

IX. PRIOR AUTHORIZATION (PA)

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IX. PRIOR AUTHORIZATION (PA)

Prior authorization (PA) is a utilization management tool that ensures members receive medically necessary, cost-effective health care in the most appropriate setting (Also see Chapter XIII - Medical Management). Contracted and non-contracted health professionals, hospitals, and other Providers are required to comply with Missouri Care's authorization policies and procedures. Noncompliance may result in delay of reimbursement or denial of claims.

Prior authorization review includes:

- Verification of the member's Missouri Care enrollment at the time of the request and on each date of service
- Verification that the requested service is a Covered Service
- Determination if the requested service is Medically Necessary and in the most appropriate setting
- Determination whether the request requires medical director review
- Determination whether additional documentation, information, medical records, etc. are required
- Determination whether the requested service will be provided by a contracted Provider

Providers are reminded that member eligibility must be verified at the time of service. Loss of eligibility will cause denial of payment regardless of the prior authorization of services.

9.1 REQUESTING AUTHORIZATION

1. Requests for authorization are to be directed to Missouri Care's PA Unit.
2. For members receiving emergency services that require inpatient or observation care, the facility is to contact the prior authorization unit within twenty-four (24) hours or the next business day following the admission to request authorization. Missouri Care's policies on emergency/ nonemergency medical services are based on the definition of emergency services included in the glossary. PCPs should perform emergency medical services and immediately refer the member to the nearest and most

- appropriate contracted facility without regard to authorization. (notification requirements will still apply to the contracted facility)
3. Both participating and nonparticipating health professionals and Providers must verify that any required authorization has been obtained before rendering service to a member. Services that require prior authorization will be considered for payment only if PA has been obtained. Missouri Care does not backdate authorizations
 4. Either the PCP or the Specialist may initiate and coordinate requests for PA. Missouri Care recognizes that other Providers may need to contact the PA Unit directly. Requests for authorization must be received PRIOR to rendering services.
 5. Requests for authorization may be directed to Missouri Care's PA Unit by mail, telephone, or fax as follows:
 - Telephone: (573) 441-2196
(800) 322-6027
 - Fax: (573) 441-2198 Medical
(866) 207-6431 Pharmacy
 - Mail: Missouri Care
Attn: Prior Authorization Unit
2404 Forum Blvd.
Columbia, MO 65203

Prior authorization decisions and responses are provided in a timely manner that accommodate the urgency of the condition, and are as follows:

- within twenty-four (24) hours for urgent services
 - within two (2) business days for routine services
 - within twenty-four (24) hours for pharmacy
 - emergency services do not require authorization
6. If a request for authorization is approved, the PA department will give the Provider a prior authorization number. Providers must obtain an authorization number and include the number on claims submitted to Missouri Care's Claims Department. Failure to do so may result in denial or delay of reimbursement.
 7. If a request for authorization is denied, the Provider may request a reconsideration of the decision (see 9.3 below). The Provider will receive written notification of the final decision, following the reconsideration.
 8. If the Provider is performing a sterilization procedure, which may only be performed on patients age twenty-one (21) and above who appear to be mentally competent, the

federal Sterilization Consent Form (Attachment XI.C) must be completed. Sterilization procedures also require prior authorization from Missouri Care.

Providers must wait thirty (30) days between the patient signing the consent form and performance of the procedure, except in the case of premature delivery or emergency abdominal surgery. Once the thirty (30) days have elapsed, fax or mail the consent form to Missouri Care and Missouri Care will provide your office with a PA number. You will not receive a PA number if the thirty (30) day requirement has not been satisfied. The consent expires 180 days from the Member's date of signature. A new consent form is required if the procedure is to be performed after the 180 day period.

The proper and timely completion of the consent form is closely monitored by federal government auditors and Missouri Care is required to insist on proper adherence to the requirements.

9.2 REIMBURSEMENT

Authorization does not ensure payment

- if the member is not enrolled on each date of service or
- if documentation submitted by the Provider does not support the medical necessity of the requested procedure
- or if the services billed are outside the scope of the authorization.

The Provider must verify member enrollment prior to rendering service on each date of service.

9.3 RECONSIDERATION OF A DENIAL

1. Medical Director Reconsideration

Providers who have immediate questions or disputes regarding denial of a request for PA may request a reconsideration by the Chief Medical Officer (CMO) or designee by submitting supporting documentation within two (2) days. The reconsideration decision will be made within two (2) days after the plan receives all necessary documentation.

2. Appeals

A participating or nonparticipating health professional, Provider, or member may submit a formal written appeal to Missouri Care's Grievance Department with appropriate documentation. Please refer to Section XII. Appeals, Complaints and Grievances for additional information.

9.4 SERVICES REQUIRING PRIOR AUTHORIZATION/NOTIFICATION

Non-participating providers must obtain Prior Authorization for ALL services.

MISSOURI CARE PRIOR AUTHORIZATION REQUIREMENTS

INPATIENT FACILITY	
NOTE : All inpatient admissions require PA	
SERVICE DESCRIPTION	AUTHORIZATION REQUIREMENTS
All Admissions	All related codes
OUTPATIENT FACILITY REQUIRING PA	
SERVICE DESCRIPTION	AUTHORIZATION REQUIREMENTS
Ambulatory Surgery Procedures	All related codes
Ambulatory Diagnostic Procedures	All related codes
Cardiac Rehab	Referral only
Circumcision	All related codes
Dialysis	All related codes
EEG	All related codes
Infusion/IV Therapy	All related codes
Observation (OB and non-OB)	All related codes
OFFICE BASED PROFESSIONAL SERVICES REQUIRING PA	
SERVICE DESCRIPTION	AUTHORIZATION REQUIREMENTS
Allergy & Immunology	Referral required for adults age 21 and > for all evaluations and treatments
Anesthesia-Pain Management	Referral only
Arthroscopy	All related codes
Audiology	Referrals only for age 21 and over
Dermatology	All related codes (cosmetic procedures not covered benefit)
Endoscopy	All related codes
ENT	All related codes (Referral only for age 21 and over)
Fracture care or treatment	All related codes
Genetic Testing and Treatment	All related codes
Obstetrical Services	Global OB Authorization is required for prenatal & postpartum care
Plastic Surgery	Referral only
Podiatry	All related codes (limited Podiatry services for ages 21 & over)
Transplant Evaluation and Consultations	All related codes
Sterilization	All related codes
Vasectomy	All related codes
ANCILLARY SERVICES REQUIRING PA	
SERVICE DESCRIPTION	AUTHORIZATION REQUIREMENTS
Diabetes Self Management Training	All related codes for children < 21 & pregnant members. Not a covered benefit for ages > 21.
Dialysis	All related codes
DME (Durable Medical Equipment)	All related codes (limited DME for ages 21 & over)
Home Health & Hospice	All related codes
Infusion, Enteral & Parental Therapy	All related codes
Orthotic & Prosthetic devices	PA required for children < 21 & pregnant members. Not a covered benefit for ages >21
PT/OT/ST	Referral for children < 21& pregnant members. Not a covered benefit for adults > 21.
Sterilization	All related codes
RADIOLOGY SERVICES REQUIRING PA	
SERVICE DESCRIPTION	AUTHORIZATION REQUIREMENTS
Chemo/Radiation	All related codes
CT scans	With IV sedation
MRI/MRA	All related codes
PET Scans	All related codes
Thyroid Uptake scan	All related codes

Outpatient Services that do not require Prior Authorization

- Bone Scans
- Barium swallow/ Barium swallow
- CT Scans- (scans requiring IV sedation require PA)
- Dexa Scan
- ECHO
- EKG
- EMG (if more than one extremity, requires PA)
- HIDA scan
- Mammography
- Nuclear Medicine – (Thyroid Uptake and PET- require PA)
- Other Diagnostic Services
- NST
- Pathology & Laboratory- (Genetic testing, Immunology and Nasal Smear – require PA)
- PFT
- Radiology Diagnostic – (procedures requiring IV sedation- require PA)
- Small bowel series
- Swallow study
- Ultrasounds

Office Based Services that do not require Prior Authorization

- Cardiology
- Gastroenterology
- Gynecology
- Hematology
- Neurology
- Obstetrics – (global OB authorization is required)
- Oncology
- Orthopedics
- Pulmonology
- Rheumatology

NOTES

- a. Authorization for obstetrical services is valid through delivery or termination of pregnancy plus 60 days postpartum care.
- b. When a prior authorization is obtained, the procedure must be performed on the date indicated or Missouri Care must be notified so the date can be changed.
- c. A prior authorization does not guarantee payment. Eligibility must be verified at the time service is rendered.

- d. If a PSP's contract does not allow laboratory testing in the specialist's office, the PSP will refer members to a Missouri Care participating laboratory for medically necessary testing. Referrals to non-participating laboratories require authorization.
- e. If a PSP's contract does not allow radiology services to be performed in the specialist's office, the PSP will refer members to participating radiology providers for PA for the radiology procedures listed under the radiology section of this attachment. Non-participating radiology providers require prior authorization.