Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2022-11**
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TO: **Independent Therapy Providers, Rehabilitation Clinics, Chiropractors, Home Health Agencies, Physicians, Physician Assistants (PAs), Advanced Practice Registered Nurses (APRNs), Medical Equipment, Device, and Supplies (MEDS) Providers, Laboratory Providers, General Hospitals**

RE: **Submission of Prior Authorization (PA) Requests for Medical Goods and Services**

In an effort to streamline the process for prior authorization (PA) reviews and reduce the administrative burden placed on providers, this bulletin serves as a reminder of the documentation requirements for submission of initial authorization and reauthorization requests for non-radiology medical goods and services.

Prior Authorization Requirements

All authorization requests require a completed PA request form, or a completed authorization request via the online medical authorization Web portal and must include the following critical elements:

- Billing Provider: Medicaid (CMAP) ID number, name, phone, and fax number
- Referring Provider: Name, address, National Provider Identifier (NPI), phone, and fax number
- Member: ID, name, date of birth, and address
- Diagnosis, service type, and procedure code(s)
- Date(s) of services
- Clinical information supporting medical necessity

Additional Documentation

Certain goods and services require the submission of additional documentation to support prior authorization requests. Failing to provide this information can lead to unnecessary delays. A brief outline of the documentation requirements for particular goods and services is provided below. More comprehensive documentation requirements can be found in the individual medical policies located on the HUSKY Health Web site. Click "Information for Providers," then "Policies, Procedures, & Guidelines" under the "Medical Management" menu item or click here: https://www.huskyhealthct.org/providers/policies_procedures.html.

Authorization-specific forms designed to facilitate the capture of all information necessary for prompt processing of your request are located on the HUSKY Health Web site. Click "Information for Providers", then "Prior Authorization Forms & Manuals" under the "Prior Authorization" menu item or click-here: https://www.huskyhealthct.org/providers/provider_manual.html#forms.

Urgent Requests

As a reminder, prior authorization requests should only be marked "Urgent" in situations where delaying treatment could lead to a serious deterioration of a member's health and could impose undue risk to a member's well-being or could delay discharge from an inpatient hospital. It is not appropriate to mark requests as "Urgent" due to the provider failing to send in the authorization request in a timely manner, or because the service is scheduled to start the following day.

Durable Medical Equipment

- Prescription, signed by a licensed physician, physician assistant (PA) or advanced practice registered nurse (APRN)
- Documented face-to-face encounter as appropriate based on Center for Medicare and Medicaid Services'

(CMS) list of specified Durable Medical Equipment (DME) covered items
- Detailed product description/quotation including:
  - Manufacturer
  - Model/part number
  - Product description
  - Healthcare Common Procedure Coding System (HCPCS) code(s)
  - Units
  - Pricing information
- Supporting clinical information that substantiates the medical necessity of the requested item(s)

Therapy Services

Initial Requests:
- Initial evaluation
- Treatment plan, including:
  - Assessment
  - Established short- and long-term goals
  - Treatment modalities
  - Rehabilitation potential and prognosis

Reauthorization Requests:
- Prescription signed by a physician OR therapy treatment plan signed by a physician
- Daily treatment notes (minimum of four most recent progress notes)
- Documentation of the home program or home strategies
- Most recent progress note that indicates progress towards identified goals
- Documentation of prognosis and potential to meet updated treatment goals

Chiropractic Services (Under 21 Years of Age)
- Prescription signed by a physician
- Physician office notes outlining condition, prior treatment results, and attesting to necessity of chiropractic intervention

Home Health Services

Initial Requests:
- Order signed by the licensed physician, physician assistant or APRN responsible for the plan of care
- Documented face-to-face encounter, including virtual (if available)
- Comprehensive start of care assessment that includes:
  - Clinical and psychosocial status
  - A plan of care that includes short- and long-term goals related to the educational needs of the member and primary caregiver

Reauthorization Requests:
- Recent order signed by the licensed physician, physician assistant or APRN responsible for the plan of care
- Comprehensive nursing assessment
- Two weeks of nursing narrative notes from previous certification period
- Updated comprehensive plan of care documenting progress towards established goals, and/or the need for updating treatment plan
- Member and/or primary caregiver's response to teaching

Custom Wheelchairs
- Completed wheeled mobility device letter of medical necessity form
- Documented face-to-face encounter, including virtual, as appropriate, based on CMS' list of specified DME covered items
- Prescription signed by either a licensed physician, physician assistant or APRN

- Medical evaluation by the primary care provider, completed within the past six months for persons living in the community, or ninety days for persons living in a Skilled Nursing Facility (SNF)
- Physiatrist assessment for complex rehabilitative technology (CRT) equipment for persons living in a SNF
- Detailed product description and quotation
- Current positioning program (replacement wheelchair for SNF resident)
- Completed accessibility survey

All required forms and instructions are located on the HUSKY Health Web site, www.ct.gov/husky, click "Information for Providers," then "Prior Authorization Forms & Manuals" under the "Prior Authorization" menu item.

Diapers and Incontinence Supplies

- Prior authorization required for children ages 3 to 12 years old
- Prescription must be dated and signed by the member's physician, containing:
  - HUSKY Health member name, address, and date of birth
  - Diagnosis for which the supplies are required
  - Detailed description of the items, quantities, and directions for use (when appropriate)
  - Length of need
- Supporting clinical information

Genetic Testing

- Refer to the DSS Lab Fee Schedule for a list of codes requiring prior authorization
- Click here for the Genetic Testing authorization request form: https://www.huskyhealthct.org/providers/provider_postings/provider_forms/Genetic_Testing_Prior_Authorization_Form.pdf
- Clinical policies outlining PA requirements are located on the HUSKY Health Web site, www.ct.gov/husky, click "Information for Providers," then "Policies, Procedures & Guidelines" under the "Medical Management" menu item.

Professional/Surgical Services

- All elective inpatient hospital admissions require prior authorization
- All outpatient surgical procedures as determined by the Physician Surgical Fee Schedule require prior authorization
- Clinical policies that outline required documentation for Reconstructive and Cosmetic Surgeries, including Varicose Vein procedures, are located on the HUSKY Health Web site, www.ct.gov/husky, click "Information for Providers," then "Policies, Procedures & Guidelines" under the "Medical Management" menu item.

Inpatient Hospital

All admissions to Inpatient Level of Care require authorization.

- The facility must notify the Administrative Services Organization (ASO) within two business days of inpatient emergency medical admissions that require authorization
- The facility must also notify the ASO within two business days of inpatient elective admissions that have been previously authorized
- The facility is responsible for determining client eligibility using the Automated Eligibility Verification System (AEVS) prior to requesting an inpatient medical admission authorization

- The facility is to submit the following information to process a request for Inpatient Medical Admission via the medical authorization portal or facsimile:
    - Hospitals must include a coversheet with submitting department/contact name, phone and fax number
    - Member Name, Member ID number, Member date of birth
    - Admission Date
    - Admission Type indicating Inpatient
    - Admitting Diagnosis
    - Admitting Provider Name
    - Hospital Name and Campus, if applicable
    - Hospital Unit
    - Medical Record Number
    - Primary Insurance Information
    - Medicare A benefit exhaustion must be clearly indicated
- The facility should not submit requests using Hospital Admission and Daily Census reports that include any individual not requiring an authorization for medical inpatient admission, as these will not be processed. Prior authorization for **medical** inpatient admission is not required for individuals who:
    - Are not eligible at the time of service (NOTE: When a client is granted retro eligibility, the provider has 90 days from the retro eligibility grant date to request a prior authorization. Please refer to PB 2016-24 for additional information.)
    - Have Medicare A as Primary insurance (unless exhausted benefit)
    - Are receiving the following services:
        - Ambulatory
        - Behavioral Health (excluding Medical Detox in an Intensive Care Unit)
        - Emergency Room
        - Maternity Admission with Delivery
        - Observation
        - Outpatient Medical or Surgical

Prior Authorization Submission Process

For questions regarding the prior authorization process, please contact Community Health Network of CT (CHNCT) at 1.800.440.5071, between the hours of 8:00 a.m. and 6:00 p.m.

Accessing the Fee Schedules

The updated fee schedules can be accessed and downloaded from the Connecticut Medical Assistance Program (CMAP) Web site at www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download", scroll to the bottom of the page and click on "I Accept", then select the applicable fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open".

For questions about billing or if further assistance is needed to access the fee schedules on the Connecticut Medical Assistance Program Web site, please contact the Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.