

Precertification Review Activities

The Mississippi Division of Medicaid (DOM) requires precertification of outpatient physical and occupational therapy and speech pathology services proposed to be rendered to Mississippi Medicaid beneficiaries. HSM is DOM's precertification review contractor to perform utilization and quality review of outpatient therapy services.

Objectives of Precertification Review are to:

- Ensure medically necessary therapy is provided to beneficiaries
- Control over utilization of therapy services
- Ensure appropriateness of services
- Avoid duplication of services (for areas administered by DOM and across state agencies)

Outpatient PT/OT/SLP therapy services include the following:

- Comprehensive evaluation
- Individual treatment
- Group therapy (speech language pathology only)
- Design, construction and fitting of an adaptive device

Outpatient PT/OT/SLP Therapy Review Inclusions

Services requiring Precertification by HSM are as follows:

- Therapy services provided to beneficiaries under age 21 in the office or clinic of a physical therapist, occupational therapist, or speech language pathologist (individual or group practice).

Note: Services are not covered in the above settings for beneficiaries age 21 and over.

- Therapy services provided to beneficiaries (adult and children) in the outpatient department of the hospital.
- Therapy services provided to beneficiaries under age 21 in a physician's office or clinic (individual or group). This is also applicable to physician assistants and nurse practitioners.

Note: Services are not covered in the above settings for beneficiaries age 21 and over.

- Therapy services provided to beneficiaries under age 21 through the following providers:
 - Rural Health Clinics (RHC)
 - Federally Qualified Health Centers (FQHC)
 - State Department of Health

Note: Services are not covered in the above settings for beneficiaries age 21 and over.

- Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted.

Services are rendered in the following settings:

- Hospital outpatient
- School – (those services not billed by school provider)
- Home- (those services not provided through home health agencies)
- Clinics
- Individual offices

Outpatient PT/OT/SLP Therapy Review Exclusions

Precertification of therapy services provided to beneficiaries is not required:

- Beneficiaries who are residents of a nursing facility regardless of setting.
- Beneficiaries who are residents of intermediate care/mental retardation facilities (ICF/MR) regardless of setting.
- Beneficiaries in hospice regardless of setting.
- Beneficiaries in a Home and Community Based Service (HCBS) waiver program.
- Therapy Services billed by a school provider.
- Beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.

Staff at HSM

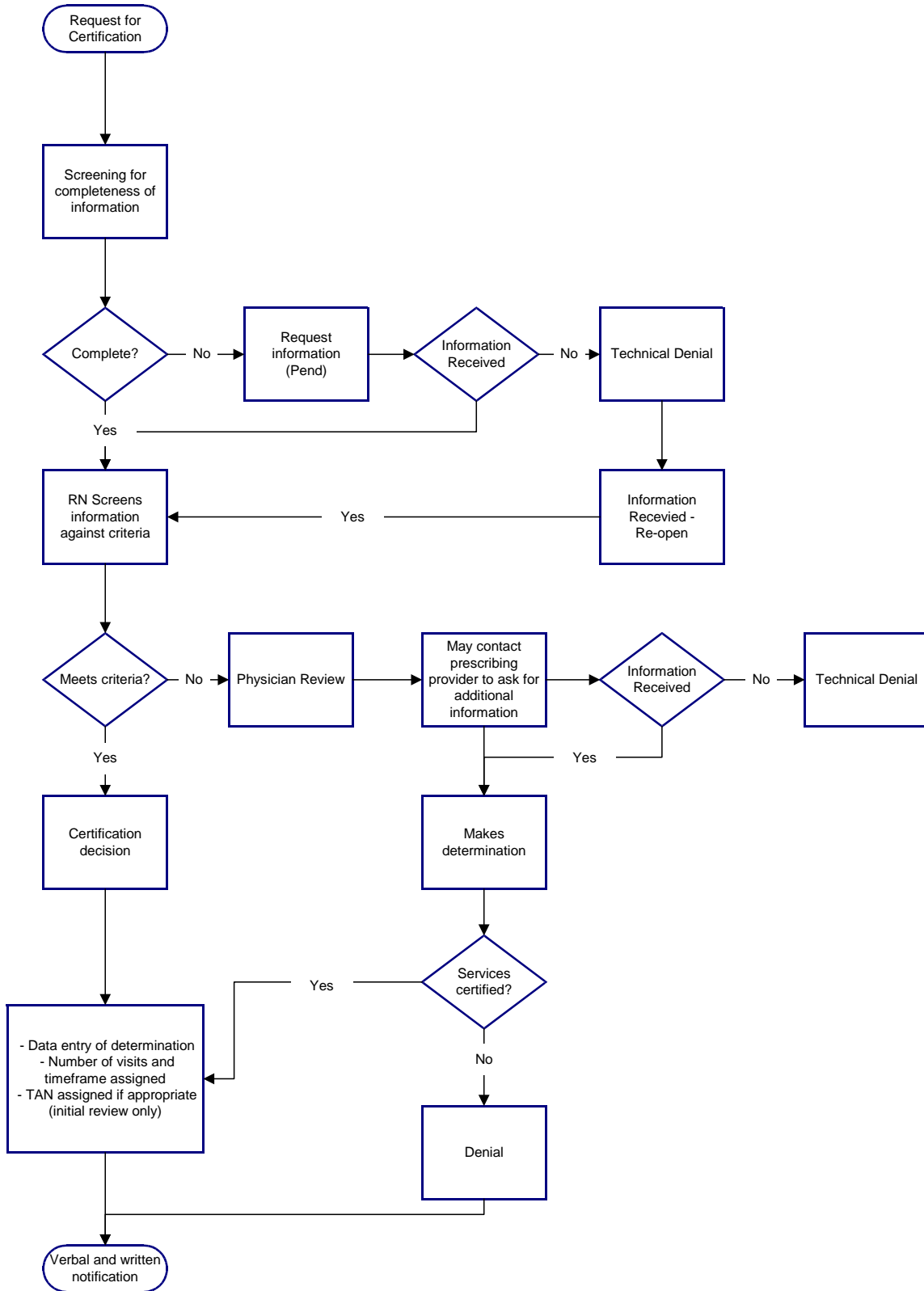
HSM's clinical staff, composed of registered nurses, physical and occupational therapists, and speech-language pathologists and physicians make certification review determinations on review requests for outpatient services as described below:

Staff	Functions
Registered Nurses Therapists	<ul style="list-style-type: none"> ➤ Apply DOM policy ➤ Apply explicit medical review criteria ➤ Apply quality of care screens ➤ Approve services based on policy or criteria, or ➤ Refer requests that cannot be approved for physician determination
Physician Reviewers	<ul style="list-style-type: none"> ➤ Make determinations based on medical practice standards and his or her clinical experience and judgment ➤ Perform reconsideration reviews for any denial decisions
Non-clinical Support Staff	<ul style="list-style-type: none"> ➤ Screen the request for completeness of non-clinical information ➤ Perform verbal notification of review determination, as appropriate ➤ Support all review functions

Overview of the review process

(A flow chart of the process is included for your reference).

- Providers submit a request to HSM in accordance with specific timeframes based on the Review Type. (Timeframes are provided in the Review Types and Submission Procedures section of this manual.)
- HSM will notify the requester when a request is incomplete or if additional administrative information is required and allow specific timeframes for submission of the information.
- If the requested information is not submitted, HSM will issue a Technical Denial.
- Upon receipt of a complete precertification request and all required administrative documentation, HSM's registered nurse and therapist reviewers assess the request for completeness of clinical information. If additional clinical information is required, the review request will be pended and the information will be requested from the provider.
- If the requested information is not submitted, HSM will end (suspend) review of the request.
- Upon receipt of complete clinical information, HSM's registered nurse and/or therapist reviews the clinical information and determines whether the requested services meet DOM's Policy, whether medical necessity criteria is met, and whether potential quality of care concerns are present.
 - The nurse or therapist may approve (certify) services that meet DOM policy and medical review criteria.
 - Request for services that do not meet DOM policy or medical review criteria are referred for physician review.
 - Every request is screened for quality of care. See the Quality Screening policy and procedure.
 - Physician reviewers review the requests for service that are referred by registered nurses or therapists.
 - The physician reviewer may approve (certify) services as requested, may modify the request, or may deny all or part (partial denial—retrospective only) of the requested services.
 - Prior to making a denial determination, HSM's physician reviewer attempts to contact the prescribing provider to discuss the case.
 - Written and verbal (if the provider is unable to receive auto-fax) notification of approval review results is sent to providers. Denial determinations are sent to the beneficiary/representative, and providers.
 - Any party to a denial may request reconsideration of the determination as described in HSM's Reconsideration Process policy and procedure.
 - If HSM upholds the denial on reconsideration the beneficiary can then request an Administrative Appeal from DOM. (See the Reconsideration Process section of this manual for additional information.)



Submitting a Review Request to HSM

Prior to submitting a review request to HSM, the provider must verify the beneficiary's eligibility for Medicaid by contacting the Division of Medicaid's fiscal agent. It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. In addition to verifying the beneficiary's eligibility, the following age specifications need to be verified prior to submitting a request to HSM.

Age Specifications

- Children and adolescents are covered through the last day of the birthday month of the year they reach twenty-one (21).
- Medicaid covers infants born to a mother who is Medicaid eligible at the time of the baby's birth through the first year of life provided he/she remains in the household of the mother. These requests may be submitted under the mother's Medicaid number with a "K" suffix until the baby is assigned its own number. The baby is covered for one year after birth even if the mother loses her eligibility.
- Adults (age 21 and older) are eligible for outpatient PT/OT/SLP services when therapy services are determined to be medically necessary and performed in the hospital outpatient setting.

Once eligibility and age specifications have been verified, a review request may be submitted to HSM. The following table describes the review types and the procedures to follow for submitting each review type to HSM. Specific timeframes have been established for submission of review requests to HSM. It is imperative that the requesting provider submits the required documentation to HSM at the same time as and along with the completed Certification Request Form.

Review Types and Submission Procedures	
Review Type	Procedures
<p>Initial precertification request: Outpatient PT/OT/ SLP providers should submit this type of request at least 3 business days prior to initiation of outpatient services and after the evaluation visit.</p> <p>In rare instances where urgent or same day/non-urgent PT/OT/SLP services are provided the following applies: Outpatient PT/OT/SLP providers are required to request certification on the next business day. Business days are defined as Monday through Friday, excluding official state holidays.</p>	<p>Submit the following to HSM:</p> <ul style="list-style-type: none"> ➤ HSM Medicaid Outpatient PT/OT/SLP Precertification Request Form. ➤ Certificate of Medical Necessity (CMN) Form ➤ HSM Evaluation/Re-Evaluation Form ➤ HSM Plan of Care (POC) Form
<p>Concurrent Request: Outpatient PT/OT/SLP providers should submit this type of request when prior services have been certified and additional services are needed. The request should be submitted on or before the last certified day.</p>	<p>Submit the following to HSM:</p> <ul style="list-style-type: none"> ➤ HSM Medicaid Outpatient PT/OT/SLP Certification Request Form. ➤ Current POC (dated within the last 6 months) Documentation of patient’s progress toward achieving goals or modification of goals (this should be reflected in the POC). ➤ If a re-evaluation has been performed, submit a completed HSM Evaluation/Re-evaluation Form for review and an updated HSM POC form. ➤ Therapy notes from the last visits prior to request for concurrent review.

Review Types and Submission Procedures (continued)	
Review Type	Procedures
<p>Retrospective Review: Outpatient PT/OT/SLP providers should submit this type of request when the beneficiary was not eligible at the time of admission but has since received a retroactive eligibility status.</p> <p>HSM will conduct retro review of cases with dates of service older than (1) year ONLY in the following situations:</p> <ul style="list-style-type: none"> ➤ The patient’s Medicaid eligibility was retroactively established and the request for certification was received within (1) year of the eligibility determination date. ➤ The patient was determined to be retroactively Medicaid eligible at the time of admission and the outpatient PT/OT/SLP provider submits proof that the claim was filed with the fiscal agent in a timely manner by submitting the Transaction Control Number (TCN) assigned to the claim. <p>If all or parts of the requested services are denied during retrospective review, the provider has the right to request a reconsideration of the denied services.</p> <p><i>NOTE: Cases not meeting the above criteria are not eligible for certification and should not be submitted to HSM for review.</i></p>	<p>Submit the following to HSM:</p> <ul style="list-style-type: none"> ➤ HSM Medicaid Outpatient PT/OT/SLP Precertification Request Form. The PT/OT/SLP provider must clearly state the reason for the retrospective review on the request form. ➤ A copy of the complete outpatient PT/OT/SLP medical record including therapy notes.

The following table depicts the timeframes and documentation requirements for submitting a request for services.

Precertification, Concurrent and Retrospective Review Timeframes			
Activity	Timeframes		
	Admission	Continued Stay	Retrospective
Provider will submit a request to HSM	Request must be received at least three (3) working days prior to initiation of service –after evaluation completed	Request must be received on or before the last certified day	Only done when beneficiary was not Medicaid eligible at the time therapy was provided. Within one (1) year of the retroactive Medicaid eligibility determination
Length of time provider given to submit additional information	Within three (3) business days of HSM's request for additional information	Within one (1) business day of HSM's request for additional information	Within ten (10) business days of receipt HSM's request for additional information
HSM will issue a Technical Denial	Close of business on the working day that the additional information is due and not received (Given three (3) days to submit)	Close of business on the working day that the additional information is due and not received (Given one (1) day to submit)	Close of business on the working day that the additional information is due and not received (Given ten (10) days to submit)
Written and verbal (if no auto-fax) notification to provider of review determination	Within two (2) business days of receipt of review request and all necessary information	Within two (2) business days of receipt of review request and all necessary information	Within twenty (20) business days of receipt of all necessary information
Written notification to provider of review determination	Within one (1) business day of verbal notice	Within one (1) business day of verbal notice	Within one (1) business day of verbal notice