Prior Authorization

Certain Medicaid services/procedures require prior authorization from the fiscal intermediary's (FI) Prior Authorization (PA) Unit. ~~-~~The physician who is to perform the procedure that requires PA must submit the prior authorization request.

Current Procedural Terminology (CPT) codes requiring PA are identified on the Professional Services Fee Schedule.~~-~~ Clarification on whether or not a code requires PA can be obtained by contacting the PA Unit. ~~-~~(See Appendix ~~A~~ ~~5.5.1~~A for information on how to access the Professional Services Fee Schedule and how to contact the PA Unit)

Routine Prior Authorization Requests

When requesting prior authorization for a procedure/service, providers must:

- Complete a Request for Prior Authorization (PA-01 Form)~~-~~;
- Attach all documentation to warrant medical necessity~~-~~; and
- Send the information to the PA Unit by fax, electronic prior authorization (e-PA) or mail. (See Appendix ~~A~~ ~~5.5.1~~A for PA Unit address and contact information and Appendix ~~B~~ ~~5.5.2~~B for PA-01 Form information)

The provider and ~~recipient~~ beneficiary will receive written notification of the PA decision and will receive a PA number, if one has been assigned. ~~-~~The PA number must be entered in item 23 of the CMS-1500 claim form or the appropriate loop of the 837P for all claims associated with the procedure.

Post Authorization

When a ~~recipient~~ beneficiary becomes retroactively eligible for Medicaid, post authorization may be obtained for those procedures that would normally require prior authorization. Such requests must be submitted within six months from the date of Medicaid certification of retroactive eligibility.

Reconsiderations

If the PA request is not approved, the provider and ~~recipient~~ beneficiary will receive written notification of the reason(s) for denial. The provider may resubmit a request for reconsideration by:

- Writing the word "Reconsideration" across the top of the denial letter, and writing the reason for the request of reconsideration at the bottom of the letter~~,~~;
- Attaching to the request all original documentation and any additional information which confirms medical necessity~~,~~; and
- Sending the information to the PA Unit.

Electronic Prior Authorization (e-PA)

Electronic prior authorization is a web application providing a secure web-based tool for providers to submit and review the status of routine prior authorization requests. Providers must have access to a computer and/or fax machine to be able to utilize e-PA for their PA requests. (See Appendix A for information on how to access e-PA or contact the PA Unit)

E-PA is restricted to the following provider types:

- ~~01 – Inpatient~~
- 05 – Rehabilitation
- 06 – Home Health
- 07 – Air Ambulance Services
- 09 – Durable Medical Equipment (DME)
- 14 – EPSDT Personal Care Service
- 16 – Pediatric Day Health Care Services
- 18- Home Health Skilled Nursing and Home Health Aide Services for over 21 years of age
- 88 – Hospice Services
- 99 – Other

Reconsideration requests can be submitted using e-PA as long as the original request was submitted through e-PA.

Emergency Requests for Prior Authorization

NOTE: Emergency requests cannot be submitted via e-PA.

Louisiana Medicaid has provisions and procedures in place for emergency situations. A request is considered an emergency if a delay in obtaining the medical service, equipment, appliance or supplies would be life-threatening for the ~~recipient~~beneficiary. Emergency requests may also be submitted for services required for a hospital discharge.

Emergency requests are made through the PA Unit for any of the Medicaid services requiring prior authorization. The provider must contact the PA Unit immediately by telephone and provide the following information in order for the request to be considered under the emergency PA procedures:

- The ~~recipient's~~ beneficiary's name, age, and 13-digit identification number~~,~~;
- The treating physician's name~~,~~;
- The diagnosis~~,~~;
- The time period of need for the item or service~~,~~;
- A complete description of the item(s) or service(s) requested~~,~~;
- The reason that the request is a medical emergency~~,~~; and
- The cost of the item (only applies to Durable Medical Equipment).

The PA Unit will make a decision and contact the provider by telephone within two working days of the date the completed request is received. The PA Unit will then follow up with written confirmation of the decision.

NOTE: It is always the responsibility of the provider to verify ~~recipient~~ beneficiary eligibility. The PA Unit only approves the existence of medical necessity, not ~~recipient~~ beneficiary eligibility.

Emergency requests for PA of services that are not truly emergencies will be denied as such, and the provider must resubmit the request as a routine request.

Prior Authorization of Surgical Procedures

Many surgical codes do not require PA if the procedure is performed in an outpatient setting.

In an inpatient setting, certain surgical procedures always require prior authorization from the PA Unit before they can be performed and reimbursed.

~~Clarification on whether or not a code requires PA can be obtained by referring to the Professional Services fee schedule. (See Appendix A for information on accessing the fee schedule)~~

Authorization for a surgical procedure to be performed in an inpatient setting will be valid for 90 days from the approval date unless the ~~recipient~~ beneficiary becomes ineligible for Medicaid benefits prior to that time. ~~-~~Providers must validate the ~~recipient's~~ beneficiary's eligibility for the date of service.

Providers should note that obtaining prior authorization for a surgical procedure does not replace, or in any way affect, valid claims editing or other policy requirements which may apply to surgical claims~~;~~ (~~-~~e.g., timely filing requirements, sterilization consent requirements, assistant surgeon services). ~~-~~ Obtaining prior authorization ensures only the proposed procedure has been reviewed for medical necessity.

To expedite the review process, providers should attach the appropriate medical documentation that substantiates the need for the service being provided in an inpatient setting. ~~-~~Documentation of extenuating circumstances should be included with the request~~-~~, if applicable.