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Section 8 - Prior Authorization**SECTION 8-PRIOR AUTHORIZATION****8.1 BASIS**

Under the MO HealthNet Program, certain covered services and equipment require approval from the Department of Social Services, MO HealthNet Division, prior to provision of the service as a condition of reimbursement. Prior authorization is used to promote the most effective and appropriate use of available services and to determine the medical necessity of the service.

Please refer to Sections 13 and 14 for program-specific information regarding prior authorization.

8.2 PRIOR AUTHORIZATION GUIDELINES

Providers are required to seek prior authorization for certain specified services *before* delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization. Certain services require prior authorization only when provided in a specific place or when they exceed certain limits. These limitations are explained in detail in Sections 13 and 14 of the applicable provider manuals.

The following general guidelines pertain to all prior authorized services:

- A Prior Authorization (PA) Request *must* be completed and mailed to the appropriate address. Unless otherwise specified in Sections 13 and 14 of the manual, mail requests to:

Infocrossing Healthcare Services
P.O. Box 5700
Jefferson City, MO 65102

A PA Request form can be printed and completed by hand or the form can be completed in Adobe and then printed. To enter information into a field, either click in the field or tab to the field and complete the information. When all the fields are finished, print the PA Request and send to the address listed above.

- The provider performing the service *must* submit the Prior Authorization Request form. Sufficient documentation or information *must* be included with the request to determine the medical necessity of the service.
- The service *must* be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.



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- Do *not* request prior authorization for services to be provided to an ineligible person. (see Sections 1 and 13).
- Expanded HCY (EPSDT) services are limited to participants 20 years of age and under and are *not* reimbursed for participants 21 and over even if prior authorized.
- See Section 20 for specific criteria and guidelines regarding prior authorization of non-covered services through the Exceptions Process for participants 21 and over.
- Prior authorization does *not* guarantee payment if the participant is or becomes enrolled in managed care and the service is a covered benefit.
- Payment is *not* made for services initiated before the approval date on the Prior Authorization Request form or after the authorization deadline.
- For services to continue after the expiration date of an existing Prior Authorization Request, a new Prior Authorization Request *must* be completed and mailed.

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

Complete the Prior Authorization Request form describing in detail those services or items requiring prior authorization and the reason the services or items are needed. With the exception of x-rays, dental molds, and photos, documentation submitted with the Prior Authorization Request is *not* returned. Providers should retain a copy of the original Prior Authorization Request and any supporting documentation submitted for processing. Instructions for completing the Prior Authorization Request form are on the back of the form. *Unless otherwise stated in Section 13 or 14 of the provider manual*, mail the Prior Authorization Request form and any required attachments to:

Infocrossing Healthcare Services
P.O. Box 5700
Jefferson City, Missouri 65102

The appropriate program consultant reviews the request. A MO HealthNet Authorization Determination is returned to the provider with any stipulations for approval or reason for denial. If approved, services may *not* exceed the frequency, duration or scope approved by the consultant. If the service or item requested is to be manually priced, the consultant enters the allowed amount on the MO HealthNet Authorization Determination. The provider should keep the approved MO HealthNet Authorization Determination for their files; do *not* return it with the claim.

After the authorized service or item is provided, the claim form *must* be completed and submitted in the usual manner. **Providers are cautioned that an approved authorization approves only the medical necessity of the service and does *not* guarantee payment. Claim information *must* still be complete and correct, and the provider and the participant *must* both be eligible at the time the service is rendered or item delivered. Program restrictions such as age, category of**



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assistance, managed care, etc., that limit or restrict eligibility still apply and services provided to ineligible participants are *not* reimbursed.

If the request for authorization of services is denied, the provider receives a MO HealthNet Authorization Determination (Reference Section 8.7). The participant is notified by letter each time a request for prior authorization is denied. (Reference Section 1 for a sample Prior Authorization Request Denial.)

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

- Medicare crossovers when Medicare makes the primary reimbursement and MO HealthNet pays only the coinsurance and deductible.
- Procedures requiring prior authorization that are performed incidental to a major procedure.
- Services performed as an emergency. Emergency services are services required when there is a sudden or unforeseen situation or occurrence, or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
 1. Placing the patient's health in serious jeopardy; or
 2. Serious impairment to bodily functions; or
 3. Serious dysfunction of any bodily organ or part.

In the case of an emergency when prior authorization *cannot* be obtained before the service or item is rendered, the necessary and appropriate emergency service should be provided. Complete the claim form and write "emergency" across the top of the claim form. Do *not* submit a Prior Authorization Request form.

Attach a Certificate of Medical Necessity form to the claim and submit it to the appropriate address (reference Section 15). The provider *must* state on the Certificate of Medical Necessity form, in detail, the reason for the emergency provision of service. (See Section 7 for information on completing a Certificate of Medical Necessity form.)

Emergency requests are suspended and reviewed by the appropriate medical consultant. If the Certificate of Medical Necessity form is *not* attached or the reason does *not* substantiate the provision of the service on an emergency basis, the claim is denied.

- The participant was *not* eligible for MO HealthNet at the time of service, but eligibility was made retroactive to that time. Submit a claim along with a Certificate of Medical Necessity form to the appropriate address (reference Section 15). The provider *must* state on the Certificate of Medical Necessity form that the participant was *not* eligible on the date of



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service, but has become eligible retroactively to that date. The provider *must* also include, in detail, the reason for the provision of service. (See Section 7 for information on completing a Certificate of Medical Necessity form.) Retroactive eligibility requests are suspended and reviewed by the appropriate medical consultant. If the Certificate of Medical Necessity form is *not* attached or the reason does *not* substantiate the provision of the service, the claim is denied.

8.5 INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION REQUEST FORM

Instructions for completing the Prior Authorization (PA) Request form are printed on the back of the form. Additional clarification is as follows:

- Section II, HCY Service Request, is applicable for participants 20 years of age and under and should be completed when the information is known.
- In Section III, Service Information, the gray area is for State Use only.

Also, the PA Request forms *must* reflect the appropriate service modifier with procedure code and other applicable modifiers when requesting prior authorization for the services defined below:

Service Modifier	Definition
26	Professional Component
54	Surgical Care Only
55	Postoperative Management Only
80	Assistant Surgeon
AA	Anesthesia Service Performed Personally by Anesthesiologist
NU	New Equipment (required for DME service)
QK	Medical Direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals
QX	CRNA (AA) Service; with Medical Direction by a Physician
QZ	CRNA Service; without Medical Direction by a Physician
RP	Replacement and Repair (required for DME service)
RR	Rental (required for DME service)
SG	Ambulatory Surgical Center (ASC) Facility Services
TC	Technical Component

- Section V, Prescribing/Performing Practitioner, *must* be completed for services which require a prescription such as durable medical equipment, physical therapy, or for services



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which are prescribed by a physician/practitioner that require prior authorization. Check the provider manual for additional instructions.

The provider receives a MO HealthNet Authorization Determination (Refer to Section 8.7) indicating if the request has been approved or denied. Any comments made by the MO HealthNet/Mc+ consultant may be found in the comments section of the MO HealthNet Authorization Determination. The provider does *not* receive the Prior Authorization Request or a copy of the Prior Authorization Request form back.

It is the provider's responsibility to request prior authorization or reauthorization, and to notify the MO HealthNet Division of any changes in an existing period of authorization.

8.6 PRIOR AUTHORIZATION (PA) REQUEST

Providers are encouraged to follow the steps outlined on the back of the form to assure proper completion of an initial submission for prior authorization.

- Complete Section I.
- Complete Section II if the participant is under the age of 21 and the services requested are expanded Healthy Children and Youth services.
- Complete Section III.

Field #24 in Section III, in addition to being used to document medical necessity, can also be used to identify unusual circumstances or to provide detailed explanations when necessary. Additional pages may be attached to the Prior Authorization Request for documentation.

- Place a provider label in Section IV or complete each field in that section. See Sections 13 and 14 of the provider manual to determine if a signature and date are required in this field. Requirements for signature are program specific.
- Section V is only required for certain programs. Refer to the program requirements in Sections 13 and 14 of the provider manual.

8.6.A WHEN TO SUBMIT A PRIOR AUTHORIZATION (PA) REQUEST

Providers may submit a PA Request to:

- Initiate the start of services that require prior authorization.
- Request continued services when services continue to be medically necessary beyond the current approved period of time.



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1. The procedure for the services requested *cannot* overlap dates that are already approved and *must* be submitted far enough in advance to obtain approval prior to the expiration of the current approved PA Request.
- Correct a participant MO HealthNet number if the original PA Request had a number on it and services were approved.
 1. When requesting a PA Request due to an error in the participant MO HealthNet number on the original PA Request, attach a copy of the MO HealthNet Authorization Determination giving original approval to the new request.
 2. Fields #17 through #23 in Section III *must* be identical to the original approval.
 3. The PA Request form should be clearly marked as a “correction of the participant MO HealthNet number” and the error *must* be explained in detail in Field #24 of Section III.
 4. Mark the PA Request “*Special Handle*” at the top of the form.
- Change providers within a group during an approved authorization period.
 1. When requesting a PA Request due to a change of provider *within a group*, attach a copy of the MO HealthNet Authorization Determination showing the approval to the new PA Request form.
 2. Section III, Field #19 “FROM” *must* be the date the new provider begins services and field 20 “THROUGH” *cannot* exceed the through date of the previously approved PA Request.
 3. The PA Request form should be clearly marked at the top “change of provider,” and the change *must* be explained in Field #24 of Section III.
 4. Mark the PA Request “*Special Handle*” at the top of the form. Use Field #24 to provide a detailed explanation.

8.7 MO HEALTHNET AUTHORIZATION DETERMINATION

The MO HealthNet Authorization Determination is sent to the provider who submitted the Prior Authorization Request. The MO HealthNet Authorization Determination includes all data pertinent to the PA Request. The MO HealthNet Authorization Determination includes the PA number; the authorized provider number, name and address; the participant's DCN, name, and date of birth; the procedure code, the from and through dates (if approved), and the units or dollars (if approved); the status of the Prior Authorization Request on each detail line ("A"-approved; "C"-closed; "D"-denied; and "I"-incomplete); and the applicable Explanation of Benefit (EOB) reason(s), with the reason code description(s) on the reverse side of the determination.

Section 8 - Prior Authorization**8.7.A A DENIAL OF PRIOR AUTHORIZATION REQUESTS**

The MO HealthNet Authorization Determination indicates a denied authorization by reflecting a status on each detail line of "D" for a denial of the requested service or "I" for a denial due to incomplete information on the form. With either denial status, "D" or "I", a new Prior Authorization Request form *must* be submitted for the request to be reconsidered.

8.7.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

The following lists the fields found on the MO HealthNet Authorization Determination and an explanation of each field.

FIELD NAME	EXPLANATION OF FIELD
Date	Date of the disposition letter
Request Number (No.)	Prior Authorization Number
Receipt Date	Date the PA Request was received by the fiscal agent
Service Provider	Authorized provider number, name and address
Participant	Participant's DCN, name, date of birth and sex
Procedure Code	The procedure code
Modifier	The modifier(s)
Authorization Dates	The authorized from and thru dates
Units	The units requested, units authorized (if approved), units used
Dollars	The dollar amount requested, dollar amount authorized (if approved), dollar amount used
Status	The status codes of the PA Request The status codes are: A—Approved C—Closed D—Denied I—Incomplete
Reason	The applicable Explanation of Benefit (EOB) reason(s)
Comments	Comments by the consultant which may explain denials or



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	make notations referencing specific procedure code(s)
Physician/Provider Signature	Signature of provider when submitting a Request for Change (RFC)
Date	Date of provider's signature when submitting a RFC
Reason Code Description	Reason code description(s) listed in Reason field

8.8 REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST

To request a change to an approved PA Request, providers are required to make the applicable changes on the MO HealthNet Authorization Determination. Attach additional documentation per program requirement if the requested change is in frequency, amount, duration or scope or if it documents an error on the original request, e.g., plan of care, physician orders, etc. The amended MO HealthNet Authorization Determination *must* be signed and dated and submitted with applicable documentation to the address below. When changes to an approved PA Request are made on the MO HealthNet Authorization Determination, the MO HealthNet Authorization Determination is referred to as a Request For Change (RFC). **Requests for reconsideration of any detail lines that reflect a "D" or "I" status *must not* be included on an RFC. Providers *must* submit a new PA Request form for reconsideration of denied detail lines.**

When an RFC is approved, a MO HealthNet Authorization Determination incorporating the requested changes is sent to the provider. When an RFC is denied, the MO HealthNet Authorization Determination sent to the provider indicates the same information as the original MO HealthNet Authorization Determination that notified the provider of approval, with an EOB stating that the requested changes were considered but were *not* approved.

Providers *must not* submit changes to PA Requests until the MO HealthNet Authorization Determination from the initial request is received.

Unless otherwise stated in Section 13 or 14 of the provider manual, PA Request forms and RFCs should be mailed to:

Infocrossing Healthcare Services
P. O. Box 5700
Jefferson City, MO 65102

8.8.A WHEN TO SUBMIT A REQUEST FOR CHANGE (RFC)

Providers may submit a RFC to:

- Correct a procedure code.



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- Correct a modifier.
- Add a new service to an existing plan of care.
- Correct or change the “from” or “through” dates.
 1. The “from” date may *not* precede the approval date on the original request unless the provider can provide documentation that the original approval date was incorrect.
 2. The “through” date *cannot* be extended beyond the allowed amount of time for the specific program. In most instances extending the end date to the maximum number of days allowed requires additional information or documentation.
- Increase or decrease requested units or dollars.
 1. An increase in frequency and or duration in some programs require additional or revised information.
- Correct the provider number. The provider number can only be corrected if both of the following conditions are met:
 - The number on the original request is in error;
 - The provider was *not* reimbursed for any units on the initial Prior Authorization Request.
- Discontinue services for a participant.

8.9 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

PA Requests and RFCs for the Personal Care and Home Health Programs' services for children under the age of 21 *must* be submitted to DHSS, Bureau of Special Health Care Needs (BSHCN) for approval consideration. The BSHCN submits the request to Infocrossing Healthcare Services. The BSHCN staff continues to complete and submit PA Requests and RFCs for Private Duty Nursing and Physical Disabilities Waiver Programs' services.

PA Requests and RFCs for AIDS Waiver and Personal Care Programs' services for individuals with HIV/AIDS continue to be completed and submitted by the DHSS, Section of STD/HIV contract case management staff.

Personal Care and Aged and Disabled Waiver Programs' services continue to be authorized by DHSS, Division of Senior Services and Regulation staff through the Long Term Alternative Care Services (LTACS) system. The LTACS system has been upgraded to allow 12 detail lines of service information.

Please reference the provider manual for further information.



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8.10 OUT-OF-STATE, NON-EMERGENCY SERVICES

All non-emergency, MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out-of-state is defined as *not* within the physical boundaries of the State of Missouri nor within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

A Prior Authorization Request *form* is *not* required for out-of-state nonemergency services. To obtain prior authorization for out-of-state, nonemergency services, *a written request must* be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102

The request may be faxed to (573) 526-2471.

The written request *must* include:

1. A brief past medical history.
2. Services attempted in Missouri.
3. Where the services are being requested and who will provide them.
4. Why services can't be done in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

8.10.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/MO HealthNet crossover claims.
2. All Foster Care children living outside the State of Missouri. However, nonemergency services that routinely require prior authorization continue to require



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prior authorization by out-of-state providers even though the service was provided to a Foster Care child.

3. Emergency ambulance services
4. Independent laboratory services

END OF SECTION

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