

The Basics of Medicaid Precertification

- **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 setting.”

- Medically Necessary – Severity of Illness/Intensity of Service
- Eligible Medicaid Member
- Most Cost-effective Setting

Precertification does not guarantee reimbursement.

What Needs Precertification

- **All inpatient admissions, including psychiatric admits.** Emergency admissions need precertification within 30 days of the admit date.
- **All elective inpatient surgical procedures.** All electives need precertification prior to the surgery admit date.
- **Elective outpatient procedures, if the CPT code is listed on *Appendix E or O*.** For emergent procedures done during an observation stay, you have 30 days from the date of the procedure to submit a request.
- Radiology and imaging procedures, injectable meds, DME, non emergency transportation, short term hospital outpatient PT/OT/ST, dental requests, hearing, vision, orthotics & prosthetics, additional office visits, transplants and out of state requests.

Is Anything Exempt from Precertification ?

- Observation setting or emergency outpatient services NOT listed on either *Appendix E or O*.
- Members with both Medicare A and B as primary.
- Uncomplicated cesarean or vaginal hospital deliveries.
- Newborns at birth hospital under 31 days old.

Who Is Responsible for Precertification?

- The *attending Medicaid physician* is responsible for obtaining authorization services. Services provided without an authorization are not reimbursable. The physician's failure to obtain precertification will be imputed to the hospital and will result in denial of payment, per the Hospital Services Manual.
- Many hospitals coordinate with their staff physicians to assure that an authorization has been obtained for inpatient and outpatient services.

Note: If the attending physician is not a Medicaid provider or the member has Medicare Part B only, then the hospital is responsible for obtaining the precertification number and making it available to each provider associated with the case, per the Hospital Services Manual.

Types of Certification

- **Precertification:** All inpatient stays and outpatient procedure codes listed on Appendix 'O'. If you cannot perform the procedure within 90 days contact GMCF to extend the expiration date. Initial requests are usually processed within one (1) full business day.
- **Prior Approval:** All procedure codes listed on Appendix 'E'. All transplants and Out of State cases are considered prior approvals. GMCF has 10 business days to process prior approvals and are not processed over the phone.
- **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.
- **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 timeframe is considered untimely.

Sample Page of Appendix E and O

- Physician Services Provider Manual (Part II) Appendix E and O list CPT codes that require review. Only submit CPT codes that require review to avoid claims edits. **Appendices are updated at the beginning of every quarter.**
- **Example of Appendix E: Prior Approval.** Written description.
Laparoscopy/Hysteroscopy
58552 with removal of tube(s) and/or ovary(s)
58553 Laparoscopy, surgical, with vaginal hysterectomy,
 for uterus greater
- **Example of Appendix O: Precertification.** No written description.
11310 11312
11311 11313

Precert Process

- **Precert Nurses** – Cases are received via phone, fax, web, or mail. These cases are reviewed by nurses using InterQual Criteria and established GMCF Criteria. If the cases meet criteria, they are approved by the nurse and a precert/tracking number is issued. If the cases do not meet criteria they are referred to the Referral Coordinator. Please note – no additional information can be added to a case after it's been referred for physician review.
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- **Referral Coordinators** – This is the second review of the clinical information. The Referral Coordinator reviews the request and either approves the case or refers it to a Physician Consultant.
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- **Physician Consultants** – Physician Consultants review the clinical 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 is issued. If the consultant denies a case, the provider is notified of the denial reason and additional/new information can be supplied in writing within 30 days. Appeals/reconsideration for physician denials are best done via the Provider Workspace Reconsideration link.

Appeal/Reconsideration Process

- **Second Physician Consultant** – When the appeal/reconsideration is received, the Referral Coordinator reviews any additional information and either approves the case, if it meets InterQual or GMCF criteria, or refers it to a Physician Consultant. At this appeal/reconsideration level, the physician consultant must be Board Certified in the appropriate specialty. The physician reviews any additional information submitted with the request and may approve or deny it. At any time during the process, the attending physician has the option of calling and discussing the case with the Medical Director or the Director of Physician Review. However, our physician consultants are in active practice and remain anonymous.



- **DCH Administrative Review** – A provider who feels that a case has been unjustly denied, by GMCF, may request an Administrative Review per DCH Policy Manual Part 1. The Administrative Review must be requested directly to DCH Customer Service and Resolution Department within 30 days of the date on the Final Denial Letter.

Need to Know Information

- **Re-admissions within 3 days** with the same or a related diagnosis are to be combined and should be billed using the original precert number.
- **Submission/Appeal/Reconsideration:** Admitting physician and facility need to coordinate admissions and any submission of appeals. All hospital and facility based precert requests should have the requesting/admitting physician name and provider ID on the request and facility name/REF number.
- **Authorization Period is effective for 90 days.** Some review types may vary in the effective/end date. Recertification is required for inpatient stays over 90 days.
- **Admission Type:** Planned/elective admits require precert before services are rendered. Emergent/urgent admits or procedures must be submitted within 30 days from the admission/procedure date. Submission timeframe starts on date of admit/procedure.

Need to Know Information, cont.

- **Technical Denials** are untimely submission for elective procedures performed without precert/prior approval and emergent cases not submitted within the 30-day time frame.
- **Observation vs. Inpatient:** When the need for inpatient stay is questionable, observation is a good option. Observation can be up to 24-48 hours. Over 48 hours observation stay may be needed, and if ordered, will be subject to prepayment review at the time claims are submitted. Medical observation stays, regardless of time, do not require a precert unless a procedure is performed that is listed on Appendix E and O.
- **Upgrades:** If the member fails observation and needs to be upgraded to 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. Submit change request *via phone, fax or via web* change request menu in affected PA. Change request received after 30 days will be considered untimely and given a Technical Denial.

Transfers

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

Transfers **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.

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

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

Transfers, cont.

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

- What services can the new facility provide that the current facility cannot provide?
 - Are the rendered services medically necessary?
 - Will the accepting facility keep the member or does the accepting facility plan to send the member back to the first facility?
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- Social transfers or those transfers done at the request of the beneficiary or family, or for the physician's convenience are **NOT** covered.
 - If a transfer is deemed non-covered, **the accepting facility will not be paid.**

Technical Denials (TD's)

- TD's are issued when cases are not submitted within the required time lines (untimely):
 - **Urgent/Emergent:** 30 days
 - **Elective:** Before the procedure or admission
 - **Retro-eligible:** within 6 months of eligibility date
 - **Changes:** within 30 days
 - **Medicare Exhaust:** within 3 months of exhaust notice

Technical Denials (cont.)

- TD's are NOT based on medical necessity, but for timeliness of submission. The cases are reviewed for medical necessity at the time the TD is issued. However, cases will be approved or referred for physician review **ONLY** if the TD is overturned.
- Once a TD is issued, you have 30 days to appeal in writing. Appeals/Reconsiderations need to include the PA tracking number and **the reason the case was not submitted in a timely manner.**
- Appeals/Reconsiderations are best submitted via the Provider Workspace on the web in the affected case.

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 GMCF to verify information and status of request.
- Admission before screening process is complete will result in a premature admit status and may cause payment withholding or fines.
- If the patient has a mental illness or a history of mental illness/mental retardation, they may require a Level II screening.
- Level II screenings are performed by APS (American Psychiatric Services) or other contracted agency as designated by DCH.
- **Level II screenings can take up to 5 business days to process and the patient must stay in their current setting until the Level Two process is complete.**
- If attending physician is considering nursing home placement, submit request as early as possible to avoid process delays.

Swing Bed

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

Radiology Reviews

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

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

Two PA types for Radiology

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

Radiology (cont.)

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

Radiology PA Process

- When submitted, the case is pended (*suspended*).
- Cases are reviewed by nurses utilizing InterQual criteria and DCH policy guidelines.
- There is a 10 day turn around (10 business days).
- If denied, Providers may submit a request for reconsideration via web portal's Provider Workspace Reconsideration link.
- Written notification of review outcome is sent to the providers.
- Providers may search for the status of a prior authorization request via the web.
- You have 30 days to request a precert for emergent procedures.
- Elective procedures require a precert in hand before performing the procedure.

Radiology Exceptions

- PA is not required for the first ultrasound performed during a pregnancy.
- Radiology outpatient procedure codes that require a PA, do not require a PA if performed during an inpatient hospital admission.
- ER imaging procedures which need a PA must be submitted within 30 days.
- Required Precert codes are listed in the Physician Services Manual on Appendix L.

Radiology Entry Restrictions

- Only radiology codes may be entered on a radiology PA request form and submitted via web portal under specified radiology review type- facility or office setting.
- The Web portal PA system will not permit entry of required outpatient radiology procedure codes to be entered in any other PA review type.

Durable Medical Equipment (DME)

- The DME Services Manual can be found on the web portal at www.mmis.georgia.gov.
- The manual is updated by the Department of Community Health (DCH) quarterly.
- Providers need to be aware of the changes and their effective date.

DME PA Process

- DME requests are submitted via the web portal or by fax to 678-527-3032. Phone submissions are not allowed.
- There is a 30 calendar day turn around time for PA determination.
- 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. Providers have 10 business days to submit the requested information by fax or via the web reconsideration link.

DME PA Process (cont.)

- DME can only be approved for use in the member's home and is not reimbursed for members in a nursing home or institution
- The Schedule of Maximum Allowable Payments for DME Services, also called the Fee Schedule, can also be found on the web portal under 'Fee Schedules'.
- The schedule is also updated quarterly and includes the maximum units allowed for the HCPCS codes as well as the maximum allowed payments. This schedule 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 is for short term therapy of an acute condition.
- The acute condition and date of onset needs to be documented on the online request form.
- Providers should also indicate the frequency and duration of therapy visits on the online request form.
- Policy guidelines for this PA type are found in Section 903.5 of the Medicaid Hospital Services Manual.

Hospital Outpatient Therapy (cont.)

- Hospital Outpatient Therapy PAs may only be submitted via the web portal.
- Supporting documentation may be attached to the online request form.
- Review turnaround time is 10 days.

Dental Authorizations

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

Dental (cont.)

- Authorization requests should be entered via the web portal or can be sent by fax, no phone requests are accepted. X-rays can be attached via web portal or mailed to:
GMCF
PA/Dental Dept.
PO Box 105329
Atlanta, GA 30348.
- Turn around time for Dental Authorization review is 30 days after all required information has been received.
- Hospital dental care guidelines are found under Section 805.1 in the Dental Policy and are limited to those cases which cannot be handled in the dental office setting.

Contact GMCF For Precertification

- All review types may be submitted via web portal at www.mmis.georgia.gov.
- A few review types may be done by phone. Contact HP Customer Service to access correct precertification department at 800-766-4456. Please have your provider ID & PA number ready as entering them will get you to the correct team rapidly.
- Must enter 9 digit Medicaid Provider ID with ending letter in order to access any precertification department. Callers without a correct ID will be sent to the general inquiry queue.
- Callers with a correct ID wanting to start a new precertification will be given several options to select the correct review department.
- Callers with a correct ID with questions regarding an existing PA, will be asked to enter PA number and call will be routed to the appropriate review department.

Thank you...

Any Questions...