Chapter 5

# Service Authorization

Some IMCare-covered services require authorization. The Service Authorization requirement is used to safeguard against inappropriate and unnecessary use of health care services. Some authorization requirements are governed by State law and Federal regulations. When members have private insurance, providers must follow authorization and other rules that apply to the primary insurance.

Providers should submit an *IMCare Service Authorization* prior to providing a service. The Service Authorization requirements apply when IMCare is primary, secondary, or tertiary payer for the member. There is an exception when Medicare fee-for-service (FFS) is primary: if Medicare pays for any service, IMCare does not require authorization. If Medicare denies or does not cover any service, all IMCare authorization rules apply.

Requests for authorization after the service has been provided are subject to the same review criteria as those that are received prior to providing the service.

Receiving an approval for a Service Authorization request does not guarantee payment. Providers must follow IMCare billing policy guidelines, and the IMCare member must be eligible at the time the service is rendered.

**All IMCare Utilization Management (UM) determinations are based only on the appropriateness of care and service and coverage.** IMCare does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial or other incentives for IMCare UM decision makers to encourage decisions that result in underutilization.

## Definitions

**Authorization:** The written approval and issuance of an authorization number by a medical review agent under contract with IMCare.

**Fair Hearing:** An administrative proceeding to examine facts concerning the matter in dispute and to advise the Commissioner if the decision to reduce or deny benefits is appropriate.

**Investigative Health Service:** A procedure that has limited human application and trial and lacks wide recognition as a safe and effective procedure in clinical medicine. A drug or device (identified in the Food, Drug, and Cosmetic Act) the United States Food and Drug Administration (FDA) has not yet declared safe and effective for the use prescribed.

**Local Trade Area:** The geographic area surrounding a member's residence commonly used by local residents to obtain similar health care services.

**Medical Necessity:** A health service that is consistent with the member's diagnosis or condition and is:
1. Recognized as the prevailing medical community standard or current practice by the provider's peer group; and
2. Rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or
3. Is a preventive health service as defined in MN Rules part 9505.0355.

**Out-of-State Provider:** A provider located outside of the State of Minnesota and the member's local trade area.

**Referee:** A person who conducts fair hearings and provides recommendations to the Commissioner.

## IMCare Authorization Criteria

IMCare requires Service Authorization as a condition of IMCare payment (regardless of whether IMCare is primary, secondary, or tertiary insurance for the member) if any of the following apply:

1. The health service is of questionable medical necessity
2. The health service requires monitoring to control the expenditure of IMCare funds
3. A less costly, appropriate alternative health service is available
4. The health service is investigative or experimental
5. The health services is newly developed or modified
6. The health service is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial
7. The health service is comparable to a service provided in a Skilled Nursing Facility (SNF) or hospital but is provided in a member's home
8. The health service may be considered cosmetic
9. Authorization is mandated by the State of Minnesota

IMCare Utilization Review staff processes requests for Service Authorization. Utilization Review staff accepts requests for Service Authorization by fax or telephone. Faxed requests for IMCare Service Authorization are accepted on the IMCare Service Authorization Forms, which are available on the website.

Appropriate documentation for medical necessity is required for all requests. Refer to the appropriate covered services chapter for more information about specific documentation requirements, or contact IMCare Member Services at:

IMCare
1219 SE 2nd Ave
Grand Rapids, MN 55744
**1-800-843-9536** (toll free)
**218-327-5545** (fax)

Per MN Stat. sec. 62M.09, subd. 3, and in compliance with National Committee for Quality Assurance (NCQA) UM standards, a licensed physician reviews all cases in which the utilization review staff has concluded that the authorization criteria are not met. Under these circumstances, subsequent denials can only be made by a physician reviewer based on medical necessity determinations. The physician reviewer is licensed in the State of Minnesota and is reasonably available by telephone to discuss the determination with the attending health care professional.

*Approval and denial letters will be sent to the address provided on the authorization request form that was submitted by the provider.

**Previously Authorized Services for New Members**

IMCare follows established procedures for transitioning newly enrolled members. During the transitional process, IMCare considers the member's individual health concerns and existing services at the time of enrollment and makes efforts to seamlessly transition new members to contracted network providers for covered services. When considering requests for authorization for continued services from an out-of-plan provider, IMCare requires that new members transition their health care services to a participating provider, provided that such transition does not create undue hardship on the member and the transition is clinically appropriate. IMCare provides all members with medically necessary covered services that an out-of-plan provider, another

health plan, or the State had authorized before enrollment in IMCare. IMCare may require the member to receive the services by an IMCare provider, if such a transfer would not create undue hardship on the member and is clinically appropriate.

## Documentation Requirements

The criteria listed below are used by IMCare Utilization Review when processing requests for authorization. To merit authorization, the service must be all of the following:

1. Medically necessary, as determined by prevailing medical community standards or customary practice and usage
2. Appropriate and effective for the member's medical needs
3. Timely, considering the nature and present medical condition of the member
4. Provided by a provider with appropriate credentials
5. The least expensive, appropriate alternative available
6. An effective and appropriate use of IMCare funds

## Modifiers

If a modifier is required for a particular procedure code, the request for Service Authorization submitted to IMCare must include the modifier. Information on the approved authorization, including the procedure code(s) and the modifier(s), must match claim information for the service, or the claim will be denied.

## Out-of-Plan Providers

Except for emergency services, out-of-plan providers must obtain prior authorization before providing IMCare-covered services. Requests for prior authorization of services provided outside of the IMCare network or by non-contracted providers in or out of state must include documentation establishing medical necessity and the unavailability of that service in Minnesota or in the IMCare network. IMCare covered services provided to an IMCare member by an out-of-state, out-of-plan provider will be covered under the following circumstances:

1. The services are medically necessary;
2. The services are provided in response to an emergency while the member is out of the state and the provider is out of plan;
3. The services are not available in network or by an out-of-state contracted provider, and the attending physician has determined medical necessity and obtained prior authorization from IMCare. The cost to the member is no greater than it would be if the services were furnished in-network. (The county is responsible for travel expenses associated with obtaining the out-of-state services.); or
4. The services are required because the member's health would be endangered if he/she were required to return to Minnesota or to an in-plan or in-network provider for treatment.

There is an exception to the Service Authorization requirement for out-of-plan providers for members in MSHO/ IMCare Classic (HMO SNP). Non-contracted physician specialists are allowed to see members in this group without a Service Authorization. This exception for this group of members applies only to clinic or outpatient hospital office visits provided by physician specialists (example: cardiology, pulmonology, pediatric endocrinology, neurosurgeons, infectious disease specialists, rheumatologists, oncologists, gastroenterologists, dermatologists, plastic surgery, etc.) and diagnostic testing or laboratory services ordered by the same physician specialists.

## Out-of-Country Care

IMCare does not cover emergency or other health care services received from providers located outside the United States. For the purpose of this section, United States includes the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

## Notice of Action Taken

IMCare will notify the provider by telephone and in writing and the member, in writing, of action taken on an authorization request. IMCare Utilization Review will notify the provider if additional information is needed to determine medical necessity. If a request is denied, the member and provider will receive a notice of member's right to Appeal.

## Peer-to-Peer Conversation

IMCare professionals who conduct clinical review of Service Authorization requests are available to discuss review determinations with attending physicians or other ordering providers. This review can occur by telephone, in person, or by secure email. Providers who wish to discuss review determinations with the professional clinical reviewer should contact IMCare's UM department Monday – Friday, 8 a.m. – 4:30 p.m., at **1-800-843-9536** (toll free) to request a peer-to-peer conversation. The peer-to-peer conversation may be conducted by the physician who made the initial decision, or if that reviewer is not available, with another clinical peer within one business day of the request. This peer-to-peer conversation is not considered an Appeal.

## Availability of Utilization Management Criteria

The IMCare Utilization Management department uses the most current InterQual™ criteria, adopted clinical practice guidelines, Minnesota Department of Human Services (DHS) policies, State of Minnesota coverage policies, Centers for Medicare & Medicaid Services (CMS) national coverage determinations (dual eligible members only), local Medicare coverage determinations published by Wisconsin Physicians Service Insurance Corporation (dual eligible members only), and other IMCare approved medical policies in its authorization decisions. Criteria are available upon request of the practitioner. The practitioner may request the criteria either by phone, fax, email, or by written request sent via the United States Post Office. The criteria will be provided to the practitioner upon request through any of the distribution methods listed above or through either of the following methods:

1. In person
2. By telephone

## Appeals and Fair Hearings

If the request is denied or reduced, the member may Appeal the decision to IMCare Appeals and Grievances and/or request a fair hearing before a referee from the Minnesota Department of Human Services (DHS). To request a fair hearing, a member must contact the Appeals Unit at DHS.

Providers do not have the right to Appeal a denied request under the Department's fair hearing process. Providers may submit additional documentation and ask IMCare for a reconsideration of a decision.

This can be done by submitting an Appeal for Service to the IMCare Compliance Coordinator at 1-800-843-9536 ext 2183 or Appeal for payment to 1-800-843-9536 ext 2118. For more information about provider Appeals, please refer to your provider contract.

## Authorization List

- ***Applies only to Minnesota Health Care Programs (MA and MNCare).***
- ***Medicare-covered services do not require an authorization.***

New technology, investigative health services, etc., will always require Service Authorization. In addition, please refer to Chapter 13, Inpatient Hospital Notification and Authorization, for authorization requirements for inpatient hospitalizations. Some general information about certain categories of services is listed below. IMCare follows DHS policy of requiring authorization for certain services for which no Healthcare Common Procedure Coding System (HCPCS) cases are assigned.

All out-of-network services require prior authorization and referral from a network provider, except for the following:

- Urgent Care visits
- Emergency Department visits
- Certain diagnostics (e.g., specific laboratory tests and radiologic imaging)
- Open access services (family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases and testing for AIDS or other HIV-related conditions)
- Physical therapy (PT), occupational therapy (OT), speech therapy (ST)

The following services always require prior authorization (both in-network and out-of-network):

| Category | Service/Item |
|---|---|
| **Chemical Dependency** | Medication Assisted Therapy visits - Buprenorphine |
| | Medication Assisted Therapy visits - Methadone |
| **Cosmetic (potentially)** | Cervicoplasty |
| | Chemical exfoliation for acne |
| | Chemical Peel |
| | Correction of inverted nipples |
| | Correction of lagophthalmos |
| | Correction of lid retraction |
| | Cryotherapy for acne |
| | Dermabrasion |
| | Electrolysis epilation |
| | Excision of excessive skin and subcutaneous tissue |
| | Facial Osteoplasty |
| | Malar augmentation |
| | Mastectomy, Subcutaneous |
| | Mastopexy |
| | Otoplasty |
| | Planing of skin of nose |
| | Punch graft for hair transplant |
| | Removal of mammary implant |
| | Rhytidectomy |
| | Staged laser treatment |
| | Subcutaneous filling (collagen) |
| | Tattooing |
| **Diagnostics** | Capsule Endoscopy |
| | CT Colonography |
| **Durable Medical Equipment (DME)** | TENS Units |
| | All other DME/supplies > $1,000 |
| **Experimental/Investigational** | All |
| **Genetic Testing** | All |
| **Home Care** | All |
| **Inpatient Hospital** | Admission and Concurrent Review<br>• In-network: MNCare members only<br>• Out-of-network: MA and MNCare members |
| **Mental Health** | Children's Residential Treatment |
| | Dialectical Behavioral Therapy (DBT) |
| | Intensive Residential Treatment Services |

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| **Miscellaneous** | Autopsy for IUFD/stillborn or neonatal death (other autopsies not covered) |
| | Biofeedback for incontinence |
| | Community Paramedic Services |
| | New Technology |
| **Rehab** | Functional evaluation; physical performance test |
| **Screenings** | Screening Colonoscopy for members < 50 years old |
| | Screening Mammogram for female members < 40 years old |
| **Surgeries/Procedures** | Abdominoplasty/panniculectomy |
| | Bariatric/Weight Loss surgeries/procedures |
| | Blepharoplasty |
| | Breast implant removal |
| | Cholecystectomy w/transduodenal sphincterotomy or sphincterplasty |
| | Circumcision |
| | Electric stimulator (bone), implant |
| | Endoprosthesis for aorta repair |
| | Epidural Steroid Injection |
| | Experimental/Investigational surgeries/procedures |
| | Gynecomastia Surgery |
| | Keratoprosthesis |
| | Lipectomy (not cosmetic) |
| | Lung removal for lung volume reduction |
| | LVAD (left ventricular assistive device)/VAD (ventricular assistive device) |
| | Mandible, Coronoidectomy |
| | Maxilla, osteotomy |
| | Neurostimulator implant, subcortical |
| | Other surgeries/procedures listed under Cosmetic |
| | Paravertebral Facet Joint Injection/Medial Branch Block |
| | Penile implant insertion |
| | Percutaneous Neuroablation |
| | Ptosis repair |
| | Reconstructive surgeries/procedures |
| | Reduction Mammaplasty/ Breast Reduction (female or male) |
| | Refractive Surgery - LASIK(laser in situ keratomileusis), RK (radial keratotomy), corneal relaxing, corneal wedge resection, LRI (limbal relaxing incisions and CLR (clear lens replacement) |
| | Rhinoplasty |
| | Rosacea lesion destruction |
| | Sacroiliac Joint Injection |
| | Scar revisions (including keloid revisions) |
| | Sclerotherapy for spider veins |
| | Sclerotherapy for varicose veins |
| | SCS (spinal cord stimulator) insertion |
| | Sleep Apnea surgeries/procedures |

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| | Spinal Fusion |
| | Total Disc Arthroplasty (including revision and removal) |
| | Transcatheter Aortic Valve Replacement |
| **Transplants** | All |

**Dental Services**
It is essential that requests submitted for Service Authorization consideration be accompanied by adequate case information and appropriate diagnostic materials (e.g., radiographs of patient's current dental condition, prosthesis information, teeth to be replaced, prognosis for remaining dentition, complete six-point periodontal charting for cast metal partials). Refer to Chapter 19, Dental Services, for coverage guidelines and authorization.

**Vision Care Services**
Refer to Chapter 20, Eyeglass and Vision Care Services.

Contact lenses need Service Authorizations before they are provided to members without a diagnosis of Aphakia, Aniseikonia, Keratoconus, or Bandage Lenses.

Tints and polarized lenses require a Service Authorization before being provided.

IMCare does not require a Service Authorization before obtaining the second pair of eyeglasses in a 24-month dispensing period. Providers are only to dispense a second pair if the replacement criteria of receiving eyeglasses more frequently than every two years are met. The providers are still under the obligation of documenting the reason the second pair of eyeglasses was provided and of keeping that documentation in the member's medical record. Refer to Chapter 20, Eyeglass and Vision Care Services, for criteria.

**Medical Supplies and Equipment**
TENS units and all DME exceeding $1,000 require prior authorization.

**Face-to-Face Encounter for Some Durable Medical Equipment (DME), Effective October 1, 2013**
Section 302(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added Section 1834 (a)(1)(E)(iv) to the Act, which provides that payment may not be made for a covered item consisting of a motorized or power wheelchair unless a physician (as defined in section 1861[r][1] of the Act, or a physician assistant [PA], nurse practitioner [NP], or Clinical Nurse Specialist [CNS] as the terms are defined in Section 1861[aa][5] of the Act) has conducted a face-to-face examination of the beneficiary and written a prescription for the item.

The face-to-face encounter must be within six months before ordering or on the date of ordering. The documentation must show that the member was evaluated and/or treated for a condition that supports the DME item(s) ordered. Please refer to Chapter 23, Equipment and Supplies, of the IMCare ***Provider Manual***, for a complete list of the codes for face-to-face encounters.

Providers must get authorization for all equipment and supplies listed in Chapter 23, Equipment and Supplies, where authorization is indicated. Authorization is required for the following general areas:

1. All wheelchairs: When purchased, rented, or for use in nursing facilities.
2. Repairs (if parts and labor is more than $1000) to equipment: Specify who owns the equipment.
3. E1399 is the unspecified equipment code. This code is to be used only when no specific, descriptive HCPCS code is assigned.

**Prostheses and Orthoses**
Providers must request authorization for prostheses and orthoses (orthotics) when the cumulative cost exceeds $1,000.

**Hearing Aids**
Refer to Chapter 17, Rehabilitative Services, for specific information.

Services in the following categories require authorization:
1. Hearing aid systems regardless of price: hearing aid in glasses, contra lateral routing of signal (CROS) in glasses, bilateral contra-lateral routing of signal (BiCROS) in glasses, assistive listening device, pocket talker, device for use with cochlear implant
2. The provision of more than one hearing aid or hearing aid dispensing fee in a five-year period
3. The purchase of a hearing aid when pure-tone average is less than 25 dB HL in an adult and less than 20 dB HL in a child

**Drugs**
Refer to Chapter 22, Pharmacy Services, for a complete list of medication and pharmacy services provided through the pharmacy that need authorization. The list includes how we notify providers if a pharmacy item or medication is added to the Service Authorization requirement.

**Rehabilitative Services**
Refer to Chapter 17, Rehabilitative Services.

**All Other Services**
The following health services require authorization:
1. All air ambulance transportation that originates from or is to a destination outside of Minnesota **and** is to and/or from an out-of-network or out-of-plan provider
2. Investigative health services and procedures that may be considered cosmetic. If staged reconstructive surgery is being proposed for correction of a congenital anomaly, the complete plan for future surgeries must be submitted with the first authorization.
3. All surgical or behavioral modification services aimed specifically at weight reduction
4. Services provided outside of Minnesota. This requirement for prior authorization does not include emergency services. A Service Authorization **is** required before providing non-emergent services needed because the member's health would be endangered if the member were required to return to Minnesota. A Service Authorization is also required for services provided to children placed outside of Minnesota through the subsidized adoption assistance program under MN Stat. sec. 256B.055, subd. 1 or 2.

# Legal References

MN Stat. sec. 62M.09, subd. 3 – Staff and Program Qualifications; Annual Report: Physician reviewer involvement
MN Stat. sec. 256B.02 – Definitions
MN Stat. sec. 256B.04 – Duties of State Agency
MN Stat. sec. 256B.055, subd. 1 – Eligibility Categories: Children eligible for subsidized adoption
MN Stat. sec. 256B.055, subd. 2 – Eligibility Categories: Subsidized foster children
MN Stat. sec. 256B.093 – Services for Persons with Traumatic Brain Injuries
MN Stat. sec. 256B.0625 – Covered Services
MN Rules part 9505.0175 – Definitions
MN Rules part 9505.0215 – Covered Services; Out-of-State Providers
MN Rules parts 9505.0501 – 9505.0540 – Hospital Admissions Certification
MN Rules parts 9505.5000 – 9505.5105 – Conditions for Medical Assistance and General Assistance Medical Care Payment
Title 42 Code of Federal Regulations (CFR) Part 431.52 – Payments for services furnished out of State
42 CFR 440.230 – Sufficiency of amount, duration, and scope

MN Rules parts 9505.5000-9505.5105 – Conditions for Medical Assistance and General Assistance Medical Care Payment
Title 42 Code of Federal Regulations (CFR) Part 431.52 – Payments for services furnished out of State
42 CFR 440.230 – Sufficiency of amount, duration, and scope