Alabama Medicaid Agency
Obstetrical (OB) Ultrasound Requests for Prior Authorization (PA)
Frequently Asked Questions (FAQs)
As of December 9, 2016

1. **When is a PA required for OB ultrasound?**
   Response: PA is required after the second ultrasound.

2. **If a PA request is received, is it assumed the recipient has met or exceeded the required second ultra sound?**
   Response: No. Each request must have supporting documentation. The request must include the date and diagnosis code of the two previous ultrasounds. The medical information can be entered in the internal text.
   Some examples of required information include:
   - Date(s) of the requested ultrasound(s) Date range is acceptable, as are multiple units on a single detail
   - List should include each date, and diagnosis for prior ultrasounds for the current pregnancy
   - Recipients date of birth and Medicaid number
   - EDC-Estimated Date of Confinement
   - Medical diagnosis to substantiate the ultrasound that is being requested
   - Benefit of the ultrasound(s) that is being requested
   - Anticipated total number of ultrasounds for the current pregnancy

3. **How should medical records be submitted for the requested service?**
   Response: The medical information supporting the request can be entered in the internal text of the PA request or submitted as an electronic upload to FEITH.

   Note* the medical record must include the **date** and **diagnosis code** of the two previous ultrasounds to avoid a denial.

4. **What if the information submitted does not include the required date and diagnosis code of the two previous fee for service ultrasounds?**
   Response: The PA will be denied. Providers have up to 30 days from the date of the denial letter to submit information for a reconsideration.
   Information submitted must include the date and diagnosis code of the previous ultrasounds.

5. **Should the requesting provider submit the patient's full medical record with the request or should specific documentation related to the reason for the ultrasound be submitted with the request?**
   Response: Only submit medical documentation related to the reason(s) for the ultrasound.

6. **Is it a requirement that the ultrasound procedure code be included in the medical record documentation?**
   Response: No. The ultrasound procedure code is not required to be documented in the medical record.

7. **How will PA requests be processed for additional ultrasounds without additional medical supporting information?**
   Response: While special circumstances may occur, all requests for PA must include medical supporting documentation.

8. **If a different ultrasound procedure code is submitted for the same date of service, how should this request be handled? For example, the recipient is pregnant with or without twins and the procedure code(s) is different.**
   Response: Specific medical supporting documentation allows for quicker turnaround time. Supporting documentation that is unclear, will require a second level review by the Contractor's Medical Director.

9. **How will the PA request be completed for provider submissions with multiple date ranges?**
   Response: Multiple requests will be combined appropriately.
   For example, if the same procedure code is requested on multiple details, with the same (or different) date range, the reviewer will cancel all other detail lines and approve (if PA criteria are met) for the total number of units requested on a single detail, for the date range requested.
   Example:

PA 1316075076			**Units Requested**
76815	**03/07/2016**	**to 06/30/2016**	**1**
76815	**03/07/2016**	**to 06/30/2016**	**1**
76815	**03/07/2016**	**to 06/30/2016**	**1**
76815	**03/07/2016**	**to 06/30/2016**	**1**
76815	**03/07/2016**	**to 06/30/2016**	**1**
76815	**03/07/2016**	**to 06/30/2016**	**1**
76815	**03/07/2016**	**to 06/30/2016**	**1**
PA criteria met; APPROVE			**Units Approved**
76815	**03/07/2016**	**to 06/30/2016**	**7 units**

   The other SIX details will be CANCELED
   The "Analyst's Remarks" in the PA decision letter will state: Only one unit of the approved procedure code may be billed for each date of service. Billing more than one unit for a date of service will result in a claim denial for a duplicate service.

10. **Can a provider submit a request with a 6 month date range or should specific dates be submitted based on the date the procedure was performed?**
    Response: The provider is allowed to submit date ranges.

11. **For OB ultrasounds performed in 2016, will the utilization count for a request submitted in 2017?**
    Response: Yes, for a request submitted in 2017, the provider must submit the dates of service of the two previous ultrasounds performed in 2016 on the PA request **except** for the ultrasounds performed by a subcontractor of District 12, Southwest Alabama Maternity Care, L.L.C. The ultrasounds with dates of service prior to January 1, 2017, submitted to Medicaid for consideration of override and payment under the maternity district plan will not be counted against the utilization for a PA request submitted with a date of service in 2017. District 10 (Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery and Pike Counties), became FFS January 01, 2016. Providers in District 10 may bill a limit of two ultrasounds without requiring a prior authorization.

12. **How should PAs be submitted for multiple babies (twins, triplets)?**
    Response: The policy states under Limitations, "if twins are involved, approve only one unit of the ultrasound procedure." However, modifier 59 can be used to support multiple fetuses, with medical justification.

13. **What procedure code modifiers can be used when submitting a request?**
    Response: Modifier 59 can be used to support multiple fetuses.

14. **What is the process if the PA has already been denied based on date range and reconsideration is submitted by the provider?**
    Response: All PA requests must be submitted as outlined the Alabama Medicaid Provider Manual. Please review Alabama Medicaid Provider Billing Manual Chapter 28, Chapter 4, and Chapter 7 at a minimum.

15. **The cutoff date for a reconsideration is 30 days, who should the provider contact to discuss the denied claim?**
    Response: All claim inquiries should be addressed to Alabama Medicaid Fiscal Agent, HPE, at (800) 688-7989.

16. **When should a provider submit the 471 Form?**
    Response: The Form 471 should only be used for PAs in an evaluation or approved status, not for denied PAs.

17. **Where can a provider go to request provider training?**
    Response: A provider can visit http://www.medicaid.alabama.gov/content/10.0_Contact/10.3_Provider_Contacts.aspx to contact the Medicaid Fiscal Agent, HPE. Provider representatives can provide training.