Frequently Asked Questions for
Suspension of Prior Authorizations or Continued Stay Reviews and Clinical Requirements for Some Medicaid Programs Provider Notice Effective April 23, 2020

1. **I don't see my program listed in the Prior Authorization notice. What does this mean?**
   The program then falls under the third paragraph in bolded language where, for the duration of the COVID-19 epidemic, prior authorization and continued stay reviews are lifted but clinical criteria in rule will remain in place:
   For most Montana Medicaid programs, prior authorization and continued stay reviews are lifted for the duration of the epidemic but clinical criteria in rule will remain in place. It is the responsibility of the provider to document the clinical criteria.

2. **My program is included in #1 of the Prior Authorization notice. What does this mean?**
   For the duration of the COVID-19 epidemic, prior authorization and continued stay reviews are still required.

3. **My program is included in #2 of the Prior Authorization notice. What does this mean?**
   For the duration of the COVID-19 epidemic, prior authorization, continued stay reviews, and clinical criteria in rule are not required.

4. **What is an example of span billing for multiple days?**
   Generally, providers who have, for example, residential services, billed Medicaid for a span of time the person is in services, i.e., they may bill weekly. The date span billed on a claim for this example would be 01/01/2020 to 01/07/2020 for seven days rather than having seven separate lines for the same procedure.

5. **I submitted a claim for a service that does not require a prior authorization, but my claim denied for no prior authorization. What does this mean?**
   You will need to resubmit your claim. If you believe your claim denied in error, please contact the appropriate division listed at the bottom of this page.

6. **I submitted a prior authorization or a continued stay review request for a service and I received the following message from Mountain Pacific Quality Health. What does this mean?**
   Please refer to the State of Montana provider noticed dated 4/22/2020 where certain prior auth requirements are suspended during the public health crisis. The provider notice can be found here:

https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2020PN/provnoticesuspensionofPAorContinuedStayReviewsandClinicreqforsomemedicaidprograms04222020.pdf.
For services that have the prior authorizations/continued stay reviews suspended: Please do NOT submit further requests for this service as all will be marked No Review Required.

The prior authorization has been lifted for the service you submitted, and no further action is required. Please submit your claims for payment without a prior authorization number. If you have any issues processing, refer to the provider notice to contact the appropriate Division to help you with your claim.

7. **I submitted a prior authorization or a continued stay review request for a service and I received the following message from Telligen. What does this mean?**
We are closing this case as No Review Required due to provider notice of Suspension of Prior Authorizations or Continued Stay Reviews and Clinical requirements for Some Medicaid Programs that can be found here: https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2020PN/provnoticesuspensionofPAorContinuedStayReviewsandClinicreqforsomemedicaidprograms04222020.pdf.

   The prior authorization has been lifted for the service you submitted, and no further action is required. Please submit your claims for payment without a prior authorization number. If you have any issues processing, refer to the provider notice to contact the appropriate Division to help you with your claim.

8. **Private Duty Nursing (PDN) is considered an EPSDT service, does that mean prior authorizations are still required for PDN services?**
   Yes, for the duration of the COVID-19 epidemic, prior authorization and continued stay reviews are still required for PDN services.

9. **What about existing DME prior authorizations? Will providers use the authorization they may already have on file for the remaining months for a Durable Medical Equipment (DME) capped rental item until it meets the purchase price?**
   Providers may continue the use of prior authorizations they may already have for DME items, however, any claims with a date of service on or after April 23, 2020 do not require a prior authorization on the claim if reimbursement is under $5,000.00.

10. **How do providers handle prior authorizations for DME items such as ventilators that do not ever meet a purchase price and continue renting for however long the patient needs it?**
    Providers do not need to obtain a prior authorization for capped rental items that do not ever meet a purchase price such as ventilators as long as the claim reimbursement is not greater than or equal to $5,000.00. Providers are expected to follow the coverage criteria as it is outlined under Covered Services in the DMEPOS Provider Manual .

11. **How long will this revised DME policy last? Is there a projected end date?**
    Providers are encouraged to watch for notices posted on the Montana Healthcare Programs Provider Information Website.

12. **Members on ventilators are those who are the most immuno-compromised, many will not go see a physician at this time. What type of clinical record is required?**
    Providers are strongly encouraged to take advantage of Telemedicine/Telehealth at this time. Documentation of Telemedicine/Telehealth visits must be documented in the medical record. Please see the provider notice posted March 27, 2020 Medicaid Coverage and Reimbursement Policy for Telemedicine/Telehealth.

13. **For members requiring continuation of rental items for DME, if there is no change in the member's condition can the provider use the last visit as documentation for continued use?**
    Providers are reminded that all documentation requirements for continued use remain the same. If the requirement states, there must be a 90 day follow up visit, the use of Telemedicine/Telehealth is appropriate.

14. **Will DME suppliers have to submit supporting documentation to the Department or Mountain-Pacific Quality Health for approval for items that no longer require prior authorization?**
    In most cases, providers do not need to submit any documentation for approval. Supporting documentation will still be required for items that are reimbursed over $5,000.00 so the Department's utilization review professionals at Mountain-Pacific Quality Health can review for medical necessity. All other items must follow the documentation requirements as posted on the CMS website. Providers must clearly document in the members medical record all required information.

15. **If there is no authorization required for DME items, how is payment handled?**
    Claim adjudication will be the same as any item that previously did not require prior authorization. Montana Healthcare Programs will not be denying claims for lack of prior authorization for claims that previously required prior authorization numbers if the reimbursement is under $5,000.00. If you feel your claim was denied inappropriately during this time, contact Provider Relations at (800) 624-3958.

16. **If the prior authorization requirements are changed in the future and a different threshold is established, are members required to start the process over or have an in person visit to continue the use of DME items already in use?**
    Providers are encouraged to watch for notices posted on the Montana Healthcare Programs Provider Information Website for any upcoming changes for prior authorization requirements. Please keep in mind, providers are required to make available documentation related to the rental of a DME item as requested by the Department.

17. **If the prior authorization requirements change in the future will the providers be able to submit a telehealth visit from the previous month(s) to get an authorization to move forward?**
    Providers are encouraged to watch for notices posted on the Montana Healthcare Programs Provider Information Website for any upcoming changes for prior authorization requirements. Telemedicine/Telehealth visits will be treated just as an in person visit if clearly documented in the medical record so long as such services are medically necessary and clinically appropriate for delivery via telemedicine/telehealth.

18. **What do providers do or document on the delivery ticket/proof of delivery ticket for DME items if they are unable to obtain a signature?**
    Montana Healthcare Programs will be following the CMS signature requirements for DME when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.

19. **Will emergent ambulance transports continue to require retrospective review and approval of medical necessity?**
    Yes, medical necessity review is still required. Continue to submit ambulance trip reports to the Department's utilization review professionals at Mountain-Pacific Quality Health through the Qualitrac portal within 180 days of the date of service.

20. **Will non-emergent planned uses of ambulance continue to require prior authorization?**
    Yes, planned use of ambulance is considered Non-Emergency Medical Transportation and prior authorization is still required. Call the ambulance line at 877-362-5861 for prior authorization.

21. **Are there any changes that impact Ambulance providers?**
    No, it is business as usual for ambulances.

22. **Will ambulance providers continue to need a 10-digit prior authorization number to bill all Medicaid ambulance cases?**
    Yes, Ambulance providers will need to continue submitting cases for review into the Qualitrac Portal, obtaining a 10-digit prior authorization number on those approved, and then submitting with the prior authorization number to Conduent for claims processing.

23. **Prior to the temporary suspension of prior authorizations for some Medicaid programs, extended prior authorizations were approved initially for 120 days and an additional 90 days for continued stays. Now that the prior authorizations for some services have been suspended, how long do the services have to meet medical necessity?**
    Services that do not require a prior authorization but continue to meet medical necessity will remain approved for the duration of the COVID-19 emergency, i.e., the 120-day initial approval and 90-day continued stay limits can be disregarded.

The Department is working on and will provide a transition plan before prior authorizations are reinstated once the COVID-19 emergency has been declared terminated.

Contact Information

Katie Hawkins, Health Resources Division, email khawkins@mt.gov or telephone (406) 444-0965
Jackie Jandt, Addictive and Mental Disorders Division, email jjandt@mt.gov or telephone (406) 444-9656
Rebecca Corbett, Developmental Services Division, email rcorbett@mt.gov or telephone (406) 444-2748
Micky Brown, Senior and Long Term Care Division, email mbrown2@mt.gov or telephone (406) 444-6064

For claims questions or additional information, contact Montana Provider Relations at (800) 624-3958 or (406) 442-1837 or email MTPRHelpdesk@conduent.com.
Visit the Montana Healthcare Programs Provider Information website at https://medicaidprovider.mt.gov.