PRIOR AUTHORIZATION

Prior authorization (PA) is an integral part of the DME program. **ALL** services within the scope of DME require authorization. If a DME equipment or supply is not authorized prior to the service being rendered, providers have six months after the date of service to request authorization. Providers who neglect to obtain authorization within the first six months will not receive reimbursement.

Requests for Prior Authorization

Providers may submit requests for prior authorization by completion of the Louisiana Request for Prior Authorization Form, the PA-01 (see Appendix A). No other form or substitute will be accepted. Completed requests must be sent to the Prior Authorization Unit (PAU). Requests may be mailed, faxed or submitted through electronic PA (e-PA). The preferred method is e-PA.

Electronic Prior Authorization (e-PA)

Electronic-PA is a web application that provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. For more information regarding e-PA visit the Louisiana Medicaid web site or call the PAU (see Appendix E for website and contact information).

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

Routine Requests

All routine PA request packets should include:

- Completed PA01 form
- Medical information from the physician
- Written prescription from a licensed physician or physician's representative
- Diagnosis related to the request
- Length of time that the supplies or equipment will be needed
- Other medical information to support the need for the requested item
- Statement as to whether the recipient's age and circumstances indicate that they can adapt to or be trained to use the item effectively
- Plan of care that includes a training program when any supplies or equipment requires skill and knowledge to use
- Any other pertinent information, such as measurements

Mail the completed PA packet to the PAU.

Providers are required to release equipment upon approval from the PAU and verification of eligibility.

NOTE: It is the responsibility of the provider to verify eligibility on a monthly basis. Prior authorization only approves the existence of medical necessity, not recipient eligibility.

Emergency Requests

Louisiana Medicaid has provisions and procedures in place for emergency situations. A request is considered an emergency if a delay in obtaining the medical equipment or supplies would be life-threatening to the recipient. In an emergency, telephone or verbal requests shall be permitted. (See Appendix E for contact information).

The items listed below are examples of medical equipment and supplies considered for emergency approval. However, other equipment will be considered on a case by case basis through the PAU.

- Apnea monitors
- Breathing equipment
- Enteral therapy
- Parenteral therapy (must be provided by a pharmacy)
- Suction pumps
- Wheelchair rentals for post-operative needs and items needed for hospital discharge

The providers of emergency items must contact the PAU immediately by telephone and provide the following information:

- The recipient's name, age and 13-digit identification number or card control number (CCN).
- The treating physician's name.
- The diagnosis.
- The time period needed for the item.
- A complete description of the item(s) requested.
- The reason that the request is a medical emergency; and
- The cost of the item.

A decision will generally be made by the PAU within 24 hours, but in no case later than the working day following the date the completed request is received. The PAU will contact the provider by telephone with a decision. If approved, the item shall be supplied upon the verbal approval. The PAU will follow up with written confirmation of the decision.

Medicare Part B Recipients

If the request for medical equipment and supplies is covered by Medicare and the recipient is enrolled in Medicare Part B, no prior authorization is required; however Medicare **must** be billed prior to billing Medicaid.

If the item is not covered by Medicare, the request will be processed as if it were being processed for non-Medicare recipients.

Federal law and regulations require states to institute policies and procedures to ensure that Medicaid recipients use all other resources available to the recipient prior to payment by Medicaid.

NOTE: Refer to Sections 18.6 of this chapter and Chapter One, General Information and Administration for more information on third party liability (TPL).

Prior Authorization Determination Time Limits

Prior authorization requests submitted to the PAU for the purchase of supplies or the purchase, rental or repair of equipment shall be processed no later than 25 days from the receipt date. Failure to make a timely determination shall result in an automatic approval.

Date of Service Change for Prior Authorization

It is a requirement of Medicaid that providers **not bill for durable medical equipment, services, supplies, prosthetics, or orthotics until the services have been rendered or the items have been delivered** or shipped to the recipient. It is also a requirement that the date of service and the date of delivery is the same date in order for a claim to be paid.

When requesting authorization of payment for these items or services, the provider should request authorization on the actual date of the service, delivery, or shipment of the item, or if not known, the provider should request a span date of sufficient duration to allow for authorization by the PAU and delivery of the service or item. This will prevent unnecessary denial of payment on the claim.

In the event a provider needs to change the date of service to match the date of delivery, a reconsideration request must be submitted to the PAU. A copy of the delivery ticket must be attached if the delivery of the service or item has already been made.

Requests for adjustments to dates of service must be sent in writing to the PAU and should always include the reason for the adjustment and documentation of the delivery date. Telephone requests are not allowed for the change.

The guidelines as described below should be followed and considered in requesting a change in the dates of service:

- A telephone authorization has been obtained for DME services to be provided after a recipient's discharge from a hospital facility. If the discharge was delayed beyond the anticipated date of discharge and service, a date of service may be adjusted at the provider's request to reflect the actual discharge date as the date of service.

- A change in providers after PA is approved for services may justify a change in the "thru" or end date of services for the old provider's PA file.

- When a delay in the delivery of an item after prior authorization by the FI, is justified as unavoidable by the provider. The date of service would be adjusted to match the delivery date. The provider must document the reason for the delay and the actual date of delivery (documented with a delivery ticket).

- An adjustment of the date of service may only be considered if the date of delivery is within six months of the original, anticipated date of service that was entered onto the PA file when the request was approved. Any delays of delivery longer than six months after the date of service on the PA file cannot be considered for a date of service adjustment.

- Delays by the provider in submissions of a claim for payment, not involving a justified delay in delivery, cannot be considered by the PAU as a reason for changing the date of service on the PA file. Any delays by the provider in submitting a claim after delivery, which result in a problem in meeting the timely filing deadlines, can be considered only for resolution through the established procedures for an override of the timely filing limits for claims.

- If a provider is approved for a service and is able to deliver the approved item at an earlier time than the anticipated date of service that was entered on the PA file, the provider may ask that the date of service be adjusted to an earlier date to match his/her earlier delivery date. The provider must send documentation (copy of the delivery ticket) with the request.

- The provider is allowed to wait to deliver until prior authorization has been approved; however, the item must be delivered before the claim can be submitted.

NOTE: It is a violation of federal and state Medicaid policy to bill for a service that has not been delivered but has been ordered.

Please remember that information on DME claims (not prior authorization request) cannot be changed after submittal.

The PA system was designed to act on an original request with the receipt of medical information or a request for extension of services which is considered a "new" request and must contain all necessary information in order for the PAU to approve the service. This includes the original/current diagnosis, an up-to-date prescription and other pertinent documentation to support that the services, supplies, and equipment are ongoing.

Requests that are submitted noting the diagnosis is a lifetime condition or includes a reference to previously submitted information will not be approved. The prescription date shown in field 9 of the request for prior authorization (PA-01 form) should fall within 60 days of the initial request or re-request (continuation).