



JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

February 11, 2002

Dear Medicaid Provider:

In the May 2001 legislative session, the Florida Legislature required the Agency for Health Care Administration (AHCA) to implement a prior authorization program for Medicaid inpatient hospital admissions. Florida Medicaid will implement a new prior authorization program for most Medicaid inpatient admissions for medical, surgical, and rehabilitative services. The new program is distinct from the prior authorization program in place for inpatient psychiatric admissions. The purpose for prior authorizing inpatient admissions is to ensure that admissions and services are medically necessary. Payment will be denied if the admission or continued stay are determined not to be medically necessary.

The Agency for Health Care Administration has contracted with the Keystone Peer Review Organization (KePRO South) of Harrisburg, Pennsylvania, to perform prior authorization, admission and concurrent review functions for the state's Medicaid inpatient hospital program. The medical inpatient prior authorization program will be implemented with admissions on and after March 1, 2002. In January 2002, KePRO South conducted five hospital provider seminars to instruct and train providers on the new inpatient prior authorization process. In February 2002, KePRO South will conduct statewide testing of the new inpatient prior authorization process. KePRO South is sharing implementation details with the Florida Hospital Association, the Florida Osteopathic Medical Association, and the Florida Medical Association. Please check for additional information on the KePRO South website at www.keprosouth.com, and the AHCA website at www.fdhc.state.fl.us under the Medicaid link.

Several inpatient admissions are exempt from prior authorization. Please read the attached information carefully to determine whether your office will be required or not to seek authorization for your Medicaid patients. Inpatient admissions that are not exempt from the medical inpatient prior authorization process will be subject to prior approval or concurrent review by KePRO South. It will no longer be the responsibility of the recipient's MediPass primary care physician to authorize inpatient admissions, except as noted on the next page. Emergency or urgent admissions for all ages, and elective admissions for recipients under age 21 will not require prior approval but will be reviewed concurrently for medical necessity. Elective admissions for recipients under 21 will be approved for the first 24 hours, then subject to concurrent review. The physician recommending an elective admission for a recipient 21 and over must request prior approval from KePRO South before the admission. The hospital may request prior approval for such admission instead of the physician, if there is a mutual understanding and agreement between the physician and the hospital for the hospital to do so.



When billing Medicaid for KePRO authorized inpatient admissions, the hospital provider will be given a prior authorization number to enter on the UB-92 claim form before sending the bill to Medicaid for reimbursement of the stay. A Medicaid prior authorization number or a MediPass authorization number are **not required** on the HCFA-1500 claim form for reimbursement of the physician's inpatient services. Medicaid will reimburse the physician's inpatient services without either of these numbers. Please remember that physician billers must leave blank the prior authorization number and MediPass number fields on the HCFA-1500 when the place of service is "21" (Inpatient).

Please note that inpatient admissions for Medicaid children enrolled in the Children's Medical Services (CMS) Network are exempt from the medical inpatient prior authorization program, and thus, not subject to KePRO approval for inpatient services. However, this group of recipients remains subject to prior approval from the MediPass primary care physician for inpatient admissions. Consequently, a MediPass authorization number is required on the HCFA-1500 claim form when billing Medicaid for reimbursement of the physician's inpatient services.

Authorization from a MediPass primary care physician and a MediPass authorization number remain requirements for recipient access to outpatient hospital services and for the billing of those services to Medicaid. KePRO South's prior approval authority, however, is limited to inpatient services only. The MediPass primary care physician must continue to authorize outpatient hospital encounters.

It is not the responsibility of KePRO South to prior approve physician requests for referral of Florida Medicaid recipients to out-of-state hospitals for inpatient services. Physician requests for out-of-state referrals must continue to be submitted to AHCA Medicaid for out-of-state approval. Likewise, physicians must send prior approval requests for heart transplant evaluations and heart transplant procedures for recipients 21 and over to the Medicaid office, as is currently the case. Inpatient admissions for all other transplant services are subject to authorization and approval by KePRO South.

In the attachment, please find a listing and explanation of all inpatient encounters and recipient groups subject to or exempt from the new prior authorization requirement, hospital billing procedures, and other pertinent information. It is essential that the information contained in this letter and its attachment is shared with the appropriate physicians admitting Medicaid recipients to the hospital. Hospital and physician providers must comply with the new Medicaid prior authorization requirements beginning with admissions on and after March 1, 2002.

It is important to note that for hospital providers the transmission of prior authorization requests and determinations to and from KePRO South will be performed through an enhanced secure Internet system. The enhanced Internet security system will allow transmission of information between KePRO South and ACS, Medicaid's fiscal agent, and between KePRO South and the hospitals. For those providers who do not yet have Internet capability, the method of

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transmission of information between the provider and KePRO South will be via the FAX machine. All hospitals will be required to have secure Internet capability by January 1, 2003. Physician offices will not be expected to conform to this requirement. Physicians without Internet capability may utilize the FAX machine to submit their prior authorization request to KePRO South for elective admissions for ages 21 and over. Physicians with additional inquiries regarding the new medical inpatient prior authorization program and their role relating to it may contact KePRO South at their website www.keprosouth.com or call KePRO South at the number noted below.

The implementation of the new inpatient medical prior authorization program is a significant change for hospital providers, physicians, and Medicaid, and will require much coordination and concerted effort on the part of all involved. Barring normal startup adjustments in transitioning to the new process, Medicaid and KePRO South expect a smooth implementation once hospitals and physicians become familiar with the process.

Please note that KePRO South will maintain current and pertinent prior authorization information for hospital and health care practitioners to access. As noted earlier, the KePRO South website is www.keprosouth.com. Medicaid is also creating a website for quicker and continuous relay of inpatient medical prior authorization information to hospital providers and health care practitioners. A "Utilization Review" link is available at www.fdhc.state.fl.us.

If you have further questions, please contact KePRO South at (813) 287-5020, or Madeleine Nobles, AHCA Registered Nurse Consultant, at (850) 922-7326.

Sincerely,

Bob Sharpe
Deputy Secretary for Medicaid

BS/om

Attachments

cc: Florida Hospital Association
Florida Medical Association
Area Medicaid Offices 1-11
KePRO South

MEDICAL INPATIENT PRIOR AUTHORIZATION PROGRAM SUMMARY

Type of Admission	Prior Authorization (Before admission)	Admission Review (Within 24 hours after admission)	Concurrent Review (After admission review)	Retrospective Prepayment Review (After discharge)	Who Requests	COMMENTS
Elective Under age 21	No	No	Yes, for day 2 and on	No	Hospital	First day has automatic approval, therefore exempt from admission review
Elective age 21 and Over	Yes (by admitting MD or hospital)	No	Yes	No	Hospital to request concurrent review	
Emergency (All ages)	No	Yes, within 24 hours of admission if stay is over a one day stay	Yes	No	Hospital	One day emergency stays are exempt from this program
Urgent (All ages)	No	Yes, within 24 hours of admission	Yes	No	Hospital	
Pending Eligibles	No	No	No	Yes	Hospital	If determined eligible during hospitalization, request concurrent review
Medically Needed	No	No	No	Yes	Hospital	If determined eligible during hospitalization, request concurrent review
Third Party Liability	No	No	No	Yes	Hospital	If determined no third party liability during stay, obtain concurrent review

MEDICAL INPATIENT PRIOR AUTHORIZATION PROGRAM

Introduction

Effective with admissions on and after March 1, 2002, admissions of Florida Medicaid recipients in any in-state hospital participating in the Medicaid program must be prior authorized before Medicaid reimbursement can be made. However, there are several recipient categories and special circumstances that are exempt from the prior approval requirement. All exceptions are discussed in detail in the following sections.

Only certain types of admissions are subject to prior authorization, others are subject to concurrent reviews, and others, retrospective prepayment review.

Authorizing Entity: the PRO

Prior authorization functions, admission reviews, and concurrent reviews, retrospective prepayment reviews are conducted by the peer review organization (PRO), an entity contracted with the Agency for Health Care Administration (AHCA) to perform these services. The PRO also performs reconsideration reviews of inpatient hospital denials when requested by the provider.

The primary method of provider interaction with the PRO will be via the internet for internet capable providers. Non-internet capable providers may interact with the PRO via FAX. By January 1, 2003, all hospitals will be required to utilize the internet to do business with the PRO.

Recipient Categories Subject to PA

Prior authorization requirements are applicable to hospital admissions for fee-for-service Medicaid recipients and those enrolled in MediPass, barring any exceptions noted below.

Recipient Category Exemptions

Hospital admissions for any of the recipient categories listed below are exempt from prior authorization, concurrent review, or retrospective prepayment review.

- Adult recipients in health maintenance organizations (HMOs).

Medical Inpatient Admissions, continued

Recipient Category
Exemptions
(continued)

- Recipients under age 21 in health maintenance organizations (HMOs) through and including the 45th day of HMO coverage.
Note: Children under 21 are limited to 45 days of inpatient hospital care under the HMO plan. When recipients in this age group have exhausted their 45-day coverage under the HMO, they become eligible for coverage under fee-for-service, thus, subject to inpatient prior authorization requirements. See prior authorization requirements for this age group in the section labeled “Elective Admissions for Recipients under 21”.
- Recipients in provider service networks (PSNs).
- Children in the Children Medical Services Network (CMS);
Note: These children are identified by a “C” indicator in the Medicaid Eligibility Verification System (MEVS).
- Dually eligible recipients with Medicare coverage primary over Medicaid.
- Recipients with Medicare Part A coverage.
- Recipients with Medicare Part B Only coverage.
- Qualified Medicare Beneficiaries (QMBs).
- Qualified Medicare Beneficiaries with End-Stage Renal Disease (QMBRs).
- Specified Low Income Medicare Beneficiaries (SLMBs).
- Admissions for Child Health Check-Up recipients under 21 who have been screened within one year of an inpatient admission for a surgical procedure and for whom the medically necessary admission was the direct result of the Child Health Check-Up screening performed by a physician.

Medical Inpatient Admissions, continued

Recipient Category Exemptions (continued) This type of admission does not require PRO approval nor does the claim billed to Medicaid for such admission require a prior authorization number in form locator 63B.

Note: The billing of a Child Health Check-Up claim requires the entry of condition code “A1” in form locators 24-30 of the UB-92 claim form.

- Recipients who are admitted for psychiatric treatment (ICD-9-CM codes 290-314.9) in acute care or freestanding psychiatric hospitals.

Note: Psychiatric admissions are prior authorized by a separate entity under contract with the Agency for Health Care Administration. See “Prior Authorization for Inpatient Psychiatric and Substance Abuse Services” in this chapter.

Newborn Delivery Exemption

All hospital admissions for deliveries are exempt from the prior authorization requirement. Exempted deliveries are identified by ICD-9-CM procedure codes in the range of 72.0 through 74.9 and primary diagnosis codes in the range of 630.0 through 677. Such admissions have a type of admission of 4 (Newborn) and a source of admission of 1 through 9. Deliveries are Medicaid reimbursable without a prior authorization number on the UB-92 claim form.

Note: All admissions for primary diagnoses in the range of 630.0 through 677 without a delivery are subject to PRO review. The hospital must request a prior authorization number from the PRO to bill the PRO-approved inpatient days to Medicaid.

Inpatient Medical Admissions, continued

Non-Concurrent
Newborn Stays

When a newborn remains in the hospital beyond the mother's discharge, the newborn's inpatient stay is treated as a new admission beginning on the date of the mother's discharge. The hospital should request a concurrent review within 24 hours of the mother's discharge as soon as the hospital knows the Medicaid ID number of the newborn. The PRO will issue a prior authorization number to the hospital to bill Medicaid for the PRO-approved inpatient days.

Same Day
Admission and
Discharge with
Patient Status 20
(Expired)

There is no prior authorization requirement on claims for patients who've expired on the same day they were admitted. Such claims have a patient status entry of 20 in form locator 22 of the UB claim.

EMERGENCY
Admission

All emergency admissions that are life-threatening situations requiring immediate attention are exempt from the prior authorization requirement. Emergency admissions for children and adults require no prior approval from the PRO. If the emergency stay is one day only with the admission and discharge on the same day, or with the admission on one day and discharge on the next day, no PRO approval and no prior authorization number is required to bill the day to Medicaid. If the patient remains in the hospital longer than one day, the hospital must request concurrent review from the PRO. A prior authorization number will be given to the hospital to bill the PRO-approved days to Medicaid.

If the admission is found not to be medically necessary, the case will be denied from the time of admission.

Note: Emergency admissions are denoted by the entry of code "1" in form locator 19 (Type of Admission) of the claim form.

Medical Inpatient Admissions, continued

URGENT Admission

All urgent admissions that are non-life-threatening but requiring immediate attention are exempt from the prior authorization requirement. Urgent admissions require no prior approval from the PRO before admission, but within 24 hours of the admission, the receiving hospital must request an admission review from the PRO. The admission review also applies to one-day stays. A prior authorization number will be issued to the hospital to bill PRO-approved days to Medicaid.

If the admission is found not to be medically necessary, the case will be denied from the time of the admission.

Note: Urgent admissions are denoted by the entry of code “2” in form locator 19 (Type of Admission) of the claim.

ELECTIVE Admission for Recipients under Age 21

Elective admissions for recipients under the age of 21 do not require prior approval from the PRO before the recipient can be admitted. If the elective admission is only for one day, with admission and discharge the same day, or with the admission one day and discharge the next day, there is no PRO approval or prior authorization number required to bill the one day to Medicaid.

When it is anticipated that the stay will be longer than one day, within 24 hours of the admission, the hospital must request the PRO to conduct a concurrent review. A prior authorization number will be issued to the hospital to bill the PRO-approved days to Medicaid.

If the elective admission is found not to be medically necessary, the case will be denied from Day 2.

Note: Elective admissions are denoted by the entry of code “3” in form locator 19 (Type of Admission) of the claim.

Inpatient Medical Admissions, continued

ELECTIVE
Admission for
Recipients of Age
21 and Over

Unless exempt from the prior authorization requirement, elective admissions for recipients of age 21 and over require the PRO's approval prior to the admission. A prior authorization number will be issued to the hospital to bill the PRO-approved days to Medicaid.

Billing an elective admission to Medicaid for the adult age group requires a valid prior authorization number on the UB-92 claim form whether the recipient was admitted and discharged on the same day, or, was hospitalized more than one day.

If the elective admission is found not to be medically necessary, the case will be denied from the time of the admission.

Note: Elective admissions are denoted by the entry of code "3" in form locator 19 (Type of Admission) of the claim.

Admissions for In-
State Transplant
Services

In-state inpatient admissions of children and adults for covered Medicaid transplant services, except hearts for adults, in designated Florida transplant centers require prior approval from the PRO before services can be rendered. Following approval, the PRO will issue a prior authorization number to the hospital to bill.

Note: It is not a responsibility of the PRO to prior approve adult heart transplant evaluations and heart transplant procedures. These services remain subject to prior approval by the Medicaid Program Development Office.

Referrals to Out-of-
State Hospitals

It is not a responsibility of the PRO to prior approve the referral of Medicaid recipients to out-of-state acute care or specialty hospitals. Requests for recipient referral to out-of-state facilities, for reasons that the needed services or technology are not available in Florida hospitals, must continue to be submitted to the Medicaid Program Development Office for approval.

Inpatient Medical Admissions, continued

Individuals with Pending Medicaid Eligibility

In the case of pending Medicaid eligibility for an individual who is a patient in the hospital, as soon as the hospital is informed of the individual's Medicaid eligibility, the hospital must request the PRO to conduct a concurrent review of the stay. A prior authorization number will be issued to the hospital to bill Medicaid for the PRO-approved days.

When a hospital is informed of an individual's Medicaid eligibility after the patient has been discharged and the Medicaid eligibility is retroactive to cover this individual's inpatient stay, in whole or in part, the hospital is responsible for requesting that the PRO conduct a retrospective prepayment review before billing Medicaid. A prior authorization number will be issued to the hospital to bill the PRO-approved days to Medicaid.

Note: The procedures described above for pending eligibles are also applicable to recipients categorized as Medically Needy.

Recipients with Third Party Insurance Coverage

Inpatient hospital stays for Medicaid recipients with third party insurance coverage are subject to retrospective prepayment review by the PRO, if, following third party payment or denial, Medicaid is responsible for paying a portion or all of the stay. Prior to billing Medicaid, the hospital must request that the PRO conduct a retrospective prepayment review of the stay. A prior authorization number will be issued to the hospital to bill the PRO-approved days to Medicaid.

Note: If, prior to the admission or during the inpatient stay, the hospital already knows that the third party insurer will not pay the hospitalization, the hospital can request that the PRO conduct an admission review or a concurrent review, whichever is applicable, instead of a retrospective prepayment review.

Medical Inpatient Admissions, continued

Facility to Facility Transfers

Prior authorization procedures for facility to facility transfers of Medicaid recipients are as follows:

- The original admitting hospital must request prior approval from the PRO in accordance with the procedures noted earlier for the various types of admission (emergency, urgent, or elective, under 21, 21 and over, etc.). A prior authorization number will be issued to the hospital to bill the PRO-approved days to Medicaid.
- The second or “receiving” hospital, to which the patient is transferred, does not need to request prior approval from the PRO to admit the patient, but within 24 hours of the admission, this hospital must request an admission review from the PRO. If the recipient remains in the hospital longer than the number of days originally approved by the PRO, the hospital must request a concurrent review. A prior authorization number will be issued to the hospital to bill the PRO-approved days to Medicaid.

The Prior Authorization Number

The prior authorization number is a 10-digit number required in form locator 63B of the UB-92 claim form to bill PRO-approved days to Medicaid. Unless an inpatient admission requires no prior authorization number by virtue of the PA exemptions noted in the segments above, the prior authorization number is essential for Medicaid reimbursement. The PRO posts the prior authorization number on the internet for the requesting hospital. The hospital provider retrieves the number to bill Medicaid. It is important to note that:

- One prior authorization number only is issued for a 9-digit hospital provider number. It is incumbent upon the hospital to bill Medicaid using the **identical** 9-digit provider number given to the PRO when prior authorization, admission review, concurrent review, or retrospective prepayment review was requested.

Medical Inpatient Admissions, continued

The Prior Authorization Number, continued

- One prior authorization number is required on all medical inpatient claims where all or a portion of the hospitalization has been approved by the PRO.
 - Only one (1) prior authorization number is required in unit-to-unit transfers within the hospital during the same hospitalization, e.g., a patient is transferred from the medical unit to the rehabilitation unit within the same hospital.
 - Medical inpatient prior authorization numbers represent the approval of inpatient hospital admissions and stays and are in no way linked to ICD-9-CM procedure or diagnosis codes reported on the claim form.
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The Prior Authorization Number and Interim Billing

One prior authorization number only is required when billing the entire hospitalization on one claim.

If the hospital intends to interim bill every thirty (30) days and use the same prior authorization number for more than one billing, the hospital must request PRO approval of subsequent inpatient days prior to sending the first interim bill to Medicaid. This step allows the fiscal agent to update the total number of approved days on the recipient's PA record so that the same prior authorization number can be used for multiple billings. Otherwise, if the hospital provider's usage of the PA number depletes the number of approved days on the Florida Medicaid Management Information System (FMMIS), the same PA number cannot be used again and a new one must be reissued.

The Prior Authorization Number and Fiscal Year Split Billing

July 1 of each year marks the beginning of the new Medicaid fiscal year. Every year, for fiscal purposes, Medicaid requires that all hospital providers split bill June hospitalizations that overlap into the month of July. The provider can use the same prior authorization number issued by the PRO to bill each portion of the two bills involved in the fiscal year split billing situation. The claim for the June portion of the hospitalization has a discharge date of 0701YY, and the first inpatient day on the claim for the July portion is also 0701YY.

Medical Inpatient Admissions, continued

The MediPass
Authorization and
Number

The implementation of the inpatient prior authorization program for all medical inpatient admissions renders obsolete the necessity for the hospital to receive authorization from the MediPass physician. Effective on and after March 1, 2002, the MediPass authorization number is no longer required in form locator 63A of the UB-92 for medical inpatient admissions subject to the prior authorization requirement. That form locator must be left blank.

Note: Medicaid recipients under the age of 21 enrolled in the Children's Medical Services Network (CMS) are exempt from the inpatient prior authorization requirement, and, therefore, are still subject to MediPass authorization from the MediPass primary care physician for inpatient admissions.

The Hospital's
Medicaid Provider
Number

When requesting prior approval, admission, concurrent, or retrospective prepayment review from the PRO for inpatient services, it is the provider's responsibility to give the PRO the exact 9-digit hospital provider number the hospital will use to bill the PRO-approved days to Medicaid. The hospital provider number entered in form locator 51 of the claim form when billing Medicaid must be an exact 9-digit match to the provider number submitted to the PRO.

It is important to note that a UB-92 claim form will be systematically denied when it is submitted to Medicaid with a 9-digit provider number that is different from the 9-digit provider number submitted to the PRO when requesting the prior authorization. A new prior authorization number must be requested from the PRO every time a different provider number is used.

The Recipient
Medicaid ID
Number

It is the hospital's responsibility to give the PRO an exact and correct 10-digit recipient Medicaid identification number when requesting prior authorization from the PRO. The 10-digit recipient ID number entered on the UB-92 claim form when billing Medicaid must be **identical** to the one submitted to the PRO, otherwise, the inpatient days billed to Medicaid will be systematically denied.

Medical Inpatient Admissions, continued

UB-92 Claim Form Entries when Billing PRO-Approved Inpatient Days

When billing Medicaid for PRO-approved inpatient days, the UB-92 claim form is completed in the same manner as usual for billing inpatient hospital services, but note the following claim entries:

- Form Locator 2: The Financial Class code is FC100 (Medicaid single payer), or FC210 if a private insurance is primary over Medicaid.
- Form Locator 4: The Type of Bill is 111 (Inpatient)
- Form Locator 6: The entire hospitalization is entered in the Statement Covers Period whether or not all the inpatient stay was approved.
- Form Locator 19: The Type of Admission must be entered here. 1) Emergency, 2) Urgent, 3) Elective, or 4) Newborn.
Note: A claim with a type of admission 4 (Newborn) and source of admission 1 through 9 is exempt from prior authorization if the primary diagnosis is in the range of 630.0 through 677 and the primary procedure is in the range of 72.0 through 74.9 (Deliveries).
- Form Locator 22: Enter the appropriate Patient Status code.
- Form Locators 24-30: Enter the Condition Code(s) pertinent to this hospitalization.
 - Enter condition code C1 if the PRO approved all the days, excluding discharge day, in the Statement Covers Period (form locator 6).
 - Enter condition code C3 if the PRO approved only some of the days in the Statement Covers Period (form locator 6). If C3 is entered as a condition code, enter Occurrence Code M0 in form locator 36a followed by the first and last approved day of this inpatient stay.

Note: Condition Code A1 (Child Health Check-UP) means that the entire hospitalization requires no prior authorization from the PRO and no PA number on the claim.

Medical Inpatient Admissions, continued

UB-92 Claim Form
Entries when
Billing PRO-
Approved Inpatient
Days, continued

- Form Locator 36a: If not all of the inpatient stay was approved by the PRO and the condition code C3 (Partial approval) is in form locators 24-30, enter Occurrence Code M0 in 36a followed the first and last day approved by the PRO.
- Form Locator 51: Enter the 9-digit hospital provider number the hospital used to obtain prior approval, admission review, concurrent review, retrospective prepayment review from the PRO.
- Form Locator 63A: Leave blank. (No MediPass authorization number required.)
- Form Locator 63B: Enter the 10-digit prior authorization number that covers the approved days in this hospitalization.

Inpatient Denials
and
Reconsiderations

A hospital provider or physician who is dissatisfied with the PRO's decision on an inpatient admission or stay can request a reconsideration of the determination from the PRO. This must be requested in accordance with the procedures established by the PRO for reconsideration reviews.

Upon reconsideration, if the PRO approves an originally denied admission or inpatient stay, the PRO will issue a prior authorization number.
