AMMIS Prior Authorization Operations Manual

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1 DOCUMENT CONTROL

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1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
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1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
07/31/2012	2.0		Updated ITB Requirements	Sections 1.3.2, 1.4. and 1.5
11/04/2013	3.0		Application of CO 10898	Section 1.4 Functional Area Responsibilities, line 17. Remove “Amended”.

1.3 RELATED DOCUMENTATION

Document	Description	url

2 I INTRODUCTION

Alabama's Medicaid program guidelines designate selected non-emergency medical items and services that must receive prior approval before delivery. The Agency's Prior Authorization (PA) Unit serves as a cost monitoring, utilization review measure, and quality assurance team for the Alabama Medicaid Program. The team ensures that payment from the Alabama Medicaid Management Information System (AMMIS) is only for those treatments and services that are medically necessary, appropriate, and cost-effective. Hewlett Packard Enterprise Services (HPES) PA Unit assists in this process by data entering non-drug and by data entering and approving Targeted Case Management PA requests.

1.1 PRIOR AUTHORIZATION UNIT FUNCTIONS

The Prior Authorization unit consists of the following:

Prior Authorization (Non-Pharmacy)

Targeted Case Management (TCM)

1.2 PRIOR AUTHORIZATION TASKS

The following tasks are performed in the Prior Authorization functional area:

1. Prior Authorization Requests (Non-Pharmacy), which includes Targeted Case Management (TCM) and non-emergency requests
2. Dental Care Prior Authorization

1.3 INPUT, PROCESSES, AND OUTPUT

1.3.1 Input

The table below documents the inputs to the Prior Authorization functional area.

Prior Authorization Inputs

Input	Source	Purpose
Alabama Prior Review and Authorization Dental Request	Provider	To request prior authorization for dental services.
Alabama Prior Review and Authorization Request	Provider	To request prior authorization for non-pharmacy services.

1.3.2 Processes

Processes accomplished in the Prior Authorization functional unit include the following:

1. Non-Pharmacy and Dental prior authorization requests.
2. TCM prior authorization requests.
3. Pharmacy prior authorization requests (Processed by Pharmacy PA contractor, currently Health Information Designs [HID]).

Non-Pharmacy and Dental Prior Authorization Requests

The PA specialists enter PA requests submitted by providers for all Non-Pharmacy and Dental PA requests. After all Non-Pharmacy and Dental PA requests are entered, American Psychiatric Services Healthcare (APS) reviews the PA requests online—along with any supporting documentation submitted by providers—and makes a decision on the request based on the prior authorization criteria for the request. The Agency's decision generates an approval or denial letter. This letter is then mailed to the provider.

NOTE:

If the Non-Pharmacy PA request has a PA Assignment code of 74—Private Duty Nursing— or a line item has been denied, a letter is also be sent to the recipient.

Targeted Case Management (TCM) Prior Authorization Requests

HPES' Targeted Case Management (TCM) Prior Authorization Coordinator is responsible for issuing prior authorization numbers for Targeted Case Management for Disabled Children. Based on a request from the provider, the coordinator reviews the prior authorization file to determine if the child is already receiving services. If not, the coordinator assigns a prior authorization number and immediately loads it to the file. If the child already has an existing prior authorization number, the coordinator instructs the provider to contact Medicaid's LTC – Program Management Unit.

Pharmacy Prior Authorization Requests

Pharmacy PA requests are approved or denied by the pharmacy PA contractor, currently HID, based on criteria supplied by Alabama Medicaid. The Alabama Medicaid Agency contracts with HID to perform this function. HID processes the requests via a T1 line, which allows them to process National Council for Prescription Drug Programs (NCPDP) P4 transactions interactively with HPES as well as access the online panels.

1.3.3 Output

The table below documents the outputs from the Prior Authorization functional area:

Prior Authorization Outputs

Input	Source	Purpose
Non-Pharmacy Prior Authorization Letter	AMMIS	Inform the provider of acceptance or denial of prior authorization request for non-pharmacy services.
PA Cover Sheet	Prior Authorization	Inform the Agency of prior authorization requests that require Agency review.

1.4 FUNCTIONAL AREA RESPONSIBILITIES

The following responsibilities for the Prior Authorization functional unit were extracted from section 3.05 of the Invitation To Bid (ITB):

1. Operate the Prior Approval Subsystem, including improvements, modifications, and/or electronic interfaces as they are implemented.
2. Designate a Targeted Case Management TCM Prior Authorization Coordinator who shall be responsible for issuing prior authorization numbers to providers for Targeted Case Management for Disabled Children. Based on paper or electronic requests from the provider, the coordinator shall review the prior authorization file to determine if the child is already receiving services. If not, the coordinator shall assign a prior authorization number and load it to the file within two (2) business days of the request. Contractor shall produce a follow-up letter and a report the next day following each update. If the child already has a prior authorization number, Contractor shall instruct the provider to contact Medicaid's LTC-Program Management Unit.
3. Receive, review and enter all paper PA forms from providers within two (2) days of receipt. Review all paperforms for completeness prior to entry into the MMIS and return incomplete forms to providers within two (2) days of receipt.
4. Support online submittal and response of the electronic PA (HIPAA ASC X12N 278 5010) transaction. Allow the providers to modify a request prior to its review or approval. Allow the providers access to electronic and paper PA requests (e.g., oxygen, home health, etc).
5. Accept on-line, real-time updates to PA information from the Agency or their contractors. For pharmacy claims, prior authorization updates must be accepted from the Pharmacy AdministrativeServices contactor online real-time for immediate use in Electronic Verification System (EVS) processing.
6. Provide the capability to globally change data, for example, provider ID numbers or procedure codes or modifiers, on active or pending PAs within an Agency approved timeframe.
7. Support automated distribution of PA requests to appropriate Medicaid staff.
8. Accept and process nightly updates to the PA data set from Agency specified contractors.
9. Respond to telephone inquiries, written inquiries and questions from providers and recipients regarding prior-authorized services for those areas that are the Contractor's responsibility within two (2) business days.
10. Auto-assign unique prior authorization control numbers to prior authorization items/services at time of entry into the system.

11. Create and distribute PA forms, in electronic and paper formats, to providers at no charge.
12. Maintain and update PA files/database tables to support all prior-authorized services.
13. Research PA or certification issues or problems identified by the system and/or operational staff; obtain documentation, determine impact, present findings to system support area; and perform further reviews once the issue/problem is fixed. Provide analysis and estimated date of correction within three (3) days of notification of any issues or defects.
14. Edit prior authorization requests entered into the MMIS, including verification of the eligibility of the recipient and provider for the PA request being made, including Medicare and other Third Party Liability (TPL) coverage and Health Maintenance Organization (HMO) enrollment, as well as all field verifications and inter-field relationships (i.e., approved status but presence of a denial reason code).
15. Automatically generate and mail letters to notify Providers of approvals and durations or denials of the PA request per Agency defined criteria and provide information regarding recipient appeal rights.
16. Automatically generate and mail letters to notify recipients denials of the PA request per Agency defined criteria and provide information regarding recipient appeal rights.
17. Identify and display on-line the status of PAs, including Evaluation, Approved, Denied, Pending, Cancelled, Denied Need Further Doco and Reconsideration.
18. Maintain and update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars (decrement when appropriate); increment units and/or dollars when necessary. Deny claims for any service that has been performed by a provider or group other than the provider or group who authorized the PA for the services.
19. 21. Make available on-line, real-time, the number of authorized services provided and show how many authorized services remain, by individual prior authorization numbers.
20. 22. Produce and make available to the Agency and/or their contractors all PA reports defined in the Alabama MMIS Reports Listing located in the Procurement Library.
21. 23. Identify issues and develop recommendations regarding policy guidelines which are unclear and/or cause problems in adjudicating PA requests. The issues may be identified by the Vendor, the Agency or their PA Contractors. These are to be forwarded to the State in writing (on paper or electronically) for review and approval within two (2) business days of identification and/or notification.

24. Provide EPSDT screening data for recipients who are eligible for extended benefits through prior authorization on-line, real-time.

1.5 PERFORMANCE EXPECTATIONS

The following performance expectations for the Prior Authorization functional unit were extracted from section 3.05 of the Invitation To Bid (ITB):

1. Process and assign a unique reference number to all Prior Authorizations received from Providers, Agency staff or Agency contractors within two (2) business days of receipt. Pharmacy electronic PA requests must be accepted online, real-time.

NOTE:

HPES does not process Pharmacy PAs. All Pharmacy PA requests are processed by Health Information Designs (HID). If a pharmacy claims is received by HPES it is forwarded directly to HID.

2. After the State determines medical necessity of requests, approving or denying, the Contractor must electronically generate and mail letters and appropriate forms responding to appropriate designees (providers, recipients, etc.) for PA services within two (2) business days.
3. Respond to provider's requests for the status of PA requests within one (1) business day, or within the timeframe specified by the state for pharmacy PAs.

2. INTRODUCTION

The Prior Authorization Unit reviews requests submitted by providers for designated non-emergency medical items and services that must receive prior approval from the Agency before the service can be delivered to the recipient. Requests are scanned, reviewed, and forwarded to the appropriate unit for disposition of the request, and letters are generated that indicate the acceptance or denial of the request.

2.1 PRIOR AUTHORIZATION REQUESTS

PA requests are processed according to the following procedure:

1. A provider completes the Alabama Prior Review and Authorization Request for Non-Pharmacy services or the Alabama Prior Review and Authorization Dental Request for dental services.
2. The provider mails the completed form to Prior Authorization at P.O. Box 244032, Montgomery, AL, 36124-4032 which has been designated for PA requests.

> A request sent to P.O. Box 244032, Montgomery, AL, 36124-4032 is considered extremely sensitive in nature, due to supporting documentation that may accompany the request. Only authorized personnel in the HPES mailroom are permitted to open a PA request.

3. The courier delivers the PA mail to the mailroom, and places the mail in the PA basket.
4. The mailroom specialist authorized to open PA requests opens the requests.

> Photographs and x-rays may accompany the request but are not scanned. If the photographs or x-rays are not in envelopes within the original request envelope, then the PA specialist puts the photographs or x-rays in a separate envelope, records the recipient's Recipient Identification Number (RID) on the envelope, the requesting provider's name and provider number, and seals the envelope. The mailroom specialist then puts the sealed envelope back in the original envelope. This ensures that the photographs or x-rays are protected and that they will not become misplaced during the scanning process.

5. Prior to scanning, the PA specialist splits the requests into batches of 50, and determines the correct region code to apply to the PA. The table below identifies the region numbers that can be assigned to the PA request during the scanning process.

Prior Authorization Regions for Scanned PA Requests

Region	Region Description
10–49	Non-Pharmacy Non-Electronic
50-69	Non-Pharmacy Electronic
70–89	Pharmacy Non-Electronic
90–99	Emergency

6. The mailroom specialist scans the PA request form and any supporting paper documentation that is attached to the PA.

7. During scanning, the ICN—indicating the selected region code and the Julian date of receipt—prints on the form to identify the scan as a PA scan. The ICN also becomes the PA number for the PA request.

NOTE:

Refer to Section 3. Scanning Claims and ICN section of the Document Control Manual for further information on the scanning process and ICN values.

8. After scanning, the mailroom specialist records the new ICN number on the envelope that contains x-rays or photographs that accompany the PA request.
9. The mailroom specialist forwards all scanned PA requests, attachments, and supporting documents to the PA specialist.
10. A PA specialist sorts the PA requests by PA type.
11. A PA specialist processes the PA request as follows:
    - If the request is a Non-Pharmacy or Dental PA request, the PA specialist follows the procedures in Non-Pharmacy and Dental Prior Authorization Requests outlined in Section 2.1.1 below.

NOTE:

HPES does not process Pharmacy PAs. All Pharmacy PA requests are processed by Health Information Designs (HID). If a pharmacy claims is received by HPES it is forwarded directly to HID.

    - If the PA Request has a PA Assignment Code of AC-Targeted Case Management**,** the TCM specialist follows the procedures detailed in Targeted Case Management (TCM) Prior Authorization Requests outlined in Section 2.1.2 below.

2.1.1 Non-Pharmacy and Dental Prior Authorization Requests

Non-Pharmacy and Dental Prior Authorization System Entry

The PA specialist performs the following steps to enter the PA information into the system:

1. Double-click the AMMIS icon to open the PA application. Non-Pharmacy, Pharmacy and Dental PA requests are keyed using the following PA panels:
    - Prior Authorization Information page which includes multiple panels for PA entry.
2. Using the Prior Authorization User Manual as a reference, key the required data elements for each PA request form in the batch until all of the forms are entered. Required data elements on the form are as follows:
    - Service and Request/Prescribing Provider Medicaid or National Provider Identification (NPI) Number.
    - Current RID.
    - Requested Procedure Code (if applicable).
    - Requested Effective Date.
    - Requested End Date.
    - Requested Units and/or Requested Dollars.

NOTE:

As fields are entered on the panel, the system informs the PA specialist if the field is required. If a field is required and left blank, an error message displays and the PA cannot be added to the system until the value for the required field is added.

Non-Pharmacy and Dental Agency Delivery

1. After the PA requests are keyed, the PA specialist completes a PA Cover Sheet for the requests. There is one PA Cover Sheet created for Dental PAs. The cover sheet indicates the Julian date of the scanned PA. The specialist completes the following information:
   a. For each PA service type, the specialist checks the appropriate box and records the number of entries in the "Number in Batch" Column.
   b. The "Number in Batch" is totaled and a count entered in the "Total" Line on the cover sheet.
   c. The PA specialist initials the "HPES PA Specialist Initials" Line.
   d. The PA specialist attaches the PA Cover Sheet to the batches and related attachments, and places the batches with the cover sheets in the outgoing Agency Mail basket.

NOTE:

A separate PA Cover Sheet for each Julian date must be completed if requests for more than one Julian date are forwarded to the Agency at the same time.

2. The courier retrieves the batch(es) and related documents and delivers them to the PA Division at the Agency.

   The courier must deliver all documents for the batch to the Agency. The Agency may need the actual paper attachments, photographs or x-rays in order to make a conclusive decision on the PA request.

1. The courier waits while a representative from the Agency signs and dates the PA Cover Sheet on the "Agency PA Representative" Line. The Agency is responsible for making copies of the PA Cover Sheet; the Agency keeps the original and gives the copy to the courier.
4. The courier returns the PA Cover Sheet to the mailroom at HPES.
5. The mailroom forwards the completed PA Cover Sheet to the PA Unit.
6. The Agency reviews each PA request and either approves or denies the PA request.

2.1.2 Targeted Case Management (TCM) Prior Authorization Requests

The TCM PA Specialist reviews each request to determine if other TCM services are already being rendered for the recipient, and makes a determination based on the Agency's guidelines. The following steps are performed when reviewing a request from a TCM provider:

1. The specialist signs on to the online PA panel and determines if the recipient is already receiving TCM services. Using the RID, the specialist accesses any PA information for the recipient. If no TCM PA is present or active, the specialist proceeds to Step 2. If there is a current TCM PA on file for the recipient, the specialist goes to Step 3.
2. The specialist verifies the service requested is a covered TCM PA service. If covered, the TCM request is approved.
3. If not covered or there is an existing PA, the specialist denies the TCM PA request with a decision code of Denied (D).

2.2 PRIOR AUTHORIZATION LETTERS

During the nightly processing cycle, Alabama Medicaid Prior Review and Authorization Request Decision Letters are generated based on the Agency's and HPES' TCM PA coordinator's PA decision for each PA request. The letters are processed and delivered according to the following daily procedure:

1. HPES Operations prints the PA letters. The provider's and recipient's addresses are printed in the upper left-hand quadrant of the letter to facilitate mailing in a #10 window envelope.

NOTE:

Two letters print if the PA Type on a PA request is 74—Private Duty Nursing. One is mailed to the provider and the other to the recipient.

2. After the letters are printed, Operations delivers the letters to the PA specialist for verification. After verification, the letters are delivered to the mailroom.
3. The mailroom inserts the letters into the window envelopes and meters them with first-class postage.

If the PROCEDURE DESCRIPTION on the letter is PRIVATE DUTY NURSE or a line item has been denied, then two copies of the letter must be mailed. The mailroom specialist inserts one copy of the letter into a window envelope that shows the provider address, and inserts the other copy into a window envelope that shows the recipient address.

PA letters must be printed and mailed within two business days of the Non-Pharmacy PA decision.

2.3 PHARMACY PRIOR AUTHORIZATION REQUESTS

Providers submit a PA request to the PA contractor, currently HID, for prior authorization of specific drugs. The PA contractor accesses the on-line PA application and uses the Prior Authorization panels to enter the applicable information. Once information is entered and a PA number is assigned, the database is updated and the pharmacy provider may submit the pharmacy claim for processing.

Glossary

The table below defines the terms used in the Prior Authorization functional area.

Prior Authorization Functional Area Terms

Term	Definition
Billing/Rendering/Service provider	The provider who is authorized to perform the requested services.
Diagnosis code	The code describing the diagnosis of the patient, which is used to determine the treatment or admission of the patient. This code is designated on the prior authorization form and the claim form.
Prescribing/Requesting provider	The provider who prescribed or requested the service requiring prior authorization.
Procedure code	The code describing the medical service the provider supplied to the recipient. This code is designated on the prior authorization form and the claim form.
Non-Medicaid/License Provider	The state license number of the provider who prescribed the service requiring prior authorization.
Recipient	An individual who has been certified by the State as eligible for assistance in accordance with the State plans under Title XIV and Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, and Title IV of the Immigration and Naturalization Act.