4 Obtaining Prior Authorization

Added: (also known as…Targeted Case Management)

Prior authorization (also known as Service Authorization in Targeted Case Management) serves as a cost-monitoring, utilization review measure and quality assurance mechanism for the Alabama Medicaid program. Federal regulations permit the Alabama Medicaid Agency to require prior authorization (PA) for any service where it is anticipated or known that the service could either be abused by providers or recipients, or easily result in excessive, uncontrollable Medicaid costs.

This chapter describes the following:

- Identifying services requiring prior authorization
- Submitting a prior authorization request
- Submitting prior authorization supporting documentation
- Receiving approval or denial of the request
- Using AVRS to review approved prior authorizations
- Submitting claims for prior authorized services

4.1 Identifying Services Requiring Prior Authorization

The Alabama Medicaid Agency is responsible for identifying services that require prior approval. Prior authorization is generally limited to specified non-emergency services. The following criteria may further limit or further define the conditions under which a particular service is authorized:

- Benefit limits (number of units or services billable for a recipient during a given amount of time)
- Age (whether the procedure, product, or service is generally provided to a recipient based on age)
- Sex (whether the procedure, product, or service is generally provided to a recipient based on gender)

To determine whether a procedure or service requires prior authorization, access the Automated Voice Response System (AVRS). Refer to Section L.6, Accessing Pricing Information, of the AVRS Quick Reference Guide (Appendix L) for more information.

Refer to Chapter 22 Independent Radiology, for information regarding prior authorization for Radiology and Cardiology services. Providers performing the following services on or after March 2, 2009, requires a prior authorization from eviCore.

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiogram (MRA)
- Computed Tomography (CT)
- Computed Tomography Angiogram (CTA)
- Positron Emission Tomography (PET) scans

- Nuclear Cardiology
- Diagnostic Heart Catheterization
- Stress Test (ECHO)

Deleted: ~~Transesophageal ECHO~~ ~~Transthoracic ECHO~~

Inpatient hospital service, emergency room service, Plan First, SOBRA Adult and Medicaid/ Medicare are exempt from the PA requirement.

Send PA request for outpatient diagnostic imaging procedure to eviCore by:

Phone at (855) 774-1318

Fax at (888) 693-3210

Website at www.evicore.com

The program services chapters in Part II of this manual may also provide program-specific prior authorization information.

Deleted: ~~When a recipient…requires prior authorization.~~ Added: When a recipient…require prior authorization.

NOTE:

When a recipient has the TXIX benefit plan (Full Medicaid) and a third-party insurance, a prior authorization must be obtained from Medicaid for items and services that require prior authorization.

NOTE:

For SOBRA adult recipients who now have full Medicaid benefits, retroactive to November 1, 2015, providers may submit a PA for a date of service on or after November 1, 2015 if the procedure code requires a PA. For dates of service from November 1, 2015 to April 30, 2016, the PA must be received by Gainwell by June 30, 2016 for review. All other PAs for a date of service May 1, 2016 and after must be submitted timely, prior to rendering the service, and adhere to the normal submission guidelines in this Chapter and other applicable Chapters, such as Chapter 14, Durable Medical Equipment

4.2 Submitting a Prior Authorization Request

To receive approval for a PA request, you must submit a complete request using one of the approved submission forms. This section describes how to submit online PA requests, and includes the following sections:

- Submitting PAs (278 Health Care Services Review-Request for Review and Response) using Provider Electronic Solutions
- Submitting PAs using the Web Portal

NOTE:

PAs are approved only for eligible recipients. It is therefore recommended that provider verify recipient eligibility prior to submitting a PA request. Refer to Chapter 3, Verifying Recipient Eligibility, for more information.

In the case of a retroactive request (retroactive eligibility), the recipient must have been eligible on the date of service requested. The provider must submit the PA request within 90 calendar days of the retroactive eligibility award (issue) date. If a retroactive PA request is submitted and does not reference retroactive eligibility, the request will be denied.

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital or ambulatory surgical center **prior to rendering the service**, unless it is a medical emergency, as explained below.

PAs for radiation treatment and/or management services must be requested within 30 days of providing the service.

If a medical emergency is referenced, the provider must submit the PA request **within 30 days** of the date of service. Supporting documentation must provide evidence that the service was not scheduled and that delays greater than 72 hours would have resulted in serious injury or harm.

Prior authorizations must be received by the fiscal agent within 30 days of dispensing equipment, providing vision services, or for laboratory procedures within 30 days of the date of service.

A Letter of Medical Necessity (LMN) with sufficient information to meet criteria may be submitted. However, medical records may be requested to justify the medical necessity of the requested item or service by the Agency or its designated PA reviewer.

Medical records must be submitted to justify the medical necessity of the requested item or service. Checklists are not sufficient documentation to meet criteria.

Prior authorization requests that are received by Gainwell and rejected due to incorrect information will not be considered received timely unless resubmitted correctly within 30 days of the dispensed date.

Providers shall verify that procedure codes requested on a PA are not subject to NCCI edits, whether procedure to procedure (PTP), or medically unlikely (MUE) edits. An approved PA may not override an NCCI edit.

Providers shall review NCCI edits on the CMS site at, https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index, prior to submitting a PA.

NOTE:

Beginning January 1, 2026, the Alabama Medicaid Agency (Medicaid) will implement changes to the prior authorization (PA) process for non-pharmacy PAs to comply with the CMS Interoperability and Prior Authorization Final Rule. This Final Rule does not apply to pharmacy PA requests.

To ensure compliance to the Final Rule, the following changes will be made to the PA process:
The rule requires Medicaid to respond to expedited and non-expedited PA requests within a defined timeline. Medicaid will have 72 hours to provide a response for expedited requests and seven calendar days to provide a response for non-expedited requests.

Expedited Field – A new field will be available in the provider web portal to indicate when a request is expedited. By marking a PA as expedited, the provider is attesting that the recipient's condition requires an urgent PA determination. Medicaid will monitor provider use of the expedited field for potential abuse or overuse.

- Web Portal: Select “Y” for Yes for the Expedited field
- 278 Transaction: Use Loop 2000E – UM06 Level of Service value “Urgent”

Additional Documentation Timeline – When additional documentation is requested to support a PA decision, providers will have up to 14 calendar days to submit it (reduced from the current 30 business days). If the required documentation is not received within this time frame, the PA will be denied. Providers are encouraged to submit all supporting documentation promptly to avoid delays or denials.

4.2.1 Submitting PAs Using Provider Electronic Solutions

Providers can submit electronic PA requests using Gainwell Provider Electronic Solutions software available at no charge. Gainwell will mail the software to the provider at no cost, or the provider may download the software from the Internet.

http://medicaid.alabama.gov/content/7.0_Providers/7.8_PES_Software.aspx

Refer to Chapter 15 of the *Provider Electronic Solutions Manual* for specific information. This chapter provides instructions for submitting electronic 278 requests

The electronic 278 Health Care Services Review- Request for Review and Response claim is not limited to the use of the Provider Electronic Software. Providers may use other vendor’s software to submit a 278 electronic claim.

NOTE:

Please include a copy of the Prior Authorization response, which is received after your submission, with your PA supporting documentation. For details, refer to section 4.3 PA Requests Requiring Supporting Documentation on submitting PA supporting documentation using the Web Portal.

4.2.2 Submitting PA Requests Using the Web Portal

Providers may also submit PA requests through the interactive web portal. Please use this link for the Alabama Medicaid Agency AMMIS Interactive Services Website User Manual:
http://medicaid.alabama.gov/content/7.0_Providers/7.6_Manuals.aspx

See Section 13 of the AMMIS Interactive Services Website User Manual, Prior Authorization, for information about this process.

4.3 PA Requests Requiring Supporting Documentation

If supporting documentation is required for PA review, the required attachments must be sent to Gainwell within 48 hours to be scanned into the system to prevent a delay in review and/or a denial for “no documentation” to support the PA request. Do not fax this information to the Alabama Medicaid Agency unless a request is made for specific information by the Agency reviewer. Attachments scanned can be located in the system and are linked by the PA number on the Prior Authorization response returned by the system.

This section describes how to submit PA supporting documentation using the Web Portal, and includes the following sections:

- Submitting PA Supporting Documentation Using the Web Portal

- Instructions for Submitting PA Supporting Documentation using the Web Portal

4.3.1 Submitting PA Supporting Documentation Using the Web Portal

Providers will be able to upload or fax PA supporting documentation via the Forms menu of the Alabama Medicaid Interactive Web Portal starting:

- July 18, 2016 for Medical PA support documentation
- August 18, 2016 for Dental PA supporting documentation

Effective May 1, 2017, Alabama Medicaid will only allow the electronic upload and submission of Medical and Dental PA (including Hospital Dental PA) supporting documentation **(including Reconsideration)** via the web portal. Medical and Dental PA supporting documentation (including Reconsideration) received on paper after that date will be returned to the provider.

A form will allow providers the ability to upload Medical or Dental PA supporting documents in PDF format or create a fax barcode coversheet from the Web Portal. Providers may submit additional documentation via fax or electronic upload at a later time and have that documentation combined with the original document through the use of the same PA number.

NOTE:

Instructions for submitting additional documentation via fax:

Fax the required documentation with the provided barcode coversheet on top of the documentation to 334-215-7416

The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. **DO NOT** place anything on the bar code on the cover sheet or alter it in any manner.

Do not fax double sided pages.

Do not fax multiple sets of records at the same time. Each fax should be sent separately.

The bar code cover sheet is unique to this transaction. To submit documentation for another recipient, please complete the process for that unique recipient transaction.

A **new** bar code cover sheet should be generated when uploading/faxing documents for a reconsideration of a denied PA, using the original PA number.

4.3.2 Instructions for Submitting PA Supporting Documentation Using the Web Portal

Please use this link for the Alabama Medicaid Agency AMMIS Interactive Services Website User Manual:
http://medicaid.alabama.gov/content/7.0_Providers/7.6_Manuals.aspx

See Section 13.6.1 of the AMMIS Interactive Services Website User Manual, Forms Panel, for information about this process.

4.4 Completing the Alabama Prior Review and Authorization Request Form

Providers use the Alabama Prior Review and Authorization Request Form to submit Medical PAs. This form is available through the Medicaid Agency at the following website link:

http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library.aspx

4.4.1 Blank Alabama Prior Review and Authorization Request Form

You may fill in the blanks on the computer. Print the form and add signature and date. Mail completed form to HPE at the address below. Information that is typed in will not be saved in the form once the document is closed.

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required if Medicaid Provider) PMP ( )
Requesting Provider NPI #
Phone with Area Code
Name

Recipient Medicaid #
Name
Address
City/State/Zip
EPSDT Screening Date DOB
Prescription Date CCYYMMDD

Rendering Provider NPI #
Phone with Area Code
Fax with Area Code
Name
Address
City/State/Zip
Ambulance Transport Code
Ambulance Transport Reason Code
DME Equipment: New Used

First Diagnosis . Second Diagnosis .
Assignment/Service Code Patient Condition Prognosis Code

01 Medical Care	40 Home Health Visits	AD Occupational Therapy
02 Surgical	54 LTC Waiver	AE Physical Therapy
12 DME-Purchase	55 Medically-Related Transportation	
13 DME-Rental	69 Maternity	A4 Psychiatric*
35 Dental Care	73 Inhalation Therapy	AP Speech Therapy
42 Oral Surgery	74 Private Duty Nursing	AS Vision-Optometry
47 Home Health Care	78 Prosthetic Device	CC Case Management

Line Item	DATES OF SERVICE START CCYYMMDD	DATES OF SERVICE STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be att ached.

***If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability .

Signature of Requesting Provider Date

FORWARD TO: HPE, P.O. Box 244036 Montgomery, Alabama 36124-4032

Form 342
Revised 4-2018

Alabama Medicaid Agency
www.medicaid.alabama.gov

4.4.2 Instructions for completing the Alabama Prior Review and Authorization Request Form

Section 1: Requesting Provider Information (Required)

Alabama Coordinated Health Network (ACHN) / PCP	Refer to recipient's prescribing physician for Prior Authorization.
License # or NPI	Enter the license number or the National Provider Identifier (NPI) of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting physician.
Name	Enter the name of the prescribing physician.

Section 2: Rendering Provider Information (Required)

Rendering Provider NPI Number	Enter the National Provider Identifier of the provider rendering services.
Phone	Enter the current area code and telephone number for the provider rendering services.
Fax	Enter the current area code and fax number for the provider rendering services.
Name	Enter the name of the provider rendering services.
Address	Enter the physical address of the provider rendering services.
City/State/Zip	Enter the city, state, and zip code for the address of the provider rendering services.
Ambulance Transport Code	Enter code to specify the type of ambulance transportation. Refer to "Ambulance Transport Codes" in the section below for appropriate codes. **Used for ambulance services only**.
Ambulance Transport Reason Code	Enter code to specify the reason for ambulance transportation. Refer to "Ambulance Transport Reason Codes" in the section below for appropriate codes. **Used for ambulance services only**.
DME Equipment	Enter a check mark indicating if the DME Equipment is New or Used.

Section 3: Recipient Information (Required)

Recipient Medicaid Number	Enter the 13-digit RID number.
Name	Enter the recipient's full name as it appears on the Medicaid eligibility transaction.
Address	Enter the recipient's current address.
City/State/Zip	Enter the city, state, and zip code for the address of the recipient.

Section 4: Other Information

EPSDT Screening Date CCYYMMDD	**Required field for all requests.** Enter the date of the last EPSDT screening. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
DOB	Enter the date of birth of recipient.
Prescription Date CCYYMMDD	**Required field for all requests.** Enter the date of the prescription from the attending physician. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
First Diagnosis	**Required field for all requests.** Enter the primary diagnosis code.
Second Diagnosis	Enter the secondary diagnosis code.
Service Type	**Required field for all requests.** Outpatient hospitals requesting physical therapy must use Service type 01 (medical) and not Service Type AE (physical therapy.).

Patient Condition	Enter the code that best describes the patient's condition. Refer to "Patient Condition Codes" in the section below for appropriate codes. **Used for non-emergency ground transport, > 100 miles, ambulance services and DME providers only.**
Prognosis Code	**Required field for Service Types: 42, 44, and 74.**

Section 5: Procedure Information (Required)

Dates of Service	Enter the line item (1, 2, 3, etc.) along with start and stop dates requested. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
Place of Service	Enter a valid place of service (POS) code.
Procedure Code*	Enter the five-digit procedure code requiring prior authorization. If this PA is for inpatient stay, a procedure code is not required.
Modifier 1	Enter modifier, if applicable.
Units	Enter total number of units.
Cost/Dollars	Enter price in dollars.
Clinical Statement	Provide a clinical statement including the current prognosis and the rehabilitation potential as a result of this item or service. Be very specific.
Signature of requesting provider	After reading the provider certification, the provider signs the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.
Date	Enter the date of the signature.

NOTE:

Additional information may be required depending on the type of request.

Procedure Code Modifiers

Procedure code modifiers are not available with the current electronic 278 Health Care Services Review – Request for Review transaction. Procedure codes requiring anatomic modifiers such as "right" and "left" should be requested on separate lines on the PA request. Refer to the July 2013 Provider Insider for information about the correct use of modifiers. (www.medicaid.alabama.gov. Select Providers and then News & Notices).

Ambulance Transport Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the type of trip for ambulance service requests.

Code	***Description***
I	Initial Trip
R	Return Trip
T	Transfer Trip
X	Round Trip

Ambulance Transport Reason Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the reason for the ambulance transport request.

Code	***Description***
A	Patient was transported to nearest facility for care of symptoms.
B	Patient was transported for the benefit of a preferred physician.

Code	*Description*
C	Patient was transported for the nearness of family member.
D	Patient was transported for the care of a specialist or for availability of specialized equipment.
E	Patient transferred to rehabilitation facility.
F	Patient transferred to residential facility.

Patient Condition Codes

The table below lists condition codes which may be used in different programs. Some codes may not be appropriate for all provider types. Please refer to the provider specific chapter of the Alabama Medicaid Provider Manual for acceptable patient condition codes. **(Used for non-emergency ground transport, > 100 miles, for ambulance services.)**

Code	*Description*
01	Patient was admitted to a hospital
02	Patient was bed confined before the ambulance service
03	Patient was bed confined after the ambulance service
04	Patient was moved by stretcher
05	Patient was unconscious or in shock
06	Patient was transported in an emergency situation
07	Patient had to be physically restrained
08	Patient had visible hemorrhaging
09	Ambulance service was medically necessary
10	Patient is ambulatory
11	Ambulation is impaired and walking aid is used for therapy or mobility
12	Patient is confined to a bed or chair
13	Patient is confined to a room or an area without bathroom facilities
14	Ambulation is impaired and walking aid is used for mobility
15	Patient condition requires positioning of the body or attachments which would not be feasible with the use of an ordinary bed
16	Patient needs a trapeze bar to sit up due to respiratory condition or change body positions for other medical reasons
17	Patient's ability to breathe is severely impaired
18	Patient condition requires frequent and/or immediate changes in body positions
19	Patient can operate controls
20	Side rails are to be attached to a hospital bed owned by the beneficiary
21	Patient owns equipment
22	Mattress or side rails are being used with prescribed medically necessary hospital bed owned by the beneficiary
23	Patient needs lift to get in or out of bed or to assist in transfer from bed to wheelchair
24	Patient has an orthopedic impairment requiring traction equipment which prevents ambulation during period of use
25	Item has been prescribed as part of a planned regimen of treatment in patient's home
26	Patient is highly susceptible to decubitus ulcers
27	Patient or a caregiver has been instructed in use of equipment
28	Patient has poor diabetic control
29	A 6-7 hour nocturnal study documents 30 episodes of apnea each lasting more than 10 seconds
30	Without the equipment, the patient would require surgery

Code	*Description*
31	Patient has had a total knee replacement
32	Patient has intractable lymphedema of the extremities
33	Patient is in a nursing home
34	Patient is conscious
35	This feeding is the only form of nutritional intake for this patient
37	Oxygen delivery equipment is stationary
38	Certification signed by the physician is on file at the supplier's office
39	Patient has mobilizing respiratory tract secretions
40	Patient or caregiver is capable of using the equipment without technical or professional supervision
41	Patient or caregiver is unable to propel or lift a standard weight wheelchair
42	Patient requires leg elevation for edema or body alignment
43	Patient weight or usage needs necessitate a heavy duty wheelchair
44	Patient requires reclining function of a wheelchair
45	Patient is unable to operate a wheelchair manually
46	Patient or caregiver requires side transfer into wheelchair, commode or other
58	Durable Medical Equipment (DME) purchased new
59	Durable Medical Equipment (DME) Is under warranty
5A	Treatment is rendered related to the terminal illness
60	Transportation was to the nearest facility
68	Severe
69	Moderate
9D	Lack of appropriate facility within reasonable distance to treat patient in the event of complications
9E	Sudden onset of disorientation
9F	Sudden onset of severe, incapacitating pain
9H	Patient requires intensive IV therapy
9J	Patient requires protective Isolation
9K	Patient requires frequent monitoring
AA	Amputation
AG	Agitated
AL	Ambulation limitations
BL	Bowel limitations, bladder limitations, or both (incontinence)
BPD	Beneficiary is partially dependent
BR	Bedrest BRP (bathroom privileges)
BTD	Beneficiary is totally dependent
CA	Cane required
CB	Complete bedrest
CM	Comatose
CNJ	Cumulative injury
CO	Contracture
CR	Crutches required
DI	Disoriented
DP	Depressed
DY	Dyspnea with minimal exertion
EL	Endurance limitations
EP	Exercises prescribed
FO	Forgetful
HL	Hearing limitations
HO	Hostile

Code	Description
IH	Independent at home
LB	Legally blind
LE	Lethargic
MC	Other mental condition
NR	No restrictions
OL	Other limitation
OT	Oriented
PA	Paralysis
PW	Partial weight bearing
SL	Speech limitations
TNJ	Traumatic injury
TR	Transfer to bed, or chair, or both
UN	Uncooperative
UT	Up as tolerated
WA	Walker required
WR	Wheelchair required

Patient Assignment Codes

Use this table to determine the appropriate patient assignment code.

Code	Description
01	Medical Care
02	Surgical
12	Durable Medical Equipment - Purchase
18	Durable Medical Equipment - Rental
35	Dental Care
40	Oral Surgery
42	Home Health Care
44	Home Health Visit
54	Long Term Care Waiver Services
56	Medically Related Transportation
69	Maternity
72	Inhalation Therapy
74	Private Duty Nursing
75	Prosthetic Devices
A4	Psychiatric
AD	Occupational Therapy
AE	Physical Therapy
AF	Speech Therapy
AL	Vision - Optometry
CQ	Case Management

Prognosis Codes (Home Health and Private Duty Nursing Services Only)

Use this table for the appropriate code to describe the patient's prognosis.

Code	Description
1 - 2	Good
4 - 6	Fair
7 - 8	Poor

4.4.3 Requesting a Revision to a Prior Authorization

Providers may request a change to a prior authorization for DME and certain medical services by completing Form 471. The Form may **not** be used for pharmacy PAs. Prior authorizations, for which a claim has been paid, may not be revised until the claim has been voided. The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers.

Form 471 Restrictions:
The form is NOT to be used for the following situations:

1. **Reconsiderations of denied PAs,**
2. **Procedure code changes, or**
3. **Updated invoice pricing**. (**All invoice pricing is valid for the PA effective dates.)**

Please refer to Section 4.5, Receiving Approval or Denial of a Request, for information about submitting a request for reconsideration. Providers may submit a new PA for procedure code changes. Complete the appropriate sections on the form **and fax to the Alabama Medicaid Agency's Prior Authorization designee, at (833) 536-2134 or (833) 536-2136 for DME, surgical, vision, ambulance and PDN PAs ONLY.** The form may be accessed at:
http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library.aspx

- For dental PAs, fax to: (334) 353-3426
- For radiology, or cardiology, or ABA therapy- related PAs, fax to: (334) 353-2309.
- For targeted case management PAs, fax to: (334) 215-7416

For a recipient who has a Medicaid ID change during an authorized PA period, the provider should submit a new PA with the active Medicaid ID. The requested effective date should be the effective date of the Medicaid ID. The requested end date must be the same authorized end date of the previous PA. Document the old and new PA numbers in the "Comments" section. Under "Reason for Change, Other:" document, "recipient Medicaid ID change." The new PA with the balance of units and the same authorized end date will be approved after the information has been verified. **These Form 471s should be faxed to the Alabama Medicaid Agency's Prior Authorization Contractor, at (833) 536-2134 or (833) 536-2136 for DME, surgical, vision, ambulance and PDN PAs ONLY.**

Please allow five business days for processing the Form 471.

4.4.4 Blank Alabama Prior Authorization Change Request Form

Alabama Medicaid Agency
Prior Authorization (PA) Change Request

Supplier Information	
Contact Name:	
NPI:	
Phone Number:	

Recipient Information	
Recipient Name:	
Medicaid ID:	

Prior Authorization Number	

Reason for Change ***Please use this section to denote what field(s) on the PA request require a change. Complete all applicable fields below.*** ***Examples: Add/Change Modifier: Add "RR" to "E1088"*** ***Correct Date(s) of Service: Change requested effective date from 08/01/2010 to 10/01/2010***	
Add/Change Modifier:	
Correct Number of Service(s):	
Correct Place of Service:	
Correct Diagnosis Code(s):	
Correct Date(s) of Service:	
Correct NPI:	
Other: (Please Explain)	
Comments	

NOTE: *The Alabama Medicaid Agency cannot revise a PA for which a claim has already been paid. The paid claim must be voided before the PA can be changed. This form* ***must be received within 90 days*** *of the date of the approval on the PA decision letter.* ***The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs; for procedure code changes, or for pharmacy PAs.***

- **For DME, surgical, vision, ambulance and PDN PAs ONLY, fax to (833) 536-2134 or (833) 536-2136**
- **For dental PAs, fax to: (334) 353-3426**
- **For radiology, cardiology, or ABA (Applied Behavior Analysis) therapy related PAs, fax to: (334) 242-0533**
- **For TCM (targeted case management), fax to: (334) 215-7416**

Form 471 Alabama Medicaid Agency Revised: 09/30/2021 www.medicaid.alabama.gov

4.4.5 Blank Alabama Prior Review and Authorization Dental Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Section I – Must be completed by a Medicaid provider.

Requesting NPI or License #_____

Phone ( ) _____

Name _____

Address _____

City/State/Zip _____

Medicaid Provider NPI # _____

Section II

Medicaid Recipient Identification Number _____

(13-digit RID number is required)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number ( ) _____

Section III DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANTITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one)				
11 = DENTAL OFFICE				
22 = OUTPATIENT HOSPITAL				
21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

2. Detailed description of condition or reason for the treatment:

_____

_____

_____

_____

3. Brief Dental/Medical History: _____

_____

_____

_____

_____

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist _____ Date of Submission _____

FORWARD TO: HP, P.O. Box 244032, Montgomery, Alabama 36124-4032

Form 343
Revised 5/28/13

Alabama Medicaid Agency
www.medicaid.alabama.gov

4.4.6 Instructions for Completing the Alabama Prior Review and Authorization Dental Request Form

Section 1: Requesting Provider Information (Required)

Requesting NPI or License #	Enter the NPI or license number of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting dental provider.
Name	Enter the name of the dental provider.
National Provider Identifier	Enter the 10-digit NPI of the requesting provider.

Section 2: Recipient Information (Required)

Recipient Medicaid Number	Enter the 13-digit RID number.
Name	Enter the recipient's full name as it appears on the Medicaid eligibility transaction.
Address	Enter the recipient's current address.
City/State/Zip	Enter the city, state, and zip code for the address of the recipient.
Telephone Number	Enter the recipient's most current phone number.

Section 3: Procedure Information

Dates of Service	Enter the start and stop dates of service requested. Enter dates using the format CCYYMMDD. Use the date you complete the form and add six months. For example, 20050401 (April 1, 2005) through 20051001(October 1, 2005).
Place of Service	Circle the appropriate two-digit place of service.
Procedure Code	Enter the five digit procedure code requiring prior authorization. Use the correct CDT2005 procedure code.
Quantity Requested	Enter the number of times the procedure code will be used/billed.
Tooth Number	Enter the tooth number(s) or area of the mouth in relation to the procedure code requested.

Section 4: Medical Information

Complete Items 1-3 with the information requested. Documentation must be legible. If x-rays are sent, place them in a separate sealed envelope marked with recipient's name and Medicaid number.

Indicate whether the recipient has missing teeth and indicate the missing teeth with an X on the diagram.

After reading the provider certification, the provider signs and dates the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.

The completed form should be forwarded to Gainwell at the address given on the form.

4.5 Receiving Approval or Denial of the Request

Letters of approval will be sent to the provider indicating the approved ten-digit PA number, dates of service, place of service, procedure code, modifiers, and authorized units or dollars. This information should be used when filing the claim form. All electronic claims (278) will generate a 278 Health Care Services Review – Response, to notify the requester that of the response. Once the State has made a decision on the request, it will trigger an electronic 278 response to the provider. The electronic 278 response will either contain the PA number, rejection code or cancellation code information.

Section 1: Decision Codes

Current Decision Codes:	Description
A	Approved
E	Evaluating
D	Denied
K	Cancelled
M	Modified PA Request
P	Pending
F	Denied Need Further Doco
G	Reconsideration

Letters of denial will also be sent to the provider and recipient indicating the reason for denial.

Letters of approval or denial will be sent to both the provider and recipient for private duty nursing PAs.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). The Agency's fiscal agent, Gainwell, must receive this request for reconsideration **within 14 days** from the date of the denial letter. If you wish to request a Fair Hearing, that request must be received within 60 days of the date of denial.

Deleted: ~~or the decision…will be available~~
Added: If you wish…date of denial.

For PA requests submitted electronically:

Requests for reconsideration of a denied request may be electronically uploaded using the same process as for the initial upload of the supporting documentation. Please refer to Section 4.3 PA Requests Requiring Supporting Documentation for information about this process.

NOTE:

Providers may NOT bill a Medicaid recipient for an item for which a PA was denied.

4.6 Using AVRS to Review Approved Prior Authorizations

AVRS allows the provider to access information about an approved prior authorization number to confirm start and stop dates, procedure code(s), total units, and dollar amount authorized.

To inquire about approved prior authorizations (PAs), press 6 (the number 6) from the main menu, then AVRS prompts you for the following:

- Your National Provider Identifier (NPI), followed by the pound sign
- The ten-digit prior authorization number, followed by the pound sign

AVRS performs a query and responds with the following information for the PA:

- Recipient number
- Procedure code or NDC, if applicable (some PAs do not require procedure codes or NDCs)
- Start and stop dates
- Units authorized
- Dollars Authorized
- Units used
- Dollars Used

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the message
- Press 2 to check another Procedure Code or NDC for the same provider
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

4.7 Submitting Claims for Prior Authorized Services

Once the approved ten-digit PA has been received, providers may submit the claim electronically. The claim must match the approved PA with respect to procedure code, modifier, if any, approved dates, units and servicing provider NPI. The claims processing system will match the approved PA to the claim submitted.