

## Section 6. Prior Approval

Prior approval (PA) may be required for some services, products, or procedures. PA establishes compliance with clinical coverage policy or program criteria. This basic medical necessity determination is based on the documentation submitted by the provider. If PA is required, it must be obtained **before** rendering a service, product, or procedure. Obtaining PA does not guarantee payment, ensure recipient eligibility on the date of service, or guarantee that a post-payment review to verify that the service was appropriate and medically necessary will not be conducted. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered.

The recipient must meet all clinical coverage policy or program criteria PA criteria. **However**, the federal Social Security Act (the Act) found at section 1905(r) requires the state Medicaid agency to provide to Medicaid recipients under 21 years of age “necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan.” Additionally, if the recipient is under 21 years of age, service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies/program manuals may be exceeded or may not apply provided that documentation shows the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician. This special provision for recipients under 21 years of age is known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT criteria are specified below, and **all criteria must be met to approve coverage under EPSDT**. A list of EPSDT services is located in this section.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, “rehabilitative services” are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.
2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient’s physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
3. The requested service must be determined to be medical in nature.
4. The service must be safe.
5. The service must be effective.

6. The service must be generally recognized as an accepted method of medical practice or treatment.
7. The service must not be experimental/investigational

Additionally, services can be covered only if they are provided by a N.C. Medicaid-enrolled provider for the specific service type. For example, only a N.C. Medicaid-enrolled durable medical equipment (DME) provider may provide DME to a Medicaid recipient. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

If a service, product, or procedure requires PA, requests made on behalf of recipients under 21 years of age are **NOT** exempt from the PA requirement. Further information about EPSDT is available in **Section 2** of this billing guide, the PA table and list of EPSDT services found in this section, and DMA's EPSDT Policy Instructions Update, on the web at <http://www.ncdhhs.gov/dma/epsdt/>.

To determine if a procedure requires PA, refer to DMA's clinical coverage policies, listed on DMA's website at <http://www.ncdhhs.gov/dma/mp/>. Providers may also call the Automated Voice Response (AVR) system at 1-800-723-4337. Refer to **Appendix A** for information on using the AVR system.

## Important Points about Prior Approval

1. **In accordance with 10A NCAC 22J.0106 (d), providers cannot bill recipients when the provider failed to follow program regulations or when the claim denied on the basis of a lack of medical necessity.** For further information about when a recipient may be billed for services, please see section 3.
2. Retroactive PA is considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Exceptions **may apply** as indicated below.
  - Recipients enrolled in a Community Alternatives Program (CAP)
  - Hospice Election Reporting PA. Refer to Medicaid's Clinical Coverage Policy #3D, *Hospice Services*, on DMA's website for further information. The web address is <http://www.ncdhhs.gov/dma/mp/>.
  - If a recipient has been placed in a nursing facility, the PA date for nursing facility level of care may be retroactive to 30 days prior to the date the FL2 is approved by the fiscal agent or up to 90 days with the FL2 and supporting records.
  - When services have been rendered to a CCNC/CA enrollee without first obtaining authorization from the primary care physician (PCP) and the PCP refuses to authorize retroactively, providers may request an override using the **CAROLINA ACCESS Override Request Form** to obtain payment. Override requests will be considered only for extenuating circumstances beyond the control of the responsible parties that affected access to medical care. **Overrides will not be given for mental health services.**

3. Some requests for PA are submitted to DMA or DMA's utilization review contractors. A few PA requests may be submitted and approved verbally and followed up with a written request. However, when a request for PA is made verbally and approved, it is approved **tentatively** effective the date of the call, contingent upon receipt of the written request within 10 days of the call and validation that the documentation submitted by the provider substantiates the verbal information. If the written request is not received within the required timeframe or the written documentation does not substantiate the verbal information previously provided, the request will be denied. Following the required timeframes, a new PA request may be submitted at any time. Please see the PA table at the end of this section to determine which services may receive **tentative** verbal PA.
  
4. **Except in emergency situations**, as defined by the Social Security Act, Section 1923(b)(2)(B)(i-iii) and (C)(i-iii), 42CFR§489.24(c)(3), and 42CFR§489.24(d)(4), **all services provided to Medicaid recipients by out-of-state providers must be approved prior to rendering the service. Emergency coverage ends as soon as the recipient is stable [as defined by 42 CFR §489.24(b)]. Medicaid will not pay for out-of-state services once a recipient is stable.**

Out-of-state services must be provided in compliance with all applicable, rules, regulations, laws, and current standards of practice. Specifically, 42 CFR §431.52(b)(1-4) only allows states to pay for out-of-state services when furnished to a recipient who **resides in North Carolina** and when any of the conditions stated below are met.

- Medical services are needed because of a medical emergency as defined by the rules cited above; or
- Medical services are needed and the recipient's health would be endangered if he/she were required to travel to his State of residence (North Carolina); or
- N.C. Medicaid determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in another State; or
- It is general practice for recipients in a particular locality to use medical resources in another State. For example, recipients who reside in North Carolina but receive medically necessary care and services within 40 miles of the North Carolina border in the contiguous states of Georgia, South Carolina, Tennessee, and Virginia.

It should be noted that N.C. Medicaid allows medically necessary care and services to be provided to a foster child, who is a ward of the state, living in a foster home more than 40 miles from the border. This child is considered as a foster child living in North Carolina, and prior approval is not required for out-of-state services. Prior approval applies for all other services if PA is required by the clinical coverage policy.

In most cases, the out-of-state provider will be paid at North Carolina rates. The out-of-state provider must be a N.C. Medicaid-enrolled provider on the dates of service. For enrollment information, please refer to <http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp>.

Out-of-state providers are asked to notify N.C. Medicaid within 72 hours (three business days) of the date of emergent service (outpatient services) or the admission date for the treatment of inpatient emergent conditions, either observation or inpatient admission.

When requesting authorization for payment of services, the provider should submit the recipient's face sheet, emergency department record, observation record, admission history and physical, discharge summary, and any other relevant information that demonstrates the recipient's condition met the definition of emergent services as defined by the Social Security Act, Section 1923(b)(2)(B)(i-iii) and (C)(i-iii). See table at the end of this section for contact information.

For complete details regarding out-of-state services, please review DMA's Out-of-State Services policy, 2A-3, at <http://www.ncdhhs.gov/dma/provider/library.htm>.

5. If PA is required, the provider must request and obtain PA **before** rendering the service, product, or procedure in order to seek Medicaid payment. When submitting a request for a service to be continued (a re-authorization request), submit the request **10 days prior to the end-date of the current authorization period** to avoid a break in payment. For complete information about prior approval and recipient due process, see the resources identified below.
  - DMA's *Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures* documents the instructions for Medicaid recipient due process rights and prior approval procedures and is available online at <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>.
  - DMA's prior approval procedures are located online at <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>.
  - DMA's specific clinical coverage policies/program manuals for complete details regarding provision of and payment for services rendered are located online at <http://www.ncdhhs.gov/dma/mp/>.
6. Before admitting recipients for procedures requiring PA, hospital office personnel must determine that the physician has completed all of the necessary PA forms.
7. Behavioral health referrals for outpatient services for children may be obtained from the local management entity (LME), Medicaid-enrolled psychiatrist, or the primary care physician. This is not an authorization. It is a referral process that must take place **before** the provider sees the child. Authorization must be obtained from the appropriate utilization review (UR) vendor (LME or ValueOptions).

**Notes:**

- For psychiatric services, the admissions are usually emergent, and the hospital has 48 hours to obtain PA from the appropriate UR vendor. All other mental health services require PA from the appropriate UR vendor as well.
- All behavioral health services for individuals, whose eligibility is based in a Managed Care geographic area with the exception of emergent treatment, must be authorized by the respective MCO.
- If a CCNC/CA enrollee and if under the age of 21, outpatient behavioral health services require a referral from a Carolina ACCESS PCP, or alternatively from a Medicaid-enrolled psychiatrist or the local management entity (LME).

8. For a prior approval request to be processed, it must include the following: recipient name, address, Medicaid identification number, date of birth, identification of service or procedure code requested, provider name, Medicaid provider number who is to perform the service or procedure, date the service is requested to begin or be performed, all required signatures on forms required by statute, and/or any documents or forms required by state or federal statute in order to commence a review for prior authorization.
9. Requests for prior approval of Medicaid services should be fully documented by the provider and treating clinicians to demonstrate medical necessity. Providers must complete and submit (a) requests for prior approval to the correct UR vendor using the forms and fields required by the applicable clinical coverage policy and UR vendor, and (b) all necessary attachments (for example, person centered plans or x-rays) in order for the request to be considered complete.
10. Providers should supplement the information requested on prior approval forms and plan of care forms with other recent clinical information the provider believes will document medical necessity if the provider believes the information requested on the form is not sufficient to fully document medical necessity for the requested service. This additional documentation may include recent evaluation reports from clinicians, recent treatment records, and letters signed by treating clinicians that explain why the service is medically necessary. For children under the age of 21, documentation must show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes:
  - documentation showing that policy criteria are met;
  - documentation to support that all EPSDT criteria are met; and
  - evidence-based literature to support the request, if available.
11. UR vendors will consider all relevant information that is submitted in addition to the information provided on required forms and in required fields, regardless of whether the additional information is included on a particular form. UR vendors will make individualized medical necessity decisions based on the individual representations of each prior authorization request and the applicable law and policy, will use publicly available utilization review and best practice guidelines, and will allow case-by-case exceptions to those guidelines and policies as required by EPSDT. For more information on the best practices guidelines used by DMA's vendors, refer to <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>.
12. UR vendors will perform EPSDT reviews, or refer to DMA staff for EPSDT review where appropriate. To approve a request under EPSDT, the recipient must meet all EPSDT criteria and must be Medicaid eligible on the date the service, product, or procedure is provided. If the recipient is receiving services under a Community Alternatives Program (CAP), UR vendors will review requests for services for recipients under 21 years of age using waiver and EPSDT criteria if the requested service is covered under both the waiver and EPSDT. EPSDT covers diagnostic, screening, preventive and rehabilitative services and other treatment but does not cover habilitative services. Additionally, if on a CAP waiver, the recipient must still meet the budget and participation requirements as stipulated by the waiver. For further information about EPSDT, please visit DMA's web page on EPSDT located at <http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm>.

13. Prior to the decision on a request for prior approval, contacts with the requesting provider or recipient (including telephone and email contacts) will be limited to those needed to obtain more information about the service request and/or to provide education about Medicaid covered services. Providers and recipients will not be asked to withdraw or modify a request for prior approval of Medicaid services in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP score or other clinical assessment. Material misinformation to or intimidation of providers or recipients that has the foreseeable effect of significantly discouraging requests for Medicaid services, continuation of Medicaid services, or the filing or prosecution of appeals before the Office of Administrative Hearings is prohibited. Nothing in this paragraph should be construed to prevent clinical or treatment discussions.

14. DMA staff and vendors will make **every effort** possible to make a decision about a PA request within 15 business days. If the request is approved as submitted, an approval notice is mailed or electronically transmitted to the provider or recipient (if a provider did not make the request). The notice will state the service approved, number of units/hours approved, and the authorized time period (if appropriate).

If unable to approve the request as submitted, additional information, at the discretion of the reviewer, may be requested from the provider to make a decision on the request. The provider is asked to respond to a request for additional information by submitting the needed information within 10 business days of the date of the notice. **If the provider fails to respond, an adverse notice shall be issued by trackable mail to the recipient and by first class USPS mail to the provider.**

DMA staff and vendors may also deny, reduce, terminate, or suspend the request. The adverse notice will be mailed as described in the section on recipient due process.

15. The service must be rendered in accordance with the PA granted, including service approved, number of units approved, and time period of approval, if relevant, unless there is a more stringent requirement. For information about authorizations for continuing requests during the prior approval process, please refer to DMA's prior approval and due process procedures found at <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>.

16. Prior approval numbers are issued to the provider who submits the request. If a claim is billed for a prior approved service by a different provider, it will be denied.

17. **Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service.**

18. Recipients may change providers as indicated below.

**A. During the Appeal Process, Going Out of Business, CAP Services, Other Long Term Services**

1). For Medicaid recipients who:

- a. have appealed an adverse decision, or
- b. whose provider agency is going out of business, or

- c. have changed providers for CAP services, or
- d. are changing providers for another service with an authorization period of six months or more

The current authorization for services will transfer to the new provider within five (5) business days of notification by the new provider to the appropriate UR vendor and upon submission of written attestation that provision of the service meets Medicaid policy and the recipient's condition meets coverage criteria and acceptance of all associated responsibility; **and either**

- a. Written permission of recipient or legal guardian for transfer; or
  - b. Copy of discharge from previous provider.
- 2) Authorization shall be effective the date the new provider submits a copy of the written attestation.
  - 3) Following the appeal or prior to the end of the current authorization period, the new provider must submit a request for reauthorization of the service in accordance with the clinical coverage policy requirements and these procedures.

#### **B. At Any Other Time**

Medicaid recipients may change providers at any other time. However, the discharging provider and the new provider must follow all policy requirements and these procedures.

19. The provider has up to 365 days from the date the service is rendered to submit the claim for payment. See the specific clinical coverage policies/program manuals for complete details regarding provision of and payment for services rendered. Clinical coverage policies/program manuals can be found on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.
20. The AVR system provides information regarding a recipient's last routine eye exam or refraction only. It is in the provider's best interest to obtain an authorization/confirmation number on the day of service, prior to rendering the service.
21. Prior approval does not guarantee claims payment for recipients with Medicare or third party insurance. Refer to **Section 7, Third-Party Insurance**, for additional information.

The quick reference table that appears in this section summarizes information about some services that require PA. For complete information, refer to individual clinical coverage policies/program manuals on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

### **Early and Periodic Screening, Diagnosis, and Treatment**

For a more detailed explanation of EPSDT, see DMA's EPSDT Policy Instructions Update at: <http://www.ncdhhs.gov/dma/epsdt/> and **Section 2, Recipient Eligibility**.

1. See important points about prior approval as they apply to EPSDT service requests.

2. If the service, product, or procedure requires PA, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for PA.
3. If a recipient under 21 years of age does not meet the coverage criteria set forth in the clinical coverage policies/program manuals or needs to exceed policy limits, the provider must request and obtain PA from the appropriate authorizing agent **BEFORE** the service is rendered, **even if PA is not required.**
4. PA requests for non-covered state Medicaid plan services are requests for services, products, or procedures not included in the North Carolina State Medicaid Plan **but included** in the federal Medicaid law, 1905(r) of the Social Security Act. To review the listing of federal EPSDT services, products, or procedures coverable under federal Medicaid law, see the listing of EPSDT services at the end of this section.
5. Requests to cover non-covered state Medicaid plan services must be submitted to DMA, Assistant Director, Clinical Policy and Programs, prior to rendering the service. To access the Non-Covered State Medicaid Plan Services Request Form for Recipients *under 21 Years Old*, please visit <http://www.ncdhhs.gov/dma/provider/forms.htm>.
6. If the recipient is **21 years of age or older and the service has not been provided**, although PA was granted before his or her 21st birthday, follow DMA's published procedures and submit a new request for PA if PA is required. See the specific clinical coverage policy/program manual for complete details regarding provision of and payment for services rendered. Clinical coverage policy/program manual can be found on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.
7. EPSDT PA authorization is time limited to the first of the following occurrences:
  - the recipient reaches 21 years of age **OR**
  - The time limit specified by the PA is exhausted **OR**
  - 365 days elapses from the date of the PA.

## General Requests for Prior Approval

The Request for Prior Approval (Form 372-118) is used by several service types to assist in the review of medical necessity for the requested services. PA requests must be submitted in writing, and providers are strongly encouraged to use this form. However, utilization review contractors (UR contractors) will consider all relevant information that is submitted, regardless of whether it is included on a particular form. (See **Important Points about Prior Approval** for further information about documenting PA requests.) To obtain this form, contact HP Enterprise Services Provider Services at 1-800-688-6696. Once a PA has been issued, it must be used within the time limit set forth by the PA **OR** within 365 days, whichever time period is less. The following services use this form:

- Some medical and surgical services
- Out-of-state elective services

- Services to Medicaid for Pregnant Women recipients
- Hearing aid services
- Therapeutic leave over 15 consecutive days
- Routine eye exam or refraction services beyond established limitations
- Out-of-state and state-to-state ambulance service

**Note:** A completed and signed State-to-State Ambulance Transportation Addendum Form (372-118A) must accompany the PA request.

- Transplants (See **Transplants** in this section)

See the PA table at the end of this section to determine the authorizing agent. It is also important to remember that if services are to continue and the PA is time limited, PA must be requested again before the limits are met or 10 calendar days prior to the end-date of the current authorization to avoid an interruption in service and payment.

For additional information about prior approval, refer to DMA's website at <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>.

## Requests for Specific Types of Prior Approval

### Adult Care Home – Enhanced Care

The Adult Care Home (ACH) staff makes a referral request for enhanced care on behalf of the recipient to the county department of social services (DSS) by sending a copy of the latest FL2, the **Adult Care Home Personal Care Services Physician Authorization and Plan of Care Form** (DMA-3050R), and other referral documents, as necessary. The county DSS assigns a case manager, conducts an independent assessment, and approves the recipient for enhanced care services, if appropriate. The case manager calls this approval in to the fiscal agent, receives a service review number, and sends the resident and the provider a decision notice.

### Adult Care Home – Special Care Unit for Persons with Alzheimer's and Related Disorders

Effective October 1, 2006, Medicaid implemented a special care rate for ACH providers operating special care units for persons with Alzheimer's and related disorders (SCU-A). The provider must receive PA before admitting a new resident to a SCU-A. The provider must complete the SCU-A Prior Approval Form and submit it, along with all supporting documents, to

Adult Care Homes Unit  
Facility and Community Care Section  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh NC 27699-2501

The PA request form and instructions can be found on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>, under Adult Care Homes.

## **Auditory Implant External Parts and Accessories (Auditory Brainstem, Bone Anchored Hearing Aid, and Cochlear)**

Fax all requests for external parts replacement and repair, in letter format, to the appropriate implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech or sound processors and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the implant manufacturer.

**NOTE:** All Softband BAHA (non-implanted) requests must be submitted on the Request for Prior Approval (Form 372-118) under the Hearing Aid Services Program.

## **Community Alternatives Program (CAP) Participation**

The purpose of the Community Alternatives Programs is to offer community-based care to certain targeted populations as an alternative to institutionalization, as long as the care required can be delivered safely and is cost effective. Admission to and continuation of CAP services requires physician approval and is overseen by a CAP case manager. Admission to the program begins with the following:

1. Referral to the program.
2. Completion of an FL2 signed and dated by the recipient's physician and approved at the nursing facility level of care (for CAP/C, CAP/Choice, and CAP/DA) or completion of an MR2 signed and dated by the recipient's physician and approved at the intermediate care facility for individuals with mental retardation level of care (for CAP/I-DD).
3. Thorough assessment of the recipient to determine appropriateness for CAP.
4. Evaluation of the assessment and level of care document to determine appropriateness for CAP.

The CAP programs, lead agencies, and websites are identified below.

<b>Program</b>	<b>Lead Agency</b>	<b>Website</b>
CAP/C	DMA–Home Care Initiatives Unit	<a href="http://www.ncdhhs.gov/dma/services/capc.htm">http://www.ncdhhs.gov/dma/services/capc.htm</a>
CAP/DA	Appointed County Agency	Lead agency listing: <a href="http://www.ncdhhs.gov/dma/services/capda.htm">http://www.ncdhhs.gov/dma/services/capda.htm</a>
CAP/I-DD	Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS)	<a href="http://www.ncdhhs.gov/mhddsas/cap-mrdd/">http://www.ncdhhs.gov/mhddsas/cap-mrdd/</a>

Further information about CAP is available in specific clinical coverage policies, program manuals, and the websites specified above.

## Dental Services

Requests for PA for dental services are submitted using the 2006 ADA Form. Only PA requests for services that are indicated as requiring PA should be submitted to the HP Enterprise Services Prior Approval Unit. Refer to the Dental Program Policy Manual (#4A, *Dental Services*, and #4B, *Orthodontic Services*) on DMA's website at <http://www.ncdhhs.gov/dma/mp/> for information on dental services and limitations.

The two-part form must be used when requesting PA. The original is returned to the provider and serves as the PA/claim copy. The second page is retained by HP Enterprise Services. Until the original is returned, providers should keep a copy for their office records, noting the date the PA request was mailed.

## Durable Medical Equipment, Orthotic and Prosthetic Devices, Oral Nutrition Products for Recipients under 21 Years of Age, Pediatric Mobility Devices, and Augmentative and Alternative Communication Devices

Some of these items and services require PA. In those cases, the **Certificate of Medical Necessity/Prior Approval (CMN/PA) Form** must be submitted to HP Enterprise Services for review. The CMN/PA is reviewed to ensure that the item is medically necessary to maintain or improve a recipient's medical, physical, or functional level and the requested DME is suitable and appropriate for use in the recipient's private residence or adult care home.

PA requests for DME, O&P, augmentative and alternative communication devices, and oral nutrition products for recipients under 21 years of age (excluding requests for metabolic formulas that must be made to the Division of Public Health) that do not appear on DMA's fee schedules of covered services but are covered under 1905(a) of the Social Security Act and medically necessary under EPSDT should be submitted to DMA at:

Assistant Director  
Clinical Policy and Programs  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh NC 27699-2501  
FAX: (919) 715-7679

All requests for pediatric mobility items that do not appear on DMA's lists of covered equipment but are medically necessary under EPSDT are submitted to HP Enterprise Services for review.

PA is valid for the time period approved on the CMN/PA Form. If a physician decides that an item is needed for a longer period of time, a new CMN/PA Form must be submitted.

Refer to clinical coverage policies #5A, *Durable Medical Equipment*, and #5B, *Orthotic and Prosthetic Devices*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/> for additional information.

## Hearing Aids, Frequency Modulation Systems, and Accessories

All hearing aids, Softband BAHAs, frequency modulation (FM) systems, repairs, replacement parts, and accessories require PA except hearing aid batteries. Requests must be submitted using the general Request for Prior Approval (Form 372-118) along with a letter from the physician or otologist (including otolaryngologist or otorhinolaryngologist) certifying the need for beginning the hearing aid selection

process, a copy of a hearing evaluation (including audiogram), the results of the hearing aid selection and evaluation tests, and a copy of the hearing aid manufacturer's warranty information.

- In block 10 on the PA, record the manufacturer, model, and cost of requested aid.
- Also in block 10, document the type of aid being requested (Analog Programmable, Digital Programmable, or FM System).
- In block 12, document the reason(s) the recipient requires the requested system.

Refer to Clinical Coverage Policy #7, *Hearing Aid Services*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/> for information on services and limitations.

## Hospice Participation

Hospice providers must notify HP Enterprise Services when a Medicaid recipient elects the hospice benefit as well as when hospice benefits are revoked, a recipient is discharged from hospice, or a recipient transfers from one hospice to another. This includes Medicare/Medicaid hospice patients in nursing facilities for whom Medicaid is paying room and board. Hospice participation information may also be obtained using the AVR system.

Refer to **Appendix A** for information about using the AVR system.

## In-Home Care for Adults (IHCA)

The recipient's primary care or treating physician or discharge planner makes a referral for an independent assessment (IA) to the independent assessment entity (IAE), either by completing and faxing the referral form available at <http://www.qireport.net>, or through the Online Physician Referral System for Medicaid IHC, also accessible through <http://www.qireport.net>. The IAE contacts the recipient, schedules and conducts an IA, determines the authorized service level, refers qualified recipients to their providers of choice, issues prior approval, and sends the recipient and provider a decision notice.

## In-Home Care for Children (IHCC)

The recipient's primary care or treating physician or discharge planner makes a referral for an independent assessment (IA) to the independent assessment entity (IAE), either by completing and faxing the referral form available at <http://www.qireport.net>, or through the Online Physician Referral System for Medicaid IHC, also accessible through <http://www.qireport.net>. The IAE contacts the recipient, schedules and conducts an IA, and forwards the IA to DMA for EPSDT review. DMA determines the authorized service level. The IAE refers qualified recipients to their providers of choice, issues prior approval, and sends the recipient and provider a decision notice.

## Long-Term-Care Services

The **FL2 Long-Term-Care Services Form** (372-124 paper; FL2e electronic) is used by several programs for approval of long-term-care nursing services. If a telephone review results in approval of the FL2, the approval is **tentative (not final)**, pending submission of a completed form within 10 days of the telephone call to the fiscal agent and validation that the documentation submitted substantiates the verbal information previously provided. The FL2 must be submitted as the hard copy original or electronically through Provider Link. Should the submitted FL2/FL2e fail to validate that the recipient requires nursing facility level of care at the level specified by the requestor and in accordance with DMA's recipient notices procedure, the request may be denied or reduced, or additional information may be requested. Additionally, if the FL2/FL2e is not submitted within the required timeframe, the FL2/FL2e will be denied. The following services use this form:

- Out-of-state long-term care (nursing facility)
- Long-term-care nursing

- Ventilator-dependent care
- CAP/C, CAP/Choice, CAP/DA for level of care determinations

Providers are encouraged to submit the FL2 electronically. All electronic requests for long-term-care nursing services must be submitted through Provider Link using the FL2e Form.

### **Optical Services – Routine Eye Exams with Refractions**

Routine eye exams with refractions do not require PA. However, it is in the best interest of the provider to call the AVR system to verify the last date of service and receive a confirmation number for the patient record. If a second routine eye exam with refraction or a refraction only is requested within the time limitation period, PA is required. A **general Request for Prior Approval Form** (372-118) documenting medical necessity must be submitted and approved prior to rendering the service.

Refer to **Appendix A** for information about using the AVR system to obtain an authorization/confirmation number for an eye exam with refraction or refraction only.

### **Optical Services – Visual Aids**

All visual aids require PA, and requests must be submitted on a **Request for Prior Approval for Visual Aids Form** (372-017 or 372-017A). To obtain this form, contact HP Enterprise Services Provider Services at 1-800-688-6696. In some cases, this form must be accompanied by required documentation. Refer to the *Optical Services Manual* on DMA's website at <http://www.ncdhhs.gov/dma/services/optical/> for information on services and limitations.

### **Out-of-State or State-to-State Ambulance Service**

PA is required for ambulance service by ground or air from North Carolina to another state, from one state to another, or from another state back to North Carolina **as specified above in the section on out-of-state services**. PA for ambulance service is separate from PA for a medical procedure or treatment provided out of state. Requests for PA must be submitted on the **general Request for Prior Approval Form** (372-118) and the **State-to-State Ambulance Transportation Addendum Form** (372-118A).

**If emergent services are required, Medicaid or the appropriate approval agency must be notified within 72 hours (three business days) of service provision.** Services must be provided in compliance with all applicable rules, regulations, laws, and current standards of practice.

### **Outpatient Specialized Therapies**

N.C. Medicaid contracts with the Carolina Center for Medical Excellence (CCME) to perform the PA process for outpatient specialized therapies. PA is required for all treatment services. Please go to <http://www.medicaidprograms.org/nc/therapyservices> for information on how to submit requests for prior approval.

Refer to Clinical Coverage Policy #10A, *Outpatient Specialized Therapies*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/> for additional information.

### **Over-the-Counter Medication Requests for Recipients under 21 Years of Age**

Requests for coverage of over-the-counter (OTC) medications that are not on the list of OTC medications covered by the North Carolina State Medicaid Plan should be submitted to the DMA, Assistant Director, Clinical Policy and Programs using the **Non-Covered State Medicaid Plan Services Request Form** as specified on the form prior to providing the medication. The form must be completed by the recipient's physician or other licensed clinician. The request must include documentation that shows that **all** EPSDT

criteria are met. Coverage consideration will be given for an OTC medication for which a National Drug Code (NDC) exists and for which the medication's manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

Refer to General Coverage Policy #A-2, Over-the-Counter Medications, on DMA's website at <http://www.ncdhhs.gov/dma/mp/> for a current list of covered OTC medications.

## **Prescription Drugs**

N.C. Medicaid contracts with ACS, a Xerox Company, to manage the PA process for non-preferred drugs on the Preferred Drug List (PDL) and selected drugs or drug classes that have additional clinical criteria that must be met before PA is granted. (The PDL and drugs or drug classes requiring PA can be viewed online at <http://www.ncmedicaidpbm.com>). Providers are notified of PA changes via the general Medicaid bulletin (<http://www.ncdhhs.gov/dma/bulletin/>) and/or through the Pharmacy Newsletter (<http://www.ncdhhs.gov/dma/pharmnews/>).

The prescriber can contact the ACS Clinical Call Center (in Henderson, North Carolina) directly by telephone, fax, e-mail, or mail. Pharmacists may dispense a 72-hour emergency supply without PA.

Copies of the prescription PA forms may be obtained by contacting ACS (telephone 1-866-246-8505 or online at <http://www.ncmedicaidpbm.com>).

## **Prior Approval for Behavioral Health Services**

N.C. Medicaid contracts with independent vendors to provide utilization review of the following services:

- acute inpatient/substance abuse treatment hospital care
- ambulatory detoxification
- assertive community treatment team
- community support team
- Criterion 5 services
- day treatment
- intensive in-home
- Levels I through IV residential treatment facilities
- mental health/substance abuse targeted case management
- mobile crisis services
- multisystemic therapy
- non-hospital medical detoxification
- non-medically monitored community residential treatment
- opioid treatment
- outpatient psychiatric services
- partial hospitalization
- psychiatric residential treatment facilities (PRTFs)
- psychosocial rehabilitation

- services in facility-based crisis programs
- substance abuse comprehensive outpatient programs
- substance abuse intensive outpatient programs
- substance abuse medically monitored community residential treatment
- targeted case management for individuals with intellectual and developmental disabilities

The independent vendor reviews and approves the requests based on medical necessity according to established criteria. The Durham Center provides utilization review services for Medicaid recipients from Durham County; Eastpointe LME provides utilization review services for Medicaid recipients from Duplin, Lenoir, Sampson, and Wayne counties; and ValueOptions provides services to the remaining counties.

For recipients **over 21 years of age** and after the eighth visit, providers must obtain authorization from the appropriate utilization review vendor for continued outpatient mental health services. Recipients **under 21 years of age** are allowed 16 unmanaged visits before prior approval is required.

Refer to Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*, and 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/> for additional information.

See the EPSDT information found in **Section 2, Recipient Eligibility**, or the EPSDT Policy Instructions Update on DMA's website at <http://www.ncdhhs.gov/dma/epsdt/> for a full discussion of EPSDT and criteria.

## **Radiology – Outpatient (Non-Emergency) Diagnostic Imaging Procedures**

Prior authorization is required for certain non-emergency radiology procedures including computed tomography (CT), magnetic resonance (MR), positron emission tomography (PET) scans, and ultrasounds for recipients in Medicaid benefit categories that cover these procedures. Refer to the policy on DMA's website at <http://www.ncdhhs.gov/dma/services/radiology.htm> and to MedSolutions website at <http://www.medsolutionsonline.com> for additional information.

## **Surgical Procedures**

Not all surgical procedures require PA. The primary surgeon has the responsibility of obtaining PA from the HP Enterprise Services Prior Approval Unit or DMA staff, as appropriate. To determine if a procedure requires PA, call the AVR system (1-800-723-4337). If a recipient has Medicare or commercial insurance, PA must be requested and a response must be received from Medicare or commercial carrier before requesting PA from Medicaid.

When PA is required for a surgical procedure, supporting documentation must be included with the request. The primary surgeon has the responsibility of obtaining PA from HP Enterprise Services Prior Approval Unit or DMA staff, as appropriate. If the recipient has Medicare or commercial insurance, a copy of the response from Medicare or the commercial carrier to the request for PA must also be included with the PA request to Medicaid.

Refer to the clinical coverage policies on DMA's website at <http://www.ncdhhs.gov/dma/mp/> for information on medical necessity criteria for specific surgical procedures. All requests for PA must be submitted using the general Request for Prior Approval Form (372-118).

## Transplants

When a hospital transplant team determines that a Medicaid recipient or pending recipient requires a transplant (solid organ or stem cell), all of the supporting documentation justifying the medical necessity for the procedure must be sent to DMA for pre-approval. After the documentation is reviewed, the physician and the facility, as well as the recipient, will receive a notification of approval or denial from DMA.

Retroactive PA will not be authorized for any recipient who does not have Medicaid coverage at the time of the procedure.

In order for N.C. Medicaid to review a request for transplant coverage for a **dually eligible recipient**, providers must submit a copy of the insurance denial or payment from the primary payer with the claim, the request for coverage of the transplant service, and the complete clinical evaluation packet. These must be received within 180 days of the transplant procedure. Requests without complete clinical evaluation packets will not be considered. Upon receipt of these documents, DMA will conduct a dually eligible post review and make a determination, using clinical policy guidelines, as to whether Medicaid coverage is available. Clinical packets **must** be complete, according to the requirements below, in order to be reviewed.

Fax clinical packets to the transplant nurse consultant at 919-715-0051. The packet must include the documentation specified below as well as the clinical documentation indicated in the specific transplant clinical coverage policies, available on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

### Lab/Diagnostic Study Requirements:

**Lab results** required in a complete packet include CBC, liver enzymes, complete electrolytes, PT, INR, glucose and A1C (if Type I or Type II diabetic), blood type, MELD/PELD score if appropriate Serologies: HIV, Hepatitis, RPR, EBV, CMV, Varicella, Rubella, HSV I/II, and toxoplasmosis. **Please note:** Positive serology results may be reported that are greater than three months old.

- Recipient height and weight
- Diagnostic studies:
  - Cardiac: echo, EKG, and/or cardiac cath as appropriate for recipient's clinical status
  - Pulmonary: PFTs if recipient has cardiac or pulmonary issues, or a history of smoking
  - CXR for all transplant candidates
- Other diagnostic tests may be requested as appropriate.

### Solid Organ Transplant Packets

- Letter of medical necessity **signed by attending transplant physician** requesting transplant, summarizing clinical history, social history and transplant evaluation
- All recent lab results (refer to organ-specific policy criteria for a list of applicable lab tests); all lab results must be within three months of packet submission date, other than positive serologies
- All recent diagnostic and procedure results (not more than six months old)
- Complete psychological and social evaluation to include:
  - recipient's medical compliance,
  - support network,

- post-transplant care plan, with identification of primary and secondary care provider,
- history of mental health issues/substance abuse/legal issues

Recipients with a psychiatric history are required to have an evaluation by a psychiatrist with expertise in evaluating the specific psychiatric issues that relate to transplant candidates.

Recipients with a history of ETOH/substance abuse must fulfill the following criteria:

1. Actively using ETOH/substance within the past year
  - a. Must have six months of counseling (at least twice per month)
  - b. Monthly toxicology/etoh screens, continuing these screens monthly until listed
  - c. Toxicology/etoh screens PRN
2. Clean/sober up to 2 years.
  - a. These recipients shall have a counseling consult and the counselor will decide if the recipient requires continued recidivism counseling. Medicaid will accept the counselor's recommendations.
  - b. These recipients shall have ONE toxicology/etoh screen during their evaluation
  - c. Toxicology/etoh screens PRN
3. Clean/sober for greater than 2 years
  - a. No counseling is necessary
  - b. One toxicology/etoh screen during evaluation
  - c. Toxicology/etoh screens PRN.

Other organ-specific policy criteria (<http://www.ncdhhs.gov/dma/mp/>; see the clinical coverage policies in group 11B). Additional clinical or other documentation may be requested.

## Stem Cell Transplant Packets

Letter of medical necessity **signed by attending transplant physician** requesting transplant, summarizing clinical history to include previous chemotherapy regimens and dates, social history and transplant evaluation. All recent lab results (refer to disease-specific policy criteria for a list of applicable lab tests).

**Note:** All lab results must be within the past three months

All diagnostic and procedure results, including bone marrow aspiration (not more than six months old).

Complete psychological and social evaluation to include:

- recipient's medical compliance,
- support network,
- post-transplant care plan, with identification of primary and secondary care provider,
- history of mental health issues/substance abuse/legal issues

Recipients with a psychiatric history are required to have an evaluation by a psychiatrist with expertise in evaluating the specific psychiatric issues that relate to transplant candidates.

Recipients with a history of ETOH/substance abuse must fulfill the following criteria:

1. Actively using ETOH/substance within the past year
  - d. Must have six months of counseling (at least twice per month)
  - e. Monthly toxicology/etoh screens, continuing these screens monthly until listed
  - f. Toxicology/etoh screens PRN
2. Clean/sober up to 2 years.
  - g. These recipients shall have a counseling consult and the counselor will decide if the recipient requires continued recidivism counseling. Medicaid will accept the counselor's recommendations.
  - h. These recipients shall have ONE toxicology/etoh screen during their evaluation

- i. Toxicology/etoh screens PRN
- 3. Clean/sober for greater than 2 years
  - j. No counseling is necessary
  - k. One toxicology/etoh screen during evaluation
  - l. Toxicology/etoh screens PRN.

Other disease-specific policy criteria (<http://www.ncdhhs.gov/dma/mp/>); see the clinical coverage policies in group 11A). Additional clinical or other documentation may be requested.

### Quick Reference Table – Prior Approval for Certain Medicaid Services

More detailed information about most entries in this table is printed in the front of this section.

Service	Verbal Authorization	Written Authorization
Auditory Implant External Parts and Accessories (Auditory Brainstem, Bone Anchored Hearing Aid, and Cochlear)	No verbal authorization.	Fax all requests for external parts replacement and repair, in letter format, to the appropriate implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech or sound processors and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the implant manufacturer.
CAP/MR-DD	Call the local management entity in the recipient’s county of residency for assistance in the assessment and referral process	A completed MR2 signed by an LME representative and a physician or licensed clinical psychologist must be submitted to the Specialized Services Department at the Murdoch Center by the local management entity. Refer to the CAP/MR-DD manual at <a href="http://www.ncdhhs.gov/mhddsas/cap-mrdd/">http://www.ncdhhs.gov/mhddsas/cap-mrdd/</a>
DME, O&P, Oral Nutrition Products for Recipients under 21 Years of Age, Pediatric Mobility Devices, and Augmentative and Alternative Communication Devices	No verbal authorization.	Complete a CMN/PA Form [372-131 (8/02)] and submit to HP Enterprise Services.

Service	Verbal Authorization	Written Authorization
EPSDT: Covered State Medicaid Plan Services for Recipients Under 21 Years of Age	No verbal authorization.	<b>If services to be provided do not require PA but hard limits on the service need to be exceeded, submit documentation as specified above to the appropriate utilization review vendor before exceeding the service limits.</b>
EPSDT: Non-covered State Medicaid Plan Services for Recipients Under 21 Years of Age	No verbal authorization.  <b>Important Note:</b> This procedure is only for requesting services under EPSDT <b>(for recipients less than 21 years of age)</b> that are <b>never</b> otherwise covered under the N.C. Medicaid State Plan. To request covered services for recipients under 21 years of age in excess of numerical limits or other specific criteria in clinical coverage policies, see EPSDT for Covered State Medicaid Plan Services for State Medicaid Plan Services immediately above.	Submit a completed Non-Covered State Medicaid Services Request to DMA for non-covered state Medicaid plan services as specified on the form <b>before</b> providing the service, product, or procedure. For behavioral health services, the form must be submitted to the applicable UR vendor (Eastpointe LME, The Durham Center or ValueOptions) in the recipient's catchment area.  The form must be completed by the recipient's physician or other licensed clinician. The request must show that <b>ALL</b> EPSDT criteria are met. The reviewer will determine if the request is a coverable service. If additional information is required, the reviewer will request it.
Hearing Aids and Accessories	No verbal authorization.	Complete a general Request for Prior Approval Form (372-118) and submit to HP Enterprise Services.
Hospice	Call HP Enterprise Services (1-800-688-6696 or 919-851-8888) to report hospice benefit election.	Hospice election must be reported within 6 calendar days of the start of hospice services. PA for hospice reporting cannot be granted retroactively beyond the 6-day timeframe.

Service	Verbal Authorization	Written Authorization
Intermediate Care Facility for Persons with Mental Retardation	No verbal authorization.	For approval of this level of care, fax a completed MR2 signed by a physician, the local management entity and a qualified developmental disabilities professional, to the Murdoch Center at 919-575-1083, along with a current psychological evaluation, for approval of this level of care. If approved, Murdoch will secure a prior authorization number from HP Enterprise Services and transmit the PA number to the requester for transmittal to the department of social services and the facility where the recipient will reside.
Long-Term Care (FL2)	Call HP Enterprise Services (1-800-688-6696 or 919-851-8888) to receive tentative verbal approval.	The completed FL2 (hard copy original FL2 or electronic FL2e through Provider Link) must be received by HP Enterprise Services within 10 business days of the telephone call. Providers are encouraged to use FL2e.
Medicaid for Pregnant Women	No verbal authorization.	Complete a general Request for Prior Approval Form (372-118) and/or appropriate referral form for the following services: <ul style="list-style-type: none"> <li>• Visual aids and eye exams</li> <li>• Podiatric services</li> <li>• Dental</li> <li>• DME</li> <li>• Home health</li> <li>• Hospice</li> <li>• In-Home Care Services</li> <li>• Private duty nursing (PDN)</li> <li>• Home infusion therapy</li> <li>• Chiropractic services</li> </ul>
Optical Services – Routine Eye Examinations with Refractions	PA not required. Call the AVR system (1-800-723-4337; alternate 1-800-688-6696) for the last date of service and a confirmation number.	Complete a general Request for Prior Approval Form (372-118) for medically necessary exceptions to the time period limitations and submit to HP Enterprise Services.

Service	Verbal Authorization	Written Authorization
Optical Services – Visual Aids	No verbal authorization.	Complete Prior Approval Request for Visual Aids Form (372-017 or 372-017A) and submit to HP Enterprise Services. Include documentation of medical necessity for exceptions.
Out-of-State Non-Emergent Services	No verbal authorization; call HP Enterprise Services (1-800-688-6696 or 919-851-8888) for information and instructions for obtaining out-of-state approval. To obtain payment authorization, it will be necessary to submit the recipient’s face sheet and medical records (emergency department, 23 hour observation, and inpatient admitting history and physical, discharge summary. The provider may submit any other relevant information to support that the recipient met the definition of emergent services as defined by the Social Security Act, Section 1923(b)(2)(B)(i-iii) and (C)(i-iii).	Complete a general Request for Prior Approval Form (372-118) Add medical records and a letter from the attending physician requesting out-of-state services and stating why the services cannot be provided in North Carolina. Fax requests to 919-816-3139.
Out-of-State Emergent Services (emergency department, 23 hour observation, and inpatient admission)	No verbal authorization; call HP Enterprise Services (1-800-688-6696 or 919-851-8888) within <b>72 hours of start date of service provision</b> for information and instructions.  To obtain payment authorization, it will be necessary to submit the recipient’s face sheet and medical records (emergency department, 23 hour observation, and inpatient admitting history and physical, discharge summary. The provider may submit any other relevant information to support that the recipient met the definition of emergent services as defined by the Social Security Act, Section 1923(b)(2)(B)(i-iii) and (C)(i-iii).	

Service	Verbal Authorization	Written Authorization
Out-of-State and State-to-State Ambulance Services	No verbal authorization; call HP Enterprise Services (1-800-688-6696 or 919-851-8888) to receive information and instructions regarding obtaining out-of-state and state-to-state ambulance services approval <b>prior</b> to transport. <b>If transport needs are emergent, contact HP Enterprise Services 72 hours (three business days) following provision of service.</b>	Complete a general Request for Prior Approval Form (372-118) and an Out-of-State and State-to-State Ambulance Transportation Addendum Form (372-118A). Follow HP Enterprise Services instructions for when and how to submit the request.
Outpatient Specialized Therapies	No verbal authorization.	Submit requests through the Carolina Center for Medical Excellence (CCME) outpatient specialized therapies website at <a href="http://www.medicaidprograms.org/nc/therapyservices">http://www.medicaidprograms.org/nc/therapyservices</a>
<b>Over the Counter Medication Requests for Recipients under 21 Years of Age</b>	No verbal authorization.	Submit completed Non-Covered State Medicaid Plan Services Request to DMA as specified on the form before providing the service, product, or procedure. The form must be completed by the recipient's physician or other licensed clinician. The request must show that ALL EPSDT criteria are met.
Prescription Drugs	Call ACS (1-866-246-8505) for information and instructions.	Fax completed Pharmacy PA Forms to ACS (1-866-246-8507).
Private Duty Nursing (PDN)	Call DMA (919-855-4380) for PDN consultation. Upon review of faxed information, the PDN consultant will provide verbal authorization as indicated.	Complete and fax a PDN Referral Form and a Physician's Request Form (both online at <a href="http://www.ncdhhs.gov/dma/provider/forms.htm">http://www.ncdhhs.gov/dma/provider/forms.htm</a> ) documenting medical necessity to DMA (919-715-2859).

Service	Verbal Authorization	Written Authorization
Psychiatric Services, Inpatient (PRTF, Residential Child Care, Criterion 5, Out-of-State and Residential Services)	Contact the appropriate UR vendor for information and instructions: <ul style="list-style-type: none"> <li>• The Durham Center (Durham County): 919-560-7100</li> <li>• Eastpointe LME (Duplin, Lenoir, Sampson, and Wayne counties): 800-513-4002</li> <li>• ValueOptions (all other counties): 1-888-510-1150</li> </ul>	Submit documentation in accordance with behavioral health clinical coverage policies online at <a href="http://www.ncdhhs.gov/dma/mp/">http://www.ncdhhs.gov/dma/mp/</a>
Psychiatric Services, Outpatient (Enhanced Benefit Services, Developmental Disability)	Contact the appropriate UR vendor for information and instructions: <ul style="list-style-type: none"> <li>• The Durham Center (Durham County): 919-560-7100</li> <li>• Eastpointe LME (Duplin, Lenoir, Sampson, and Wayne counties): 800-513-4002</li> <li>• ValueOptions (all other counties): 1-888-510-1150</li> </ul>	Submit documentation in accordance with behavioral health clinical coverage policies online at <a href="http://www.ncdhhs.gov/dma/mp/">http://www.ncdhhs.gov/dma/mp/</a>
Radiology - Outpatient (Non-Emergency) Diagnostic Imaging Procedures	Requests may be made to MedSolutions by phone at 888-693-3211 during normal business hours 7:00 a.m. to 8:00 p.m. Central Time.	Submit requests by fax to 1-888-693-3210 or through MedSolutions secure website at <a href="http://www.medsolutionsonline.com">http://www.medsolutionsonline.com</a> (24 hour access 7-days a week).
Surgical Procedures	No verbal authorization; call the AVR system (1-800-723-4337) to verify if a surgical procedure requires PA.	Complete a general Request for Prior Approval Form (372-118) and submit to HP Enterprise Services. Include documentation supporting medical necessity as specified in individual coverage policies.
Therapeutic Leave for Nursing Facilities	Approval for therapeutic leave in excess of 15 consecutive days is required. Call HP Enterprise Services (1-800-688-6696 or 919-851-8888) to receive tentative approval.	Complete a general Request for Prior Approval Form (372-118) and submit to HP Enterprise Services; include supporting documentation. Therapeutic leave must be a part of the resident's plan of care, ordered by his/her attending physician, with therapeutic justification for each instance of such leave entered into the resident's medical record.

Service	Verbal Authorization	Written Authorization
Therapeutic Leave for ICF/MRs	Verbal approval for therapeutic leave in excess of 15 consecutive days is required. Call HP Enterprise Services (1-800-688-6696 or 919-851-8888) to receive approval.	Written authorization is not required. However, therapeutic leave must be a part of the resident's plan of care, ordered by his/her attending physician, with therapeutic justification for each instance of such leave entered into the resident's medical record.
Therapeutic Leave for Residential Child Care Facilities and PRTFs	Not required.	Authorization is not required. However, therapeutic leave is limited to no more than 15 days per calendar quarter and must be documented in the resident's plan of care and therapeutic justification for each instance of such leave entered into the resident's medical record.
Tocolytic Infusion Therapy	No verbal authorization.	Complete a Tocolytic Prior Approval Request Form ( <a href="http://www.ncdhhs.gov/dma/provider/forms.htm">http://www.ncdhhs.gov/dma/provider/forms.htm</a> ) and fax to DMA (919-715-9025). Include applicable supporting documents.
Transplants	No verbal authorization.	Fax completed packets/requests to the DMA transplant nurse consultant (919-715-0051).

## Denial of Prior Approval

A decision on a request for PA will be acted on with reasonable promptness (usually within 15 business days of receipt of the request unless there is a more stringent requirement). The recipient/legal guardian will be notified of the decision in writing by trackable mail. The notice states the effective date of the action, adverse action taken, reason for the adverse action, citation to support the action, and an explanation of appeal rights. Notices shall be mailed to the most recent known address of the recipient or, in the case of a minor or incompetent recipient, to the parent/legal guardian. Providers will be sent a copy of the notice only via first class mail.

The recipient's mailing will contain the notice and a pre-populated recipient appeal request form. This pre-populated form allows the Office of Administrative Hearings and Medicaid to affiliate the correct appeal form to the correct recipient, and this is vital as some recipients may have filed more than one appeal. Therefore, recipients and providers are asked to use **only the pre-populated form**.

Medicaid mails notices to the last known address filed by the recipient or his/her legal guardian with the county Department of Social Services, which is the address maintained in the state's Eligibility Information System. It is the responsibility of the recipient and/or his/her legal guardian to update this address. For recipients under 21 years of age or for recipients who have been adjudicated incompetent, notices are mailed to the provider and the parent or guardian listed in the North Carolina Eligibility Information System/NC FAST/SSI database. If any recipient or parent/guardian notifies Medicaid that the recipient's

notice was not received, a duplicate notice will be issued. **Please note that duplicate copies of notices for adults or children may be obtained by contacting Medicaid at 919-855-4350.**

Any person who believes he or she did not receive notice of a decision on a request for prior approval should contact the DHHS Customer Service Center at 1-800-662-7030 (English/Spanish) or 1-877-452-2514. (**Note:** This is a TTY number that is only answered for deaf or hearing impaired callers). In the Triangle area, call 919-855-4400 (English/Spanish) or 919-733-4851 (TTY for hearing impaired). The DHHS Customer Service Center is open from 8:00 a.m. until 5:00 p.m., Monday through Friday.

### Recipient Hearing Process

Medicaid is an entitlement program, and it is a recipient's constitutional right to appeal a Medicaid decision that denies, reduces, terminates, or suspends a request for Medicaid services. Specifically, Medicaid recipients or their personal representatives have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.* and N.C.G.S. §108A-70.9. If the recipient decides to appeal Medicaid's decision to deny, terminate, reduce, or suspend the services requested by his/her provider, the recipient must sign and date the appeal request form and send it to the Office of Administrative Hearings (OAH) by mail or fax within **30 days of the date the notice was mailed**. The mailing address, telephone, and fax numbers for OAH are located on the appeal request form. Providers may not file appeals on behalf of recipients unless the recipient lists the provider as the representative on the appeal request form.

### Understanding the Appeal Process

If the recipient chooses to appeal, he/she may represent himself/herself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for them. The recipient's case will begin as soon as the completed recipient hearing request form is **received and filed** with the OAH. The recipient will be contacted by OAH or the Mediation Network of North Carolina to discuss his/her case and to be offered an opportunity for mediation in an effort to resolve the appeal. Contact is made by telephone or **certified mail**. So, it is important to accept all **certified mail** from OAH or the mediation center.

**Note: New information about the recipient's request that was not provided to Medicaid previously may be submitted at any time during the mediation and appeal processes.**

Mediation is an informal process where the recipient, his/her representatives, and Medicaid have an opportunity to discuss the case with a mediator in hopes that the hearing issues will be resolved. If mediation resolves the case, the hearing will be dismissed, and services will be provided as specified during the mediation process. The recipient and his/her representatives may participate by telephone or in-person. **Mediation is confidential and legally binding** even if the recipient or his/her representatives are dissatisfied with the result. Best practice is always to include the recipient or the recipient's parent/ legal guardian in the mediation and hearing processes.

If the recipient does not accept the offer of mediation or the results of mediation, the case will proceed to hearing and will be heard by an administrative law judge with OAH. The recipient will be notified by **certified** mail of the date, time, and location of the hearing. The administrative law judge will make a decision and will send it to Medicaid for a final agency decision. The recipient will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision by **certified** mail. The recipient and provider should not act on the administrative law judge's decision because Medicaid must review the decision and issue the final agency decision. If the recipient does not agree with Medicaid's final agency decision, he/she may ask for a judicial review in superior court. The hearing process must be completed within 90 days of OAH's receipt of the recipient's completed Recipient Hearing Request Form.

For more information about the hearing process, please visit the Your Rights web page at <http://www.ncdhhs.gov/dma/medicaid/rights.htm>.

## Implementing the Final Agency Decision

Decisions that Uphold the Agency Action – A final agency decision which dismisses the recipient’s appeal or upholds the Medicaid agency action shall be implemented no later than three business days from the date the decision was mailed to the petitioner(s) identified by OAH at the time the appeal was filed.

Decisions that Reverse in Part or in Full the Agency Action – If the Medicaid agency decision or a mediated settlement holds that all or part of the requested services were medically necessary, payment for those services as approved in the final agency decision or settlement will be authorized within three business days for at least 20 prospective calendar days after the date of the decision. A copy of the final agency decision will be mailed by **certified mail** to the petitioner(s) identified by OAH at the time the appeal was filed. The final agency decision shall include a notification that a new request for prior authorization is required to be received by Medicaid within 15 calendar days of the decision in order to avoid an interruption in services. Upon receipt by Medicaid of a request for service authorization within 15 calendar days from the date of a final agency decision which holds that all or part of the requested services were medically necessary, authorization for payment will remain in effect without interruption for at least 10 calendar days following the mailing of the notice of decision on the new request for prior authorization. If the request is denied or reduced, it will be treated as a timely request for reauthorization and maintenance of services pending appeal will apply. Final agency decisions will notify the recipient of the importance of immediately informing the provider of the decision.

## Providing Services During the Appeal Process (Maintenance of Services)

Maintenance of services means that for a **reauthorization or continuing or concurrent request** that was denied, reduced, or terminated, the recipient is entitled to receive services during the pendency of the appeal **and** as long as he/she remains otherwise Medicaid eligible as described below, unless the recipient gives up this right.

1. If the recipient appeals within **10 days of the date the notice was mailed**, payment authorization for services will continue without a break in service. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.
2. If the recipient appeals more than 10 calendar days but within 30 calendar days of the date the notice is mailed, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the OAH. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.

Maintenance of services (authorization of payment during the pendency of the appeal) will **not** be authorized if:

1. The recipient appeals more than 30 days after the date the notice was mailed.
2. The recipient’s service request was submitted after his/her current authorization for services expired. Medicaid will treat this request as an initial rather than a reauthorization or continuing or concurrent request. Maintenance of services does not apply to an initial request.

**Changing Providers**

Medicaid recipients have the right to change providers as indicated in the section entitled “Important Points about Prior Approval.

**Obtaining Legal Assistance**

For questions regarding legal assistance, recipients or their authorized representatives may contact Legal Aid of North Carolina at 919-856-2564 or toll-free at 1-866-369-6923. Recipients with disabilities may contact Disability Rights of North Carolina at 1-877-235-4210.

**Questions About the Medicaid Prior Approval and Medicaid Recipient Hearing Processes**

For questions concerning the decision Medicaid makes about the provider’s request for service, please contact Medicaid. Questions about the appeal process may be addressed to OAH or the Appeals Unit, Division of Medical Assistance (Medicaid). Agency contact information appears below.

Agency	Mailing Address	Office Number
Office of Administrative Hearings (OAH)	Clerk 6714 Mail Service Center Raleigh, NC 27699-6714	919-431-3000
Division of Medical Assistance (Medicaid)	Appeals Unit Clinical Policy and Programs 2501 Mail Service Center Raleigh, NC 27699-2501	919-855-4350 Toll-free: 1-800-662-7030 Ask for your call to be transferred to the DMA Appeals/EPSTD Section, Clinical Policy and Programs.

**Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]**

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT (**Note:** EPSDT offers periodic screening services for recipients under age 21 and Medicaid covered services necessary to correct or ameliorate a diagnosed physical or mental condition)
- Family planning services and supplies

- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case management services

- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at [http://www.access.gpo.gov/nara/cfr/waisidx\\_06/42cfr440\\_06.html](http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html).

## Non-Covered State Medicaid Plan Services Request Form for Recipients *under 21 Years Old*

This form is available on DMA's Web site at:  
<http://www.ncdhhs.gov/dma/provider/forms.htm>.

Definitions of the federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at:  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_06/42cfr440\\_06.html](http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html)

Mail the completed, signed form to the Assistant Director of Clinical Policy and Programs, Division of Medical Assistance, 2501 Mail Service Center, Raleigh, N.C. 27699-2501 or fax it to (919) 715-7679. You may use additional sheets to supply any other information you think would be helpful. **Include evidence-based literature, if available.**

**I. Recipient Information.** This must be completed by a physician, licensed clinician, or other provider.

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) Medicaid Number \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**II. Medical Necessity.** All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name _____	Provider Name _____
Medicaid Provider # _____	Medicaid Provider # _____
Address _____	Address _____

Telephone _____	Telephone _____
Fax _____	Fax _____

Requested procedure, product or service: \_\_\_\_\_ CPT/HCPCS code: \_\_\_\_\_/\_\_\_\_\_

In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is the recipient's health history? (Include chronic illness.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name \_\_\_\_\_ MID \_\_\_\_\_ DOB \_\_\_\_\_

What treatment has been given for the diagnosis(es) above? [Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).] \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition [the problem]. This description *must* include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this request for an experimental or investigational treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, provide name and protocol # \_\_\_\_\_

\_\_\_\_\_

Is the requested product, service, or procedure considered to be safe? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, please explain. \_\_\_\_\_

\_\_\_\_\_

Is the requested product, service or procedure effective? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, please explain. \_\_\_\_\_

\_\_\_\_\_

Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is the expected duration of treatment? \_\_\_\_\_

\_\_\_\_\_

Requestor's Signature & Credentials \_\_\_\_\_ Date \_\_\_\_\_