a planned regimen of treatment in patient's home |
| 26 | Patient is highly susceptible to decubitus ulcers |
| 27 | Patient or a caregiver has been instructed in use of equipment |
| 28 | Patient has poor diabetic control |
| 29 | A 6-7 hour nocturnal study documents 30 episodes of apnea each lasting more than 10 seconds |
| 30 | Without the equipment, the patient would require surgery |
| 31 | Patient has had a total knee replacement |

| Code | Description |
|-------------|--|
| 32 | Patient has intractable lymphedema of the extremities |
| 33 | Patient is in a nursing home |
| 34 | Patient is conscious |
| 35 | This feeding is the only form of nutritional intake for this patient |
| 37 | Oxygen delivery equipment is stationary |
| 38 | Certification signed by the physician is on file at the supplier's office |
| 39 | Patient has mobilizing respiratory tract secretions |
| 40 | Patient or caregiver is capable of using the equipment without technical or professional supervision |
| 41 | Patient or caregiver is unable to propel or lift a standard weight wheelchair |
| 42 | Patient requires leg elevation for edema or body alignment |
| 43 | Patient weight or usage needs necessitate a heavy duty wheelchair |
| 44 | Patient requires reclining function of a wheelchair |
| 45 | Patient is unable to operate a wheelchair manually |
| 46 | Patient or caregiver requires side transfer into wheelchair, commode or other |
| 58 | Durable Medical Equipment (DME) purchased new |
| 59 | Durable Medical Equipment (DME) Is under warranty |
| 5A | Treatment is rendered related to the terminal illness |
| 60 | Transportation was to the nearest facility |
| 68 | Severe |
| 69 | Moderate |
| 9D | Lack of appropriate facility within reasonable distance to treat patient in the event of complications |
| 9E | Sudden onset of disorientation |
| 9F | Sudden onset of severe, incapacitating pain |
| 9H | Patient requires intensive IV therapy |
| 9J | Patient requires protective Isolation |
| 9K | Patient requires frequent monitoring |
| AA | Amputation |
| AG | Agitated |
| AL | Ambulation limitations |
| BL | Bowel limitations, bladder limitations, or both (incontinence) |
| BPD | Beneficiary is partially dependent |
| BR | Bedrest BRP (bathroom privileges) |
| BTD | Beneficiary is totally dependent |
| CA | Cane required |
| CB | Complete bedrest |
| CM | Comatose |
| CNJ | Cumulative injury |
| CO | Contracture |
| CR | Crutches required |
| DI | Disoriented |
| DP | Depressed |
| DY | Dyspnea with minimal exertion |
| EL | Endurance limitations |
| EP | Exercises prescribed |
| FO | Forgetful |
| HL | Hearing limitations |
| HO | Hostile |
| IH | Independent at home |

| Code | Description |
|-------------|------------------------------------|
| LB | Legally blind |
| LE | Lethargic |
| MC | Other mental condition |
| NR | No restrictions |
| OL | Other limitation |
| OT | Oriented |
| PA | Paralysis |
| PW | Partial weight bearing |
| SL | Speech limitations |
| TNJ | Traumatic injury |
| TR | Transfer to bed, or chair, or both |
| UN | Uncooperative |
| UT | Up as tolerated |
| WA | Walker required |
| WR | Wheelchair required |

Patient Assignment Codes

Use this table to determine the appropriate patient assignment code.

| Code | Description |
|-------------|--------------------------------------|
| 01 | Medical Care |
| 02 | Surgical |
| 12 | Durable Medical Equipment - Purchase |
| 18 | Durable Medical Equipment - Rental |
| 35 | Dental Care |
| 40 | Oral Surgery |
| 42 | Home Health Care |
| 44 | Home Health Visit |
| 54 | Long Term Care Waiver Services |
| 56 | Medically Related Transportation |
| 69 | Maternity |
| 72 | Inhalation Therapy |
| 74 | Private Duty Nursing |
| 75 | Prosthetic Devices |
| A4 | Psychiatric |
| AD | Occupational Therapy |
| AE | Physical Therapy |
| AF | Speech Therapy |
| AL | Vision - Optometry |
| CQ | Case Management |

Prognosis Codes (Home Health and Private Duty Nursing Services Only)

Use this table for the appropriate code to describe the patient's prognosis.

| Code | Description |
|-------------|--------------------|
| 1 - 2 | Good |
| 4 - 6 | Fair |
| 7 - 8 | Poor |

4.4.3 Requesting a Revision to a Prior Authorization

Providers may request a change to a prior authorization for DME and certain medical services by completing Form 471. Prior authorizations, for which a claim has been paid, may not be revised until the claim has been voided. The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs or for procedure code changes. Providers must submit reconsideration for a denied PA following the usual process of faxing or mailing the PA denial letter to HPE, along with the supporting documentation for reconsideration. Providers may submit a new PA for procedure code changes. Complete the appropriate sections on the form and fax to the Alabama Medicaid Agency at (334) 353-9352 or (334) 353-4909. Please allow five business days for processing. The form may be accessed at http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.1_Billing_Forms.aspx

NOTE:

Form 471 may not be used for dental, pharmacy or for Magnetic Resonance Imaging (MRI) scan Magnetic Resonance Angiogram (MRA) scan, Computed Tomography (CT) scan, Computed Tomography Angiogram (CTA) scan, and Positron Emission Tomography (PET) scan prior authorizations. Prior Authorization documents must support the requested change(s) or the request will be denied. The Form 471 must be received **within 90 days** of the date on the PA approval letter.

Providers use this form to submit dental PAs on paper. These forms are available through the Alabama Medicaid Agency. Dental prior authorizations may also be submitted electronically through the Web Portal.

4.4.4 Blank Alabama Prior Review and Authorization Dental Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

| | |
|---|---|
| <p>Section I – Must be completed by a Medicaid provider.</p> <p>Requesting NPI or License # _____</p> <p>Phone () _____</p> <p>Name _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Medicaid Provider NPI # _____</p> | <p>Section II</p> <p>Medicaid Recipient Identification Number _____ (13-digit RID number is required)</p> <p>Name as shown in Medicaid system _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Telephone Number () _____</p> |
|---|---|

| Section III | DATES OF SERVICE | REQUIRED PROCEDURE CODE | QUANTITY REQUESTED | TOOTH NUMBER(S) OR AREA OF THE MOUTH |
|---|-------------------|-------------------------|--------------------|--------------------------------------|
| | START CCYYMMDD | | | |
| | STOP CCYYMMDD | | | |
| <p>PLACE OF SERVICE (Circle one)</p> <p>11 = DENTAL OFFICE</p> <p>22 = OUTPATIENT HOSPITAL</p> <p>21 = INPATIENT HOSPITAL</p> | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

3. Brief Dental/Medical History:

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist _____ Date of Submission _____

FORWARD TO: HP, P.O. Box 244032, Montgomery, Alabama 36124-4032

4.4.5 **Instructions for Completing the Alabama Prior Review and Authorization Dental Request Form**

Section 1: Requesting Provider Information (Required)

| | |
|------------------------------|--|
| Requesting NPI or License # | Enter the NPI or license number of the physician requesting or prescribing services. |
| Phone | Enter the current area code and telephone number for the requesting dental provider. |
| Name | Enter the name of the dental provider. |
| National Provider Identifier | Enter the 10-digit NPI of the requesting provider. |

Section 2: Recipient Information (Required)

| | |
|---------------------------|--|
| Recipient Medicaid Number | Enter the 13-digit RID number. |
| Name | Enter the recipient's full name as it appears on the Medicaid eligibility transaction. |
| Address | Enter the recipient's current address. |
| City/State/Zip | Enter the city, state, and zip code for the address of the recipient. |
| Telephone Number | Enter the recipient's most current phone number. |

Section 3: Procedure Information

| | |
|--------------------|--|
| Dates of Service | Enter the start and stop dates of service requested. Enter dates using the format CCYYMMDD. Use the date you complete the form and add six months. For example, 20050401 (April 1, 2005) through 20051001 (October 1, 2005). |
| Place of Service | Circle the appropriate two-digit place of service. |
| Procedure Code | Enter the five digit procedure code requiring prior authorization. Use the correct CDT2005 procedure code. |
| Quantity Requested | Enter the number of times the procedure code will be used/billed. |
| Tooth Number | Enter the tooth number(s) or area of the mouth in relation to the procedure code requested. |

Section 4: Medical Information

Complete Items 1-3 with the information requested. Documentation must be legible. If x-rays are sent, place them in a separate sealed envelope marked with recipient's name and Medicaid number.

Indicate whether the recipient has missing teeth and indicate the missing teeth with an X on the diagram.

After reading the provider certification, the provider signs and dates the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.

The completed form should be forwarded to HPE at the address given on the form.

4.5 Receiving Approval or Denial of the Request

Letters of approval will be sent to the provider indicating the approved ten-digit PA number, dates of service, place of service, procedure code, modifiers, and authorized units or dollars. This information should be used when filing the claim form. All electronic claims (278) will generate a 278 Health Care Services Review – Response, to notify the requester that of the response. Once the State has made a decision on the request, it will trigger an electronic 278 response to the provider. The electronic 278 response will either contain the PA number, rejection code or cancellation code information.

Section 1: Decision Codes

| Current Decision Codes: | |
|-------------------------|--------------------------|
| A | Approved |
| E | Evaluating |
| D | Denied |
| K | Cancelled |
| M | Modified PA Request |
| P | Pending |
| F | Denied Need Further Doco |
| G | Reconsideration |

Letters of denial will also be sent to the provider and recipient indicating the reason for denial.

Letters of approval or denial will be sent to both the provider and recipient for private duty nursing PAs.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). The Alabama Medicaid Agency must receive this request for appeal **within 30 days** from the date of the denial letter, or the decision will be final and no further review will be available.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). The Alabama Medicaid Agency, or its designee, must receive this request for appeal in writing **within 30 days** from the date of the denial letter, or the decision will be final and no further review will be available. Providers should fax or mail the PA denial letter to HPE, along with the supporting documentation for reconsideration. It is recommended that the PA number be written at the top of each page of the reconsideration documents. Providers should refer to Section 4.2.1 for the HPE fax number and mailing address. At least two business days after mailing/faxing the reconsideration documents, providers should send the PA number in an email to this address: alrecon@qualishealth.org. **Do not send any PHI in the email.** The PA number is sufficient to inform Qualis Health that the reconsideration is ready for review.

NOTE:

Providers may NOT bill a Medicaid recipient for an item for which a PA was denied.

4.6 Using AVRS to Review Approved Prior Authorizations

AVRS allows the provider to access information about an approved prior authorization number to confirm start and stop dates, procedure code(s), total units, and dollar amount authorized.

To inquire about approved prior authorizations (PAs), press 6 (the number 6) from the main menu, then AVRS prompts you for the following:

- Your National Provider Identifier (NPI), followed by the pound sign
 - The ten-digit prior authorization number, followed by the pound sign
- AVRS performs a query and responds with the following information for the PA:
- Recipient number
 - Procedure code or NDC, if applicable (some PAs do not require procedure codes or NDCs)
 - Start and stop dates
 - Units authorized
 - Dollars Authorized
 - Units used
 - Dollars Used

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the message
- Press 2 to check another Procedure Code or NDC for the same provider
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

4.7 Submitting Claims for Prior Authorized Services

Once the approved ten-digit PA has been received, providers may submit the claim electronically. The claim must match the approved PA with respect to procedure code, modifier, if any, approved dates, units and servicing provider NPI. The claims processing system will match the approved PA to the claim submitted.

NOTE:

Providers must also have the appropriate Patient 1st referral for certain patients and/or services. Refer to Chapter 39.

This page intentionally left blank.