PRIOR AUTHORIZATION

Prior Authorization (PA) of certain services is necessary from a quality assurance and also from a cost benefit standpoint. This section contains the inpatient and outpatient services which require review prior to reimbursement being authorized. This section also contains the policy regarding PA and refers to Appendix A which includes the forms and instructions used to secure the PA.

Besides the services found below, Medicaid has included a process for emergency authorization of certain equipment which are considered life threatening should a delay in their receipt occur. These include Apnea monitors, breathing equipment, hyperalimentation therapy aids (parenteral and enteral) and suction machines. In addition to these items for life threatening situations, emergency requests may be made for the temporary rental of wheelchairs for post-operative needs after a hospital discharge. The providers of emergency items must contact the Prior Authorization Unit (PAU) immediately by telephone and provide the following information:

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

The decision will be made by the PAU within two working days of the date the completed request is received, and the PAU will contact the provider by telephone and also follow up in writing.

Requests for Prior Authorization

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

Outpatient Rehabilitation Services

Outpatient rehabilitation is one of the services prior authorized on the PA01 (see Appendix A for information regarding this form) and is reimbursed at a flat fee-for-service. Outpatient rehabilitation services include:

- Physical therapy
- Occupational therapy
- Speech and hearing therapy

A licensed physician must make the referral. The referral must include the diagnosis, the date of the accident (or onset of illness), the address of the referring physician, his/her specialty (if known), and the date of the referral. The hospital must retain a copy of the physician's referral on file.

The rehabilitation services department must evaluate the recipient. The evaluation does not require PA and evaluation will only be paid once every six months.

When requesting PA for outpatient rehabilitation services, the following information must be included, or the request will be denied:

- Completed copies of the PA-01 and PA-02 (see Appendix A for information on forms);
- Initial therapy and extended therapy plans;
- Number of services, visits being requested;
- Physician's referral;
- Evaluation results; and
- Revenue Code and the HCPCS code.

NOTE: The request should be sent to the PAU.

Extension requests should be submitted at least 25 days prior to the end of the approved period. The requests should have at a minimum the following information attached:

- Therapy notes,
- Current evaluation results,
- Goals and objectives, and
- Copy of the physician's referral.

In cases where a delay in therapy would result in deterioration of the medical condition (e.g., burn cases, accidents, or surgery) the treatment may be instituted subject to later approval. The request for therapy should be submitted within the first week of therapy, with an explanation and a request for approval from the start of therapy.

Reimbursement for rehabilitation services provided without an approved plan for therapy will be dependent on the approval of the treatment plan.

To expedite the approval process, if it is known that outpatient rehabilitation services will be required upon discharge, a PA request can be submitted using anticipated discharge date as the beginning date of service.

Services may be provided by any enrolled Medicaid provider even if furnished as part of an Individual Family Service Plan (IFSP) or Individual Service Plan or provided in a school setting. These services may be received at home from a provider of home services or home health agency.

Outpatient Surgery Performed On An Inpatient Basis

Certain surgical procedures are covered only when performed as outpatient unless otherwise authorized. These procedures are usually performed on an outpatient basis but can be performed inpatient if it is medically necessary and PA is obtained. Request for PA must be submitted on form PA-01. When both the primary and secondary procedures require PA, list all procedures on the PA-01. A list of outpatient procedures requiring PA to be performed on an inpatient basis may be found on the Louisiana Medicaid website under fee schedules.

NOTE: Refer to Section 25.3 for more information on Outpatient Services and 25.8 for specific billing instructions.

The PCF01 form should be submitted prior to performance of the surgery. However, post authorization may be requested in emergency situations. See post authorization information below.

Providers requesting length of stay (LOS) for outpatient surgery performed as inpatient must use the PCF01 form. To expedite the review process, the appropriate medical data should be attached to substantiate the need for the service being provided in an inpatient setting.

Approval for inpatient performance of these procedures will be granted only when one or more of the following exception criteria exists:

- Documented medical conditions exist that make prolonged pre-and/or post-operative observation by a nurse or skilled medical personnel a necessity.
- The procedure is likely to be time consuming or followed by complications.
- An unrelated procedure is being performed simultaneously that requires hospitalization.
- There is a lack of availability of proper post-operative care.
- Another major surgical procedure could likely follow the initial procedure (e.g., mastectomy).
- Technical difficulties as documented by admission or operative notes could exist.
- The procedure carries high recipient risk.

NOTE: Authorization is not required if the procedure is performed in a hospital based ambulatory surgery center.

Reimbursement for the performance of these specified surgical procedures on an outpatient basis will be made on a flat fee-for-service basis. Reimbursement for surgical procedures approved for an inpatient performance will be made in accordance with the prospective reimbursement methodology for acute care inpatient hospital services.

Organ Transplants

Transplants must be prior authorized by the Department of Health and Hospitals (DHH). Transplants (other than bone marrow and stem cell) must be performed in a hospital that is a Medicare approved transplant center for the procedure. Hospitals seeking Medicaid coverage for transplant procedures must submit documentation verifying that they are a Medicare approved center for each type of transplant other than bone marrow and stem cell transplants. A completed attestation form must be submitted to Provider Enrollment (see Appendix B for contact information). The Medicaid Director may grant an exception to a transplant center for a

specific procedure if the transplant surgeon can demonstrate experience with that specific procedure and a history of positive outcomes in another hospital. The other hospital must be a Medicare approved transplant center for that specific procedure.

In addition to the above criteria, transplant centers located in-state shall meet the following criteria for Medicaid coverage of transplant services:

- Be a member of the Organ Procurement and Transplant Network (OPTN) or the National Marrow Donor Program (NMDP), if the hospital only performs bone marrow/stem cell transplants;

- Have an organ receiving and tissue typing facility (Centers for Medicare and Medicaid Services (CMS) approved for histocompatibility) or an agreement for such services;

- Maintain a written records tracking mechanism for all grafts and recipients including:

    - Patient and/or graft loss with the reason specified for failure;
    - Date of the procedure; and
    - Source of the graft.

- Have written policy for contacting recipients and appropriate governmental officials when an infectious agent is involved;

- Have a written criteria for acceptable donors for each type of organ for which transplants are performed;

- Have adequate ancillary departments and qualified staff necessary for pre-, intra-, and post-operative care including, but not limited to:

    - Assessment team;
    - Surgical suite;
    - Intensive care;
    - Radiology;
    - Laboratory pathology;
    - Infectious disease,
    - Dialysis; and
    - Therapy (rehabilitation).

- Have minimum designated transplant staff which includes:

- Transplant surgeon- adopt standards as delineated and updated by the OPTN;
- Transplant physician - same standards as above;
- Clinical transplant coordinator:
  - Registered nurse licensed in Louisiana; and
  - Certified by NATCO or in training and certified within 18 months of hire date.
- Transplant social worker;
- Transplant dietician;
- Transplant data coordinator; and
- Transplant financial coordinator.

NOTE: For individuals identified in the bullets immediately above this note, continuing education is required to maintain licensure and certification as applicable.

- Written recipient selection criteria and an implementation plan for application of criteria;

- Facility plan, commitment and resources for a program capable of performing the following minimum number of transplants per year/per organ:

  - Heart: 12;
  - Liver: 12;
  - Kidney: 15;
  - Pancreas: 6;
  - Bone marrow: 10;
  - Other organs as established per Medicare and/or OPTN.

NOTE: If the level falls below the required volume, the hospital shall be evaluated by DHH for continued recognition as a transplant center.

- Facility must demonstrate survival rates per organ type per year which meet or exceed the mean survival rates per organ type per year as published annually by the OPTN. (If rates fall below this level, the hospital shall supply adequate written documentation for evaluation and justification to DHH.)

All organ transplants must be authorized by the PAU prior to the performance of the surgery via a prior authorization letter. The only exception is for recipients with retroactive eligibility.

Transplant charges are to be included in the inpatient hospital charges using the revenue codes 300 and 800 range. This includes donor search charges and all procedures involved in harvesting the organ from the donor. Costs associated with the search will not be covered on an outpatient basis. Costs are not covered when the Medicaid recipient donates an organ to a non-Medicaid recipient.

Required Documentation for Organ Transplant Authorization Requests

All transplants must be prior authorized using a TP-01 (Transplant Form). The only exception is for recipients with retroactive eligibility. All documentation supporting the performance of the transplant must be attached to the letter.

NOTE: The TP-01 can be located on the Louisiana Medicaid web site.

When billing for the transplant services, the hospital and all physicians involved must attach a copy of the above mentioned approval letter, and a dated operative report to the claims they submit for payment. Hospitals should comply with all applicable privacy and Health Insurance Portability and Accountability Act (HIPAA) regulations when sharing a copy of the organ transplant approval letter with all other providers involved in the recipient's transplant.

Standards for Coverage

Requests for transplants are reviewed on a case-by-case basis by applying the following criteria:

- Transplant procedure to be performed is compatible with the diagnosis.
- All alternative forms of treatment have been tried, and the only viable alternative is the transplant procedure.
- Death would be imminent if the procedure were not performed is a reasonable medical probability.
- The procedure has met with a reasonable degree of success in the past.
- The procedure may be performed out of the state, if the facilities in state are not available.
- Services to the organ donor and organ procurement costs are included in the reimbursement methodology.

Cochlear Implantation

Only recipients who meet the medical and social criteria shall qualify for implantation. Only one device per lifetime will be reimbursed unless the device fails or is damaged beyond repair, in which case, reimbursement for another device and re-implantation will be considered.

All aspects (pre-operative speech and language evaluation, implantation, device, repairs, supplies and therapy) must be prior authorized on a PA-01. The request to perform surgery must come from a multi-disciplinary team consisting of an otologist, audiologist, speech/language pathologist, psychiatrist, and a deaf educator with experience in oral/auditory instruction. This team performs the assessment on the recipient to determine the recipient's possible candidacy for implantation.

The team's recommendation for the request and the results of all evaluations (audiogram, acoustic reflexes, auditory brainstem responses, otoacoustic emissions, speech and language evaluation, social/psychological evaluation, medical evaluation, and other pertinent testing or evaluation) must be submitted with the requests in a packet to the PAU.

Medical and Social Criteria

General Criteria

The following criteria apply to all candidates**:**

- Have a profound bilateral sensor-neural hearing loss with pure tone average of 90 dB HL or greater for frequencies of 1000, 2000, and 4000Hz.
- Have no response to Auditory Brainstem Response, Otoacoustic testing or any other special testing or any other special testing that would be required to determine if the hearing loss is valid and severe enough to qualify for cochlear implantation;
- Be a child age two years or older with a profound sensorineural hearing loss or be an adult through the age of twenty years; with a profound post lingual sensorineural hearing loss;
- Receive no significant benefit from hearing aids as validated by the implant team;
- Have a high motivation to be part of the hearing community as validated by the implant team;
- Have appropriate expectations;

- Had radiologic studies that demonstrate no intra cranial anomalies or malformations which contraindicate implanting the receiver-stimulator or the electrode array;

- Have no medical contraindication for undergoing implant surgery or post implant rehabilitation; and

- Show that the recipient and his/her family are well motivated, have appropriate expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) Guidelines.

Age-Specific Criteria

Children Two Years through Nine
Children two through nine years must not receive any significant benefit from a hearing aid that was obtained in the best aided condition as measured by age appropriate speech perception material.

Children 10-17 Years

Children in this age range must meet the following criteria:

- Receive no significant benefit from a hearing aid that was obtained in the best aided condition as measured by age and language appropriate speech perception material;

- Have received consistent exposure to effective auditory or phonological stimulation in conjunction with the oral method of education and auditory training;

- Utilizes spoken language as the primary mode of communication through one of the following: an oral/aural (re) habilitation program or total communications educational program with significant oral/aural; and

- Have at least six months' experience with a hearing aid or vibrotactile device in the case of meningitis (in which case the six month period will be reduced to three months).

Adults - 18-20 Years

The following criteria must be met:

- Have a severe to profound post lingual bilateral sensorineural hearing loss;
- Receive no significant benefit from a hearing aid that was obtained in the best aided condition for speech/sentence recognition material;
- Have received consistent exposure to effective auditory or phonological stimulation or auditory communication**;**
- Have no medical contraindication for the undergoing implant surgery or post-implant rehabilitation; and
- Show that the recipient and his/her family are well-motivated, have appropriate post-implant expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) guidelines.

The criteria utilized must be appropriate for the child's age.

Reimbursement

Reimbursement for the speech processor and/or microphone repairs, headset cords, headset replacement, and batteries must be prior authorized. Request should be made on Form PA-01 to the PAU.

Requests for reimbursement for these items should be made conservatively. The PAU reserves the right to refuse authorization of these items if it feels requests are being made too frequently due to the recipient's negligence. On an average, processors require repairing every two and half years, head cords need to be replaced two to four times per year, and batteries replaced every 10-12 months.

Billing for the Device

Reimbursement will be made to the hospital for both the device and the per diem. The device must be prior authorized by using the PA-01 to request approval of the surgery. After approval has been granted, the hospital shall bill for the device by submitting the appropriate HCPCS code on a CMS 1500 claim form. Write the letters DME in red on the top of the form and the PA

number must be written in item 23. The reimbursement fee can be obtained from the fiscal intermediary (FI).

Re-Performance of the Surgery

Prior Authorization is required for re-performance of the surgery because of infection, extrusion, or other reason. The request should be submitted to the PAU and contain sufficient documentation explaining the reason the surgery must be repeated. The PA number for the re-performance must be included on the claim form.

Replacement of the External Speech Processor

Replacement of the external speech processor will be considered only if the processor is lost, stolen, or damaged beyond repair.

Upgrades due to cosmetic reasons or technological advances in the hardware do not qualify as reasons for a replacement.

When it is necessary to replace the external speech processor, the multidisciplinary team must initiate the required PA request by submitting a copy of PA's initial approval letter for the implant and documentation of the need for a new processor.

Billing for the Replacement of the External Speech Processor

Hospitals or professional services billers shall bill for this component by submitting the appropriate HCPCS code on a CMS1500 with the letter DME written in red on the top. The PA number must be written in Item 23.

Non-Covered Expenses

Service contracts and/or extended warranties and insurance to protect against loss and theft are the responsibility of the family.

Vagus Nerve Stimulator

The vagus nerve stimulator (VNS) is an implantable device used to assist in the control of seizures related to epilepsy and must be prescribed by a physician.

Effective June 14, 2010, a PA-01 is no longer required for hospital providers for the VNS device. However, reimbursement of the device continues to be dependent upon approval of the surgeon

to perform the procedure. Hospitals should confirm that the surgeon has received an authorization for the procedure prior to submitting their claim in order to prevent denials.

The hospital will bill their VNS claim using HCPCS procedure code C1767 (VNS generator) and/or C1778 (VNS leads) to the FI on a CMS 1500 claim form with the words DME written in red on the top of the form and the PA number written in Item 23 or through the electronic claims submission.

The claim will pend to the FI's Medical Review Department for review of the surgeon's approved PA request. If approved, the hospital claim will be allowed to process for payment; if there is no valid authorization, the hospital claim will deny with edit 191 (PA required).

Intrathecal Baclofen Therapy

Intrathecal Baclofen Therapy (ITB) is for the treatment of severe spasticity of the spinal cord or cerebral origin and for the surgical implantation of the programmable infusion pump by which ITB is delivered. This treatment must be **prior authorized** before its administration. To obtain pre-certification for the stay, the pre-certification process must be followed.

Criteria for Recipient Selection

Consideration will be given for reimbursement for implanting an ITB infusion pump if the treatment is considered medically necessary, the recipient is four years of age or older with a body mass sufficient to support the implanted system, and any one or more of the following criteria is met:

- Inclusive criteria for candidates with spasticity of cerebral origin:
    - There is severe spasticity of cerebral origin with no more than mild athetosis;
    - The injury is older than one year;
    - There has been a drop in Ashworth scale of one or more;
    - Spasticity of cerebral origin is resistant to conservative management;
    - The candidate has a positive response to the test dose of ITB.
- Inclusive criteria for candidates with spasticity of spinal cord origin:
    - Spasticity of spinal cord that is resistant to oral antispasmodics or side effects are unacceptable in effective doses;
    - There has been a drop in Ashworth scale of two or more; or
    - The candidate has a positive response to the test dose of ITB.

Caution should be exercised when considering ITB infusion pump implantation for candidates who:

- Have a history of autonomic dysreflexia;
- Suffer from psychotic disorders;
- Have other implanted devices; or
- Utilize spasticity to increase function such as posture, balance, and locomotion.

Exclusion Criteria for Recipients

- Fails to meet any of the inclusion criteria;
- Is pregnant, refuses or fails to use adequate methods of birth control;
- Has a severely impaired renal or hepatic function;
- Has a traumatic brain injury of less than one year pre-existent to the date of the screening dose;
- Has a history of hypersensitivity to oral baclofen;
- Has a systematic or localized infection which could infect the implanted pump; or
- Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of Lioresal during the screening trial procedure.

Prior Authorization for chronic infusion of ITB shall be requested after the screening trial procedure has been completed but prior to the pump implantation.

The request to initiate chronic infusion shall come from the multi-disciplinary team that evaluates the recipient. The multi-disciplinary team should consist of a neurosurgeon or an orthopedic surgeon, a physiatrist and/or neurologist, the recipient's attending physician, a nurse, a social worker and allied professionals (physical therapists, occupational therapist, etc.).

These professionals shall have expertise in the evaluation, management, and treatment of spasticity of cerebral and spinal cord origin and shall have undergone training in infusion therapy

and pump implantation by Medtronic or an equally recognized product supplier with expertise in intrathecal baclofen.

A recent history with documentation of assessments in the following areas must be sent to the PAU:

- Medical and physical;
- Neurological;
- Functional;
- Psychosocial;
- Ashworth scores taken before and after the administration of the IBT test dose(s);
- Documentation of any other findings about the recipient's condition which would be of interest to or would assist the PAU in making a decision regarding the recipient's need for chronic infusion, i.e., a videotape of the trial dosage.

Out-Of-State Non-Emergency Hospitalizations

Out-of-state non-emergency hospitalizations require authorization, unless the request for hospitalization is for a dual Medicare/Medicaid eligible recipient. Authorization is required for dual eligible recipients only if transportation services are being requested in addition to the hospitalization.

To obtain authorization for out-of-state non-emergency hospitalizations, send a facsimile (fax) of a "Letter of Referral" to the attention of the PAU. The referring physician should sign the "Letter of Referral" and answer the following questions:

- What is the recipient's name and Medicaid identification number?
- What is the name and telephone number of the contact person representing the recipient?
- Is the recipient both Medicare and Medicaid eligible?
- Does the recipient require transportation services as well?

- Is the facility where the recipient will be hospitalized a Louisiana Medicaid provider with a valid seven-digit provider number?

- Why is the situation so unique that it cannot be provided in Louisiana or in one of the Louisiana trade areas?

- What referrals were made in Louisiana before a referral was made to an out-of-state provider/hospital?

NOTE: Emergency out-of-state hospitalizations do not require PA.

Reconsiderations

If a request for PA is denied, a provider may submit the request for reconsideration.

Instructions for Submitting a Reconsideration

- Write the word "Reconsideration" across the top of the denial letter, and write the reason the request for reconsideration at the bottom of the page.

- Attach all of the original documentation, as well as any additional documentation or information which supports medical necessity, to the letter.

- Mail the letter and all documentation to the PAU (see Appendix B for contact information).