Prior authorization or pre-certification serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit DOM to require authorization for any service where it is anticipated or known that the services could either be abused by providers or beneficiaries or could easily result in excessive, uncontrollable Medicaid costs. Certification as referred to in this policy is synonymous with prior authorization.

Pre-certification of certain outpatient therapy services is required by the Division of Medicaid. Providers must prior authorize/pre-certify the therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. Failure to obtain prior authorization will result in denial of payment to the providers billing for services.

The UM/QIO will determine medical necessity, the types of therapy services, and the number of units reasonably necessary to treat the beneficiary's condition. Providers should be aware that the frequency of visits provided by the therapist should match the Plan of Care signed by the physician. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.

Pre-certification for outpatient therapy services is only required for certain CPT codes when the services fall into one of the following categories:

- Therapy services provided to beneficiaries under age twenty-one (21) through the EPSDT Expanded Services program by individual therapists in offices or therapy clinics. Services provided to adult beneficiaries age twenty-one (21) and over are not covered in individual therapist's offices or clinics.

- Therapy services provided to beneficiaries (adult and/or children) in the outpatient department of hospitals.

- Therapy services provided to beneficiaries under age twenty-one (21) in physician offices/clinics. Services provided to adult beneficiaries age twenty-one (21) and over are not covered in physician offices/clinics.

- Therapy services provided to beneficiaries in nursing facilities.

- Therapy services covered under regular State Plan benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program.

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

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

- Therapy services billed by school providers.

A complete list of CPT codes that require pre-certification may be obtained from the UM/QIO.

Exclusions to Prior Authorization/Pre-certification

Pre-certification is **not required**, regardless of the CPT codes used, when the services fall into one of the following categories:

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- Therapy services provided to beneficiaries enrolled in a hospice program
- Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted

Prior Authorization Request

Processes related to certification and recertification of therapy services must be handled in accordance with the procedures set forth in the UM/QIO therapy manual.

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Therapy providers must use standardized forms provided by the UM/QIO. Required forms include the following:

- Pre-certification Review Request
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Urgent Services

In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate hospitalization, moderate impairment to bodily function, serious dysfunction of a bodily organ or part, or other serious medical consequences. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

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Review Outcomes

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. If the criteria are met for therapy, a Treatment Authorization Number (TAN) will be assigned for billing purposes. If the criteria are not met or the review outcome results in a denial, written notification will be sent to the beneficiary/representative, therapy provider, and prescribing provider.

Reconsideration Process

The beneficiary, therapy provider, or prescribing provider may appeal a utilization review denial to the UM/QIO through the reconsideration process outlined in the UM/QIO manual.

Administrative Appeal

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