# Professional Billing

## Prior Authorization

Claim Adjustment Reason Code: 16-The claim/service lacks information or has submission/billing error(s) that is needed for adjudication.

Remittance Advice Remark Code: M62-Missing/incomplete/invalid treatment authorization code.

*Effective October 1, 2023, per L 23-55 only services within this letter should be using Telephone: 1-844-PACERMI (1-844-722-3764) to obtain prior authorization. Refer to specific policy requirements in the MDHHS Medicaid Provider Manual (www.michigan.gov/medicaidproviders) for prior authorization processes for other services/items.

Policy: Medicaid Provider Manual Chapter “General Information for Providers” Section 10 Prior Authorization.

> There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization (PA). In order for Medicaid to reimburse the provider in this situation, MDHHS requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific chapter for PA requirements. (Refer to the Directory Appendix for contact information for PA.)
>
> PA may not be required if the beneficiary has Medicare or other insurance coverage. (Refer to the Coordination of Benefits Chapter for additional information.)

**10.1.A. FFS Direct Data Entry (DDE) in CHAMPS**

The CHAMPS PA system allows FFS providers to submit single PA requests through the online web portal. CHAMPS validates both beneficiary and provider information. An error message is returned to the user if the information is incorrect. Any provider may request PA, however, the provider NPI entered in the servicing provider field must represent the provider who will be rendering the service. Prior Authorization: Request

Once the PA request is successfully entered, the provider receives a tracking number. If the request is approved by MDHHS, this tracking number becomes the prior authorization number to use for billing purposes. The tracking number is not valid for claims unless a PA request is approved. Modifications to existing prior authorizations on file can be requested via fax to the Program Review Division. Private Duty Nursing providers with authorization on file for a beneficiary in the Children's Waiver Program or Habilitation Supports Waiver should contact the Community Mental Health Services Program (CMHSP) for assistance. (Refer to the Directory Appendix for contact information.)

Supporting documentation may be linked to a DDE PA request either through facsimile or electronically. For electronically submitted documentation, the DDE screen will open Internet

Explorer on the user's computer and allow the retrieval of the appropriate record to link to the PA request. The system limits each PA request to 10 document attachments; each attachment is limited to a maximum size of 100MB. For documents submitted via facsimile, CHAMPS generates a cover sheet pre-populated with the beneficiary's ID number and the tracking number of the request. The fax cover sheet contains the applicable fax number and must precede the documents being uploaded into CHAMPS. There is no system limit for the maximum number of pages for faxed documents.

PA Inquiry allows providers to check on the status of submitted PA requests or query on completed PAs on file. Up to seven (7) years of PA history is accessible to providers in CHAMPS. Prior Authorization: Inquiry

**Chapter "Practitioner" 1.9 Prior Authorization**

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA in the Medicaid Code and Rate Reference tool. Medicaid Code and Rate Reference Tutorial
- Procedures/items that are normally non-covered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.).
- Referrals for elective services by out-of-state non-enrolled providers