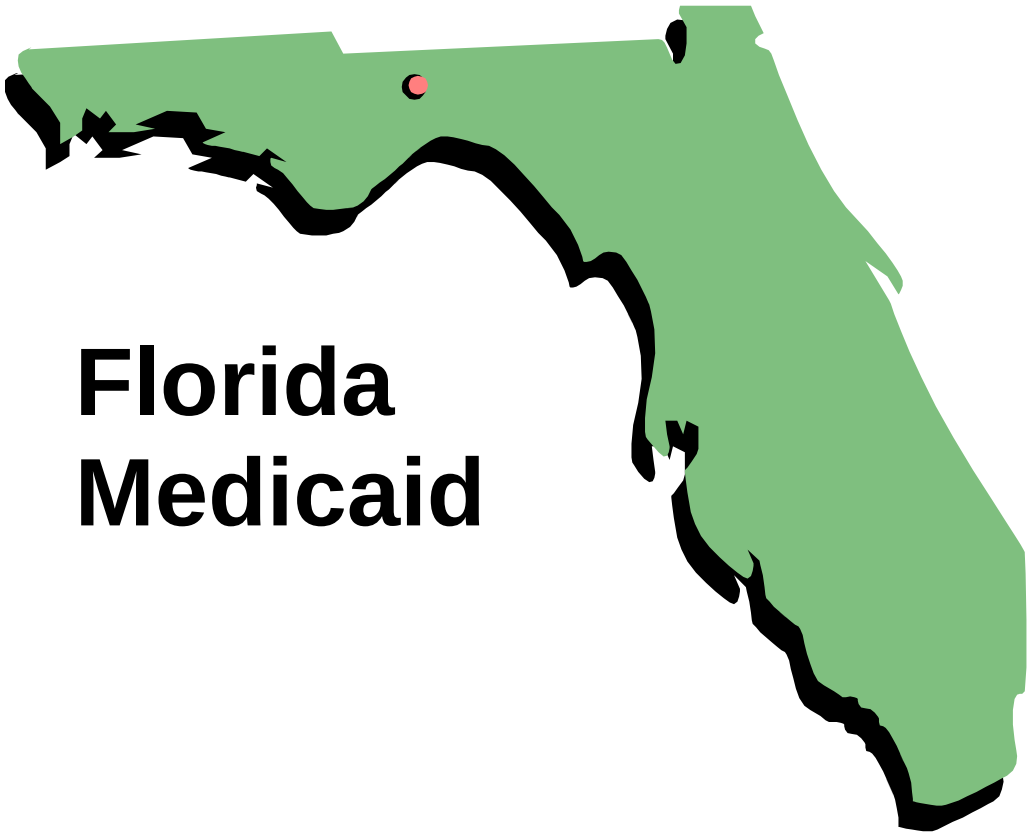

Florida Medicaid

Authorization Requirements Policy

Agency for Health Care Administration

June 2016

Table of Contents

1.0 Introduction 1
1.1 Description 1
1.2 Legal Authority 1
1.3 Definitions 1
2.0 Authorization Requirements 2
2.1 When to Request Authorization 2
2.2 Where to Obtain Authorization 2
2.3 Who Can Request Authorization 2
2.4 Submission Requirements 2
3.0 Determination Process 3
3.1 Review Criteria 3
3.2 Review Process 3
3.3 Notification 4
3.4 Final Arbiter 4
4.0 Appeals 4
4.1 Recipient Appeals 4
4.2 Reconsideration Requests 5

1.0 Introduction

1.1 Description

This policy contains general requirements for providers to obtain authorization to render Florida Medicaid services, when applicable.

1.1.1 Florida Medicaid Policies

This policy is intended for use by all providers that render services to eligible Florida Medicaid recipients through the fee-for-service delivery system, unless otherwise specified. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.1.2 Legal Authority

Florida Medicaid authorization requirements are authorized by the following:

- Sections 409.908, 409.912, 409.9127, and 409.913, Florida Statutes (F.S.)
- Rule 59G-1.053, F.A.C.

1.2 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

1.3.2 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

1.3.8 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid.

2.0 Authorization Requirements

2.1 When to Request Authorization

Providers must obtain authorization prior to rendering Florida Medicaid-covered services, except in an emergency, when:

- Specified in the service-specific coverage policy or the applicable Florida Medicaid fee schedule(s).
- Services will be performed out-of-state.

2.1.1 Other Necessary Health Care Services – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within a policy or the associated fee schedule may be approved, if medically necessary.

Providers must request authorization for proposed services for recipients under the age of 21 years that meet one or more of the following:

- The service is not listed in the service-specific coverage policy as a covered service
- The service is not listed in the applicable fee schedule(s)
- The amount, frequency, or duration of the service exceeds the coverage limits specified in the service-specific coverage policy or the applicable Florida Medicaid fee schedule(s)

2.2 Where to Obtain Authorization

AHCA contracts with private companies designated as QIOs for utilization review, quality assurance, and quality improvement of Florida Medicaid-covered services rendered by fee-for-service providers.

Providers must obtain authorization from the applicable QIO. Visit http://www.ahca.myflorida.com/Medicaid/Utilization_Review/index.shtml for more information on each QIO contracted with AHCA.

2.3 Who Can Request Authorization

Authorization requests must be submitted by the provider who plans to render the service, unless otherwise specified in the service-specific coverage policy.

2.4 Submission Requirements

Providers must submit authorization requests to the QIO's Web-based system or in paper format, as applicable, and include the following information at a minimum:

- Recipient information, including Florida Medicaid identification number
- Requesting provider information, including the provider's National Provider Identifier (NPI)
- Rendering provider information, including the provider's NPI (if different from the requesting provider)
- Ordering provider information, including the practitioner's NPI
- Procedure code(s) (with modifier(s) when applicable)
- Full description of the service(s) requested (including amount, duration, and frequency)
- Summary of the recipient's current health status, including diagnosis(es) pertinent to the recipient's need for the service being requested

- Service delivery address
- Unit(s) of service requested
- Dates of service
- A copy of the physician's order, if applicable
- A copy of the recipient's current plan of care (if applicable), signed by the physician
- Any additional submission requirements included in the service-specific coverage policy
- Any additional documentation requested by the QIO

2.4.1 Continued Authorization Requests

Providers must submit requests to continue a service past the authorized end date within the time frame specified by the QIO.

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

2.4.3 Modifications

Providers must submit a modification request to the QIO to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized.

Providers must submit additional information documenting the need for the change, including an updated physician's order and plan of care (as applicable) with the request.

2.4.4 Other Necessary Health Care Services – EPSDT Requests for Recipients Under the Age of 21 Years

Providers must submit a description of how the service will correct or ameliorate the recipient's condition with the request in addition to the submission requirements specified in this section (see section 2.1.1 for more information).

3.0 Determination Process

3.1 Review Criteria

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

3.2 Review Process

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

3.2.1 Continued Authorization Requests

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

3.2.2 Intensified Reviews

Authorization requests that differ in amount, frequency, or duration than the physician's order, or that deviate from treatment norms, established standards of care, or utilization norms, may be subject to a more intensified review by the QIO that may include:

- Telephonic or face-to-face contact with the recipient or his or her legal representative.
- Interviews with the ordering physician.
- Review of the recipient's medical record.

When the authorization request differs in amount, frequency, or duration than the physician's order, the QIO may approve up to the amount indicated on the physician's order, consistent with its own intensified review and when medically necessary.

3.3 Notification

The QIO will notify the requesting provider and recipient (or authorized representative) of the authorization request determination in writing. Providers may also check the QIO's Web-based system for the status of authorization requests.

3.3.1 Approvals

Approved authorization requests will contain (at a minimum) the following information:

- Ten-digit prior authorization number
- Authorized dates of service
- Authorized procedure code(s)
- Authorized units of service

3.3.2 Denials and Partial Denials

The QIO will notify the requesting provider and the recipient (or authorized representative) in writing of the denial or partial denial, including:

- The rationale for the decision
- How to request reconsideration for the request
- The recipient's right to appeal the decision

3.4 Final Arbiter

The Agency for Health Care Administration is the final arbiter of medical necessity for the purposes of determining Florida Medicaid reimbursement in accordance with section 409.913(1)(d), F.S.

4.0 Appeals

4.1 Recipient Appeals

Recipients, or their legal representatives, may appeal an authorization decision in accordance with 42 CFR 431.210, by contacting the Department of Children and Families, Office of Appeal Hearings at:

Office of Appeal Hearings
Department of Children and Families
1317 Winewood Blvd., Bldg. 5
Tallahassee, Florida 32399-0700
(850) 488-1429
(850) 487-0662 (fax)
Appeal_Hearings@dcf.state.fl.us

4.1.1 Continuation of Services Pending the Outcome of an Appeal

Recipients shall continue to receive services at the level previously authorized pending the outcome of an appeal as specified in in accordance with Title 42, Code of Federal Regulations (CFR), section 431.230.

4.2 Reconsideration Requests

Providers, or the ordering physician, may request reconsideration of a denial or partial denial determination. Providers or ordering physicians who request a reconsideration must submit additional information to the QIO to facilitate the approval process.

A reconsideration review of the denial decision must be requested via the QIO's Web-based system within ten business days of the date of the denial or partial denial determination.