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
- Receiving approval or denial of the request
- Using AVRS to review approved prior authorizations
- Submitting claims for prior authorized services

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 MedSolutions. 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.

Prior authorization requests for outpatient diagnostic imaging procedures may be made to 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.

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.

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.

4.2.1 Submitting PAs Using Provider Electronic Solutions

Beginning December 1, 1999, you can submit electronic PA requests using HP Provider Electronic Solutions software, available to you at no charge. If you already use this software, you will be mailed an upgrade; if you do not currently use the software, but would like to order a copy, refer to Appendix B, Electronic Media Claims Guidelines, for contact information. 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.

Electronic PA Requests Requiring Attachments

If attachments are required for PA review, the attachments must be sent to HP 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. Refer to Chapter 15 of the *Provider Electronic Solutions Manual* for specific information. This chapter provides instructions for submitting electronic 278 requests. Please be aware that the need to link the attachments sent hard copy with a PA request submitted electronically has resulted in delays in PA processing. In an effort to expedite this process follow the instructions below taken from Chapter 15, *Submitting Prior Authorization Requests, Provider Electronic Solutions Manual.*

NOTE:

Please print a copy of the Prior Authorization response, which is received after your submission, and attach the response to your attachments. It is also recommended that the PA number received be written on each page of the attachments. Fax them to (334) 215-4140, Attn: PA Unit, or mail the attachments to:

Attn: PA Unit P. O. Box 244032 Montgomery, AL 36124

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:

HP 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 or place his/her initials next to a typewritten or stamped signature to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of the patient.

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/documents/6.0_Providers/6.7_Manuals/6.7.1_Provider_Manuals_2011/6.7.1.2_April_2011/6.7.1.2_Webuser.pdf.

See Section 13 of the AMMIS Interactive Services Website User Manual, Prior Authorization, starting on page 174, for information about this process.

4.3 Completing the Alabama Prior Review and Authorization Request Form

Providers use the Alabama Prior Review and Authorization Request Form to submit non-dental PAs on paper. These forms are available through the Medicaid Agency and are on the following website link:

http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_PA_Form_342_fillable_12-7-11.pdf

4.3.1 Blank Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required if Medicaid Provider) PMP ☐

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: _____ New _____ Used

First Diagnosis _____.____ Second Diagnosis _____.____

Assignment/Service Code ____ Patient Condition ____ Prognosis Code ____

(01)	Medical Care	(44)	Home Health Visits	(AD)	Occupational Therapy
(02)	Surgical	(54)	LTC Waiver	(AE)	Physical Therapy
(12)	DME-Purchase	(56)	Medically-Related Transportation		
(18)	DME-Rental	(69)	Maternity	(A4)	Psychiatric*
(35)	Dental Care	(72)	Inhalation Therapy	(AF)	Speech Therapy
(40)	Oral Surgery	(74)	Private Duty Nursing	(AL)	Vision-Optometry
(42)	Home Health Care	(75)	Prosthetic Device	(CQ)	Case Management

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

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

Form 342
Revised 12-2011

Alabama Medicaid Agency
www.medicaid.alabama.gov

4.3.2 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 1st.
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.

Code	***Description***
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.

Code	***Description***
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.
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.)**

Code	*Description*
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
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

Code	*Description*
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
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

Code	Description
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

4.3.3 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 HP, 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 three business days for processing. The form may be accessed at *http://www.medicaid.alabama.gov/documents/Billing/5-F_Forms.Billing/5F-2_Prior.Auth.Forms/5F-2a_PA_Change_Request_Form_471_8-10-10.pdf.*

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.

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. If the prior authorization is submitted electronically, the digital x-ray should be e-mailed to Dental@medicaid.alabama.gov with the patient's name in the subject line. Regular x-rays must be mailed to:

Alabama Medicaid Agency

Dental Program

P.O. Box 5624

Montgomery, AL 36103-5624

4.3.4 Blank Alabama Prior Review and Authorization Dental Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Section I – Must be completed by a Medicaid provider.

Requesting NPI or License #_____

Phone ( ) _____

Name _____

Address _____

City/State/Zip _____

Medicaid Provider NPI # _____

Section II

Medicaid Recipient Identification Number _____
(13-digit RID number is required)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number ( ) _____

Section III

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

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:_____

_____

_____

_____

_____

When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked "Confidential."
Make sure the recipient's name and Medicaid number are included with the X-rays or photos.

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

Form 343
Revised 2/10/10

Alabama Medicaid Agency
www.medicaid.alabama.gov

4.3.5 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 HP at the address given on the form.

4.4 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:		HIPAA Decision Codes:	
A	Approved	X	Cancelled
E	Evaluating	Z	Rejected
D	Denied		
M	Modified PA Request		
P	Pending		
S	Dismissed No Hearing Approved		
R	Rejected		

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.

NOTE:

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

4.5 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

4.6 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.