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December 5, 2007

MEMORANDUM ACS-M07-22

TO: Medicaid Providers

FROM: Lois Lee, Acting Med-QUEST Division Administrator

SUBJECT: ADDITIONAL CHANGES IN PRIOR AUTHORIZATION REQUIREMENTS AND CLARIFICATIONS

Memorandum ACS M06-18 revised long standing authorization guidelines and provided a listing of supplies and equipment that no longer required prior authorization. To further improve access to medically necessary services, supplies and equipment and expedite claims payment, the Med-QUEST Division has decided to remove the prior authorization requirements for additional items.

Thus, ***effective*** **November 15, 2007,** the services/items described below will no longer require prior authorization when specific requirements, medical necessity and quantity limits are met AND the fee-for-service (FFS) Medicaid program for aged, blind and disabled (ABD) is the Medicaid recipient's primary insurer or when Medicaid is the secondary insurer and the recipient's primary insurer is **NOT** Medicare. A comprehensive list of codes no longer requiring prior authorization is available on the Med-QUEST web site located at www.med-quest.us. If you do not have internet access please contact ACS at 952-5570 or 1-800-235-4378 from the Neighbor Islands to request a paper copy. The comprehensive list of HCPCS codes includes:

- Services/items which never required prior authorization;
- Services/items for which the prior authorization requirement was lifted effective November 15, 2006 (memo number ACS M06-18); and
- Services/items for which prior authorization is being lifted effective with this memo.

Medicaid will follow Medicare criteria and Medicare criteria should be applied for services, supplies and equipment. Medicaid expects that all providers who furnish services/items covered by Medicaid and Medicare to recipients dually eligible for Medicaid and Medicare are **Medicare providers.** Medicaid will not require separate documentation for those services

which require a Certificate of Medical Necessity (CMN) from Medicare. The Medicare CMN will be adequate for auditing purposes. For services, supplies and equipment in which Medicare has no published criteria or the service is not covered by Medicare, any nationally certified criteria set may be used, such as InterQual, etc. Those criteria must be available to Medicaid at the time of an audit. In addition Medicaid can provide guidelines for those services not covered by Medicare.

Please be advised that Medicaid's Surveillance Utilization Review Section (SURS) will be actively monitoring usage. Lifting of the prior authorization requirements is not license to provide services which are not medically necessary. Abuse of services, supplies or equipment may result in recoupment and any findings of fraud will be referred to the Medicaid Fraud Control Unit (MFCU) for further investigation.

In the event of an audit, forms that are developed by entities including but not limited to a supplier or a professional association are not sufficient, by themselves, to document that coverage criteria have been met. If forms are used they cannot have the logo of the supplier or professional association nor can the supplier or professional association complete any part of the form. If forms are used there must be sufficient documentation in the patient's medical record that corroborates the information on the forms and verifies that coverage criteria has been met.

Medical and Surgical Supplies – "A" codes – In addition to lifting the prior authorization on some additional codes, the quantities of some of the diabetic testing supplies have been increased for insulin dependent diabetics. The increase in diabetic supplies will **only** affect insulin dependent diabetics. Medicare quantity restrictions for non-insulin dependent diabetics will apply. To facilitate claims processing, the modifier – KS (glucose monitoring supply for diabetic beneficiary not treated with insulin) should be used when diabetic testing supplies are provided to non-insulin dependent diabetics. For audit purposes, it will be expected that justification for maximum quantities of medical and or surgical supplies will be well documented. (Please refer to Attachment A for the specific "A" codes which do not require prior authorization and the limits.)

Enteral Therapy – "B" codes – The prior authorization requirement is being lifted for many of the enteral feeding codes. Medicaid's medical and reimbursement criteria for these codes have **not** changed. In addition, Medicaid will continue to follow its policy to pay for rental of an IV pole for six (6) months and for the infusion pump for fifteen (15) months, at which point both items will be considered purchased. (Please refer to Attachment A for the specific "B" codes which do not require prior authorization and the limits.) As a reminder, enteral formulae provided to Medicaid recipients living in nursing facilities are included in the Medicaid payment to the nursing facility and are NOT separately payable by Medicaid. Also, Medicaid DOES NOT cover Medicare co-payments for enteral formula for nursing facility residents dually eligible for Medicare and Medicaid.

Durable Medical Equipment – "E" codes – The prior authorization requirement has been lifted for oxygen rental. Oxygen saturation requirements for adults are the same as those required by Medicare. Oxygen saturations for children will follow the accepted medical standard in Hawaii of 95% or below. All supplies associated with the administration of oxygen are included in the global rental allowance for oxygen and are not separately reimbursable. Oxygen is not covered in the following situations: For use on an "as needed" basis (stand-by oxygen); angina pectoris without hypoxemia; breathlessness without cor pulmonale or evidence of hypoxemia; peripheral vascular disease from desaturation in one or more extremities; terminal illness without hypoxemia and/or pulmonary involvement. (Please refer to Attachment A for the specific "E" codes which do not require prior authorization and the limits.)

Orthotic and Prosthetic Devices – "L" codes (Please refer to Attachment A for the specific "L" codes which do not require prior authorization and the limits.)

Incontinence Supplies – T4521, T4522, T4524, T4541, A4927, A4927-22 – The limits set for incontinence supplies cannot be exceeded through the prior authorization process. Thus, supplies exceeding the limits will not be reimbursed. Although the MQD is setting maximum limits, the quantity provided by Medicaid must still be appropriate and justified by the medical needs of the Medicaid recipient. Medicaid will recoup payments in those instances where the quantities provided are not necessary. Gloves are for the use of the family caregivers of adults and older children. Employed/contracted caregivers must supply their own gloves.

The services, supplies and equipment addressed in this memo can only be provided when they are MEDICALLY NECESSARY for the specific Medicaid recipient. Written documentation that verifies that the service/supply/equipment and the quantity provided is/are medically necessary based on the physician's assessment must be maintained.

GENERAL REQUIREMENTS FOR ALL SERVICES/SUPPLIES/EQUIPMENT TO FOLLOW:

- The services/supplies/equipment must be ordered by a physician who is a Medicaid provider. The provider must keep a written record of the physician orders/prescriptions, CMN's, etc.;

- These supplies are for use in the home and community setting for treatment of medical conditions and are not separately covered when used during an office evaluation and management visit or a surgical procedure in the outpatient hospital, free-standing ambulatory surgery center (ASC), or physician's office. For Medicaid recipients in nursing facilities, items that are included in the prospective payment system/acuity based payments, cannot be separately reimbursed;

- If needed on a chronic basis, the supplies and equipment **MUST NOT BE DROP DELIVERED.** They are to be provided when the Medicaid recipient requests delivery or picks up the supplies;

- Equipment provided as a rental to purchase is priced as new equipment by Medicaid. The expectation is that the equipment will be covered under the normal manufacturer's warranty

and all repairs to that equipment during the normal warranty period will be provided under that warranty without additional cost to Medicaid;

- No prior authorization will be required IF the quantity provided does not exceed the limits (see attached tables);

- With the exception of incontinent supplies, if the Medicaid recipient has a need for a quantity that exceeds the limit, an 1144 must be submitted; and

- If the provider does not write on the top of the 1144 form "EXCEEDS LIMITS" the 1144 will not be processed and will be returned.

When sending an 1144 that exceeds the limits write "Exceeds Limits" on the top of the 1144. The quantity requested on the 1144 should represent the total quantity necessary and NOT the quantity above the limits (i.e., For A4253 the medically necessary quantity is 150 units per 30 days; the limit is 100 per 30 days; the 1144 should reflect 150 units.) This does not apply to incontinence supplies.

If you have any questions regarding this memorandum, please contact the ACS Provider Inquiry Unit at 952-5570 or 1-800-235-4378 from the Neighbor Islands.