

## 240.000 PRIOR AUTHORIZATION

### 241.000 Procedures for Obtaining Prior Authorization

4-1-07

There are certain medical, diagnostic and surgical procedures that are not covered without prior authorization, either because of federal requirements or because of the elective nature of a procedure. Arkansas Foundation for Medical Care, Inc.(AFMC), under contract with Arkansas Medicaid, makes prior authorization (PA) determinations for most Medicaid-covered surgical procedures that require PA, and for some lab procedures that require PA.

Please refer to Section 244.000 of this manual for a list of procedures requiring prior authorization.

Prior authorization determinations are made utilizing established medical or administrative criteria combined with the professional judgment of AFMC's physician advisors.

Written documentation is not required. However, the oral information given to AFMC when requesting prior authorization must be substantiated by medical record documentation and reports upon AFMC and/or State retrospective reviews.

It is the responsibility of the physician who will perform the procedure to initiate the prior authorization request. When requesting prior authorization, the physician or the physician's office nurse must contact AFMC. [View or print AFMC contact information.](#) The physician or the physician's office nurse must furnish the following specific information to AFMC: (All calls are tape recorded.)

- A. Patient Name and Address
- B. Recipient Medicaid Identification Number
- C. Physician Name and License Number
- D. Physician provider identification number
- E. Hospital Name
- F. Date of Service for Requested Procedure
- G. Card Issuance Date for Retroactive Eligibility Authorizations

When you call, please provide all patient identification information and medical information related to the necessity of the procedure you need authorized.

AFMC will give approval or denial of the request by phone with follow-up in writing. If approval is granted, AFMC will assign a prior authorization control number that must be entered in the appropriate field of the claim when billing for the procedure. If surgery is involved, a copy of the authorization will be mailed to the hospital where the service will be performed. If the hospital has not received a copy of the authorization before the time of admission, the hospital will contact the admitting physician or AFMC to verify that prior authorization has been granted.

It is the responsibility of the primary surgeon to distribute a copy of the authorization to the assistant surgeon if the assistant has been requested and approved.

Prior authorization of service does not guarantee eligibility for a beneficiary. Coverage is contingent on the beneficiary's eligibility on the date(s) of service.

### 242.000 Post-authorization for Emergency Procedures and Periods of Retroactive Eligibility 10-13-03

Post-authorization will be granted only for emergency procedures and/or retroactively eligible recipients.

- A. Requests for emergency procedures must be applied for on the first working day after the procedure has been performed.

- B. In cases of retroactive eligibility, AFMC must be contacted for post-authorization within 60 days of the eligibility card issuance date.
- C. In cases involving a hysterectomy, documentation must be provided that reflects the acknowledgement statement was signed prior to surgery or the attending physician must certify in writing: (Use form DMS-2606. [View or print form DMS-2606.](#))
  - 1. That the individual was already sterile, stating the cause of sterility; or
  - 2. That the hysterectomy was performed under a life threatening emergency situation in which the physician determined prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

**FORM DMS-2606 MUST BE ATTACHED TO THE CLAIM FOR PAYMENT.**

The document must be reviewed and approved by the Medicaid Program before payment will be considered. It should be stressed that all guidelines must be met in order for payment to be made.

<b>242.010</b>	<b>Reserved</b>	<b>1-15-15</b>
<b>243.000</b>	<b>Post Procedural Authorization for Eligible Recipients Under Age 21</b>	<b>10-13-03</b>

Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain prior authorization if the recipient is under age 21.

All requests for post-procedural authorizations for eligible recipients are to be made to the Arkansas Foundation for Medical Care, Inc., (AFMC) by telephone within 60 days of the date of service. These calls will be tape-recorded. [View or print AFMC contact information.](#)

AFMC must be provided the recipient and provider identifying criteria and all of the medical data necessary to justify the procedures.

As medical information will be exchanged for this procedure, these calls must be made by the physician or a member of his or her nursing staff.

The provider will be issued a PA number at the time of the call if the procedure requested is approved. A follow-up letter will be mailed the same day to the physician.

Consulting physicians are responsible for calling AFMC to have procedures added to the PA file. They will be given the prior authorization number at the time of the call on cases that are approved. A letter verifying the PA number will be sent to the consultant upon request. When calling, all patient identification information and medical information related to the necessity of the procedure needing authorization must be provided.

The Arkansas Medicaid Program recommends providers obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

This policy applies only to those Medicaid recipients under age 21. This policy does not alter prior authorization procedures applicable to retroactive eligible recipients.

**244.000 Procedures that Require Prior Authorization**

1-15-15

The procedures represented by the CPT and HCPCS codes in the following table require prior authorization (PA). The performing physician or dentist (or the referring physician or dentist, when lab work is ordered or injections are given by non-physician staff) is responsible for obtaining required PA and forwarding the PA control number to appropriate hospital staff for documentation and billing purposes. A claim for any hospital services that involve a PA-required procedure must contain the assigned PA control number or Medicaid will deny it. (See Sections 241.000 through 244.000 of this manual for instructions for obtaining prior authorization.)

See Section 272.449 for billing instructions for Molecular Pathology codes

J7330	S2066	S2067	S2112	S3800	21199	37241	37242
37243	37244	81161	81200	81201	81202	81203	81205
81206	81207	81208	81209	81210	81211	81212	81213
81214	81215	81216	81217	81220	81221	81222	81223
81224	81225	81226	81227	81228	81229	81235	81240
81241	81242	81243	81244	81245	81250	81251	81252
81253	81254	81255	81256	81257	81260	81261	81262
81263	81264	81265	81266	81267	81268	81270	81275
81280	81281	81282	81290	81291	81292	81293	81294
81295	81296	81297	81298	81299	81300	81301	81302
81303	81304	81310	81315	81316	81317	81318	81319
81321	81322	81323	81324	81325	81326	81330	81331
81332	81340	81341	81342	81350	81355	81370	81371
81372	81373	81374	81375	81376	81377	81378	81379
81380	81381	81382	81383	81400	81401	81402	81403
81404	81405	81406	81407	81408	92607	92608	93980

**245.000 Prior Approval and Due Process Information**

3-15-05

- A. Organ transplants in Arkansas and in states that border Arkansas require prior approval from Arkansas Medicaid.
- B. In states that do not border Arkansas, organ transplants *and* organ transplant evaluations require prior approval from Arkansas Medicaid.

**245.010 Organ Transplant Prior Approval in Arkansas and Bordering States**

3-15-05

The attending physician is responsible for obtaining prior approval for organ transplants.

- A. The attending physician submits his or her transplant evaluation (workup) results to the Utilization Review (UR) Section, requesting approval of the transplant. [View or print the UR Section contact information.](#)
- B. UR forwards the request and its supporting documentation to Arkansas Foundation for Medical Care, Inc. (AFMC) for a determination of approval or denial.
- C. AFMC advises the requesting physician and the beneficiary of its decision.

**245.020 Organ Transplant and Evaluation Prior Approval in Non-Bordering States**

3-15-05

- A. In states that do not border Arkansas, prior approval is required for organ transplant evaluations and organ transplants.
- B. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and organ transplants.
  - 1. The attending physician must request from the UR Section prior approval of a transplant evaluation, identifying the facility at which the evaluation is to take place and the physician who will conduct the evaluation. [View or print the UR Section contact information.](#)
  - 2. UR reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
  - 3. The evaluation results must be forwarded to UR with a request for approval of the transplant procedure.
  - 4. UR forwards the request and the supporting documentation to AFMC for a determination of approval or denial.
  - 5. AFMC advises the requesting physician and the beneficiary of its decision.

**245.030 Hyperbaric Oxygen Therapy (HBOT) Prior Authorization**

10-1-09

All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See Section 242.000. Prior authorization will be for a certain number of treatments. Further treatments will require reapplication for a prior authorization. **In order to request a prior authorization for HBOT, the provider must call the AFMC prior authorization number, (800) 426-2234.**

Refer to Sections 217.130, 242.000, 252.119, and 272.404 for additional information on HBOT.

**245.031 Prior Authorization of Hyaluronon (Sodium Hyaluronate) Injection**

1-15-15

Prior authorization is required for coverage of the Hyaluronon (sodium hyaluronate) injection. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for the following procedure codes:

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J7321	J7323	J7324	J7325
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A written request must be submitted to Division of Medical Services Utilization Review Section. [View or print the Division of Medical Services Utilization Review Section address.](#)

The request must include the patient's name, Medicaid ID number, physician's name, physician's provider identification number, patient's age, and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.