MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Jackie Prokop

Director, Program Policy Division
Bureau of Medicaid Policy and Health System Innovation

Project Number:	1604-PA	**Comments Due:**	May 2, 2016	**Proposed Effective Date:**	July 1, 2016

Mail Comments to: Lisa DiLernia
Bureau of Medicaid Policy and Health System Innovation
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Telephone Number: 517-335-5117 **Fax Number**: 517-335-5136
E-mail Address: dilernial@michigan.gov

Policy Subject: New Form for Prior Authorization of Practitioner Services

Affected Programs: Medicaid, Healthy Michigan Plan, MI Child

Distribution: Medicaid Health Plans, Practitioners, Tribal Health Centers, Federally Qualified Health Centers, Local Health Departments, Rural Health Clinics

Policy Summary: The purpose of this bulletin is to incorporate the MSA-6544-B form into the prior authorization process for special services such as surgeries, procedures, office-administered pharmaceuticals or biologicals, and out-of-state care effective for dates of service on or after July 1, 2016.

Purpose: The Program Review Division (PRD) has requested that a standardized form be developed and utilized by providers as part of the prior authorization process to increase the efficiency in which prior authorization requests are processed.

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: Medicaid Health Plans, Practitioners, Tribal Health Centers, Federally Qualified Health Centers, Local Health Departments, Rural Health Clinics

Issued: June 1, 2016 (Proposed)

Subject: New Form for Prior Authorization of Practitioner Services

Effective: July 1, 2016 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MI Child

The purpose of this bulletin is to update the process for obtaining prior authorization (PA) for special services that require PA such as surgeries, clinical procedures, office-administered pharmaceuticals or biologicals, and out-of-state care. Effective for dates of service on or after July 1, 2016, requests for PA must be submitted to the Michigan Department of Health and Human Services (MDHHS) via Direct Data Entry (DDE) utilizing the Community Health Automated Medicaid Processing System (CHAMPS), or in writing, along with a completed Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B). All requests must include a completed MSA-6544-B form and supportive medical documentation. All other PA processes remain unchanged.

Written requests for PA utilizing the MSA-6544-B form may be submitted by mail or fax. The MSA-6544-B form may be retrieved from the Forms Appendix of the Medicaid Provider Manual or the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms.

PA requirements for Medicaid Health Plan enrollees may differ from those described in this bulletin. Providers are advised to contact the individual plans regarding their authorization requirements.

Michigan Department of Health and Human Services

Practitioner Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-6544-B must be used by Medicaid enrolled providers to request provider services that require prior authorization (PA) (e.g. out-of-state care and genetic testing).

MDHHS requests that the MSA-6544-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms. For information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
- For more detailed information on procedure codes refer to CHAMPS – External Links – Medicaid Code and Rate Reference.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 21	Indicate whether this is the first request for services or if this is a renewal request for ongoing services
Box 23	Enter a complete description of the services, procedures, lab test, etc. requested
Box 24	Enter the HCPCS Procedure Code.
Box 25	Enter the applicable HCPCS Modifier.
Box 26	Enter the quantity of the services requested. If an injectable drug is requested, indicate the number of billing units requested.
Box 27	Enter the dates for which the requested procedure or service will take place.
Box 28	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description)
Box 29	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 30	Check each box that corresponds to documentation included in the request. No request should leave all boxes unchecked.
Box 31	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

The status of a PA request may be reviewed in CHAMPS. For additional questions, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

Michigan Department of Health and Human Services

PRACTITIONER SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	3. NPI NUMBER		4. PHONE NUMBER
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)			6. FAX NUMBER
7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ **M** ☐ **F**	9. BIRTH DATE	10. MIHEALTH CARD NUMBER
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)			
12. HOSPITAL/ FACILITY NAME	13. HOSPITAL/ FACILITY NPI		
14. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)	15. NPI NUMBER		16. PHONE NUMBER
17. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)			18. FAX NUMBER
19. CONTACT NAME			20. CONTACT PHONE NUMBER - -
21. ☐ INITIAL REQUEST ☐ RENEWAL REQUEST			

22. LINE NO.	23. DESCRIPTION OF SERVICE	24. PROCEDURE CODE	25. MODIFIER	26. QUANTITY	27. ANTICIPATED DATE(S) OF SERVICE
01					
02					
03					
04					

28. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	29. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE ON THE DATE OF SERVICE.

30. Please identify all relevant clinical documentation that has been submitted to support medical necessity: *If this is an out-of-state request, in addition to clinical documentation, please include a letter of medical necessity that explains A) why services cannot be provided in state, B) what in-state services have already been exhausted, C) the plan to transition care back to the state of Michigan.*

☐ H&P ☐PROGRESS NOTES ☐CONSULTATIONS ☐LABS

☐PATHOLOGY REPORT ☐ OPERATIVE REPORT ☐ RADIOLOGY REPORTS ☐ PHOTOS ****INCLUDE PHOTOS FOR ALL COSMETIC AND RECONSTRUCTIVE SURGERIES**

☐ DISCHARGE SUMMARY ☐ LETTER OF MEDICAL NECESSITY ☐Other Diagnostics:_____

31. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE**: DATE: