DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

DMAP General Policy Manual: Utilization Control – Prior Authorization

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Delaware Medical Assistance Program Provider Specific Policy Manual - General Policy Manual related to Prior Authorization. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the March 2010 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by March 31, 2010 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed revises the Division of Medicaid and Medical Assistance (DMMA) policy for Prior Authorization. This rulemaking is required to clarify what prior authorization is and how the DMMA uses prior authorization to determine eligibility to receive services and to determine that services are medically necessary.

Statutory Authority

- Social Security Act §1902(a)(30)(A) mandates that states "provide such methods and procedures relating to the utilization of, and payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services."
- 42 CFR §440.230(d), *Sufficiency of amount, duration, and scope* provides that a state "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."
- 42 CFR Part 456 addresses *Utilization Control,* including methods and procedures relating to the utilization of, and the payment for, care and services.

Summary of Proposal

The purpose of this rule is to adopt revised prior authorization procedures and criteria to ensure that the Delaware Medical Assistance Program (DMAP) prior authorization process follows sound fiscal practices, meets the medical needs of the State's vulnerable population, and promotes a collaborative partnership with our DMAP providers, while holding all parties involved accountable for their role in the process.

The proposed rule, identified in the DMAP General Policy Provider Manual, primarily removes detailed prior authorization criteria for specific categories of services and procedures from General Policy as prior authorization criteria already exists in each of the service's own dedicated provider policy specific manual. The intent is to improve the logical organization of the prior authorization policy set and eliminate duplication of content and inconsistency; and, make corresponding adjustments to the rule text, as appropriate.

Fiscal Impact Statement

These revisions impose no increase in cost on the General Fund.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

The Governors Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) have reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) proposal to amend a Medicaid prior authorization "policy" published s 13 **DE Reg.** 1166 in the March 1, 2010 issue of the *Register of Regulations.* Specifically, the Division proposes to delete an existing policy with specific standards in favor of revising a general policy which then cross references 16 separate policy manuals (§1.21.6). We have the following observations.

First, DMMA is required to issue its standards as regulations in conformity with the Administrative Procedures Act. See Title 29 **Del.C.** §§10161(b), 10111, and 10113. The preface to the proposal indicates that DMMA is amending "the Delaware Medical Assistance Program (DMAP) General Policy Provider Manual." At 1166. The preface then invites comments on "the proposed new regulations". Id. Unfortunately, it is, at best, unclear that the Manual is a regulation.

The Delaware Administrative Code is available on-line and contains an index for "Title 16 Health & Social Services" at http://regulations.delaware.gov/AdminCode/titlel6/index.shtml. The index lists DDDS, DLTCRP, DPH, DSS, and DSAMH, but not DMMA. The DSS site includes the DSSM (containing Medicaid regulations) but does not include DMAP provider manuals. If someone accesses the DHSS website, clicks DMMA, and then clicks "regulations", you are referred to the Administrative Code (which lacks a DMMA entry) and the DSSM. Only if you click "manuals", then "downloads", then "manuals" again on the DMMA website will you discover the 186-page General Provider Manual and thirty-one (31) policy provider specific manuals containing a host of prescriptive, substantive standards. See attachment.

There are multiple problems with this system:

A. The manuals should be adopted as regulations consistent with the APA since they contain many substantive standards. If they are regulations, they should appear in the Administrative Code.

B. The manuals are very difficult to locate without an extensive search.

C. If the manuals are not regulations, they can be changed without the benefit of publication for public comment.

Agency Response: The Delaware Administrative Procedures Act is the process that allows for notice to providers prior to making changes and gives providers the opportunity to provide input prior to implementation. The proposed defines a matter of significant interest to the public as an agency action regarding a matter that the agency knows to be of widespread citizen interest. Therefore, in the interest of due process (fairness) and public participation (notice and comment), DHSS/DMMA initiated this rulemaking through the Administrative Procedures Act (APA) process.

Since publication of the first *Delaware Register of Regulations* in 1997, the Delaware Medical Assistance Program (DMAP) has long utilized the public notice and comment process for changes to the content of provider manuals for almost thirteen (13) years. Specifically, Prior Authorization (PA) requirements were addressed approximately thirty-four (34) times since the inception of the *Delaware Register* in July 1, 1997. Revisions to prior authorization criteria first appeared in the November 1, 1997 issue; and, the most recent publication in the *Register's* December 1, 2003 issue.

Prior authorization (PA) is a utilization control process used by DMAP as a tool to control inappropriate or unnecessary spending in this program. Looked at in the larger context, the provider manuals are not to be viewed as a sole source stand-alone resource. As noted in the DMAP Contract for Services, which incorporates the provider manuals by reference, providers agree to "…abide by the rules, regulations, policies and procedures of the DMAP, and to comply with all the terms, conditions, and requirements as set forth herein…" From time to time, program policies will change. DMAP will send the provider notification in the form of bulletins and revised manual pages. Upon publication of those revised manual pages, the contract between providers and DMAP is amended. The DMAP provider manuals are best used in combination with other resources, including provider informational bulletins, provider alerts, other DMMA manuals and other types of communications.

The proposed changes to the Prior Authorization (PA) criteria is a clarification that more clearly sets forth how

DHSS/DMMA uses prior authorization to determine eligibility to receive medically necessary services; that prior authorization requirements are identified in the Delaware Medical Assistance Program Provider Manuals; and, that reimbursement is contingent upon following proper prior authorization instructions and approval. Therefore, in the interest of public participation, DHSS/DMMA initiated changes to this process through the public notice and comment process.

The intent of this public notice and comment process was to provide affected providers a voice in shaping this regulatory requirement. Much can be learned in this public process and often final order regulations provide necessary clarification and reasonable adjustments as a result of the comment period. Although this comment is outside the scope of the proposed regulation, to address the use and efficiency of the DMAP website as a resource, DMMA will consider your comments when making future improvements.

No change to the regulation was made as a result of these comments.

Second, Section 1.21.6 contains a list of sixteen (16) contexts in which prior authorization is required. However, it also recites that the list is "not all-inclusive" and directs the reader to the 21 manuals for more specific information. This is not very informative or "user-friendly". A Medicaid beneficiary will often be unable to determine whether prior authorization is required due to the "maze" of standards and the catch-all recital that the list is "not all-inclusive." A provider who fails to obtain prior approval when required by these obtuse standards is not paid. See §1.21.2. The unpaid provider may then pressure the beneficiary to pay. Although an informed Beneficiary could rely on §1.16.1 protections, this presupposes the beneficiary somehow locates the manual. Moreover, providers can nevertheless pressure payment through other means (e.g. threatening to "drop" as patient).

Agency Response: The proposed Prior Authorization rule contains major categories of services and is not intended to encompass all possible services that may require prior authorization. The absence of any service from this rule shall in no way be construed to indicate non-coverage just as inclusion imply a guarantee of coverage.

If a service beyond that described in the proposed regulation is medically necessary, documentation substantiating the need for the service or treatment is all that is required.

Although, there are numerous potential ways to reasonably present information to users, DMMA finds the DMAP website usable in the context of accessibility, layout/appearance and website navigation. As indicated in the "agency response" above, DMMA will consider your comments when making future improvements, including creating a link to access information regarding "Members Rights & Responsibilities" for DMAP recipients.

No change to the regulation was made as a result of these comments.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the March 2010 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Delaware Medical Assistance Program Provider Specific Policy Manual - General Policy Manual related to Prior Authorization is adopted and shall be final effective June 10, 2010.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #10-24
REVISIONS:

~~The practitioner must request prior authorization before a payment can be made (refer to Appendix M of this manual for required forms related to DMMA prior authorization). If prior authorization is granted, the billing provider will receive notification of the prior authorization number. The following services require prior authorization:~~

~~1.21.1 Private Duty Nursing~~

~~1.21.1.1 The DMAP may cover private duty nursing for clients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.~~

1.21.1.2 The DMAP may cover private duty nursing services for Medicaid clients who are exempt from managed care coverage.

1.21.1.3 All requests for private duty nursing must be prior authorized. (Refer to section 2.3 of this manual for procedures and refer to section 8.0 of this manual for required forms related to Diamond State Partners [DSP]).

1.21.1.3.1 Private duty nursing services for clients who are eligible for the Elderly and Disabled HCBS waiver or the Assisted Living Medicaid Waiver program, or the Acquired Brain Injury Waiver must be prior authorized by the nursing staff of the Division for Services for Aging and Adults with Physical Disabilities (DSAAPD). See the back of the General Policy for the appropriate address or telephone number.

1.21.1.3.2 All other requests should be directed to the Medical Review Team located in the Robscott Building (see Index in the back of General Policy for address and telephone number).

1.21.2 Pharmaceuticals

1.21.2.1 Certain pharmaceuticals require prior authorization. For further information refer to the Pharmacy or Practitioner Provider Specific Policy Manual.

1.21.3 Prescribed Pediatric Extended Care

1.21.3.1 The DMAP will cover Prescribed Pediatric Extended Care (PPEC) for medically and/or technology dependent children who can be maintained in the community as an alternative to inpatient hospital or nursing home care when supported by PPEC.

1.21.3.2 PPEC provides up to twelve hours of care daily (Monday through Friday) at the PPEC facility upon prescription from a child's primary General Policy Provider Policy Manual physician, thus allowing a child to obtain necessary medical services and monitoring without institutionalization.

1.21.3.3 PPEC services are authorized based on the level of nursing care and rehabilitative therapy needed.

1.21.3.4 The prescribing practitioner may request prior authorization by sending a letter with the following information to Medicaid's Physician Consultant:

1.21.3.4.1 Name of patient.

1.21.3.4.2 Patient's Delaware Medical Assistance ID number.

1.21.3.4.3 Date of birth.

1.21.3.4.4 Detailed medical history that documents the need for PPEC services.

1.21.3.4.5 Documentation that the child would require inpatient hospital or nursing home care in the absence of PPEC services.

1.21.3.4.6 Estimated amount and duration of required services (the number of days per week and the number of weeks/months that the patient is expected to need these services).

1.21.3.4.7 If home health services or private duty nurse services are ordered concurrently with PPEC, medical justification for the combination of services is required.

1.21.3.4.8 Name and address of the PPEC organization which will provide the care.

1.21.3.5 Reserved

1.21.3.6 All requests should be directed to the Medical Review Team located in the Robscott Building (see Index in the back of this manual for address and telephone number).

1.21.4 Out of State Services (Excluding Transplants)

1.21.4.1 All services provided outside of Delaware *require* prior authorization for payment, except for services from the following providers in New Jersey, Pennsylvania, Maryland, or the District of Columbia:

NOTE: DMAP clients are required to receive prior authorization for related travel expenses regardless where the medical service is provided. Refer to the Related Travel Expenses (Meals/Lodging/Other) section of this manual for details.

1.21.4.1.1 Acute Care Hospital (inpatient and outpatient)

1.21.4.1.2 DME/Oxygen Supplier
1.21.4.1.3 Ground Ambulance
1.21.4.1.4 Independent Laboratory
1.21.4.1.5 Nurse Midwife
1.21.4.1.6 Optician
1.21.4.1.7 Optometrist
1.21.4.1.8 Podiatrist
1.21.4.1.9 Pharmacy
1.21.4.1.10 Physician
1.21.4.1.11 Ambulatory Surgical Centers
1.21.4.1.12 Dialysis Centers
1.21.4.1.13 Certified Nurse Practitioner
1.21.4.1.14 Dentist

1.21.4.2 All services not noted above require prior authorization to ensure compliance with the DMAP rules and regulations. However, in the following four circumstances, it may be necessary for the provider to render service before prior approval is obtained.

1.21.4.2.1 CATEGORY 1 If the service provided is the result of an out-of-state emergency.
1.21.4.2.2 CATEGORY 2 If the client's health would be endangered if he/she were required to travel back to Delaware.
1.21.4.2.3 CATEGORY 3 If the service to be rendered is *unavailable* in Delaware, New Jersey, Pennsylvania, Maryland, or the District of Columbia.
1.21.4.2.4 CATEGORY 4 If the service is given to a foster child in an approved child care facility out of the State of Delaware.

1.21.4.3 If services in one of the above four categories are provided before prior authorization is obtained, it is still the responsibility of the provider to obtain prior authorization before billing. Services that do not comply with the DMAP rules and regulations will not be authorized for payment even if they have already been rendered.

1.21.4.4 The prescribing practitioner may request prior authorization by sending a letter with the following information to the Medical Review Team:

1.21.4.4.1 Name of the patient.
1.21.4.4.2 Patient's Delaware Medical Assistance ID number.
1.21.4.4.3 Date of birth.
1.21.4.4.4 Detailed medical history that documents the need for out-of-state care.

All requests should be directed to the DMAP State office (refer to the back of this manual for the address, telephone and fax numbers).

1.21.5 Transplants

1.21.5.1 The DMAP will cover the following transplants:

1.21.5.1.1 Heart
1.21.5.1.2 Lung
1.21.5.1.3 Liver
1.21.5.1.4 Bone Marrow
1.21.5.1.5 Pancreas
1.21.5.1.6 Kidney
1.21.5.1.7 Intestinal

1.21.5.2 ALL transplants (except those covered and paid by Medicare) must be approved by the Medical Review Team. If Medicare is covering the service, Medicaid review for the DMAP payment is not necessary.

1.21.5.3 Requests for approval of any transplants must be submitted in writing and mailed or faxed to the Medical Review Team (refer to the Index in the back of this manual for the address, telephone and fax numbers to the DMAP State office).

1.21.5.4 Failure to secure approval from the Medical Review Team can result in non-payment from the DMAP. Providers must include the prior authorization number issued by the Medical Review Team when submitting the claim.

1.21.5.5 The attending specialist and the admitting facility must request prior authorization by sending a letter with the following information:

1.21.5.5.1 Name, address, age, and the Delaware Medical Assistance ID number of the client.

1.21.5.5.2 Name of the referring physician

1.21.5.5.3 Name and address of the physician and medical facility where the transplant is to be performed.

1.21.5.5.4 Type of transplant, including detailed information, i.e., method proposed, expected outcome, etc.

1.21.5.5.5 Diagnosis, prognosis, and a brief outline of all medical problems, history and indications for transplant.

1.21.5.5.6 Documentation must be provided by the appropriate attending specialist and admitting facility that all of the following conditions are met:

1.21.5.5.6.1 The facility performing the transplant must have approval for performing the surgery through the Certificate of Need (CON) process and must supply supporting documentation of this.

1.21.5.5.6.2 Current medical therapy has failed and will not prevent progressive disability and death.

1.21.5.5.6.3 The patient does not have other major systemic disease that would compromise the transplant outcome.

1.21.5.5.6.4 There is every reasonable expectation, upon considering all the circumstances involving the patient, that there will be strict adherence by the patient to the long-term difficult medical regimen that is required.

1.21.5.5.6.5 The transplant is likely to prolong life for at least two years and to restore a range of physical and social function suited to activities of daily living.

1.21.5.5.6.6 The patient is not both in an irreversible terminal state (moribund) and on a life support system.

1.21.5.5.6.7 The patient has a diagnosis appropriate for the transplant.

1.21.5.5.6.8 The patient does not have multiple non-correctable severe major system congenital anomalies.

1.21.6 Durable Medical Equipment (DME) and Supplies

A practitioner may prescribe durable medical equipment and supplies when medically necessary to carry out a medical practitioner's written plan of care.

1.21.6.1 DME

1.21.6.1.1 DME is defined as equipment that meets all of the following criteria:

1.21.6.1.1.1 Can withstand use.

1.21.6.1.1.2 Is primarily and customarily used to serve a medical purpose.

1.21.6.1.1.3 Generally is not useful to a person in the absence of an illness or injury.

1.21.6.1.1.4 Is needed to maintain the client in the home.

1.21.6.1.2 Requests for items that are not primarily medical in nature are not covered. Most durable medical equipment is presumptively medical, such as hospital beds, wheelchairs, respirators, crutches, nebulizers, etc.

However, some items are not primarily medical in nature, such as physical fitness equipment, self-help devices, air conditioners, room heaters, humidifiers attached to

home heating systems, or other environmental control items, etc. Additionally, the DMAP does not cover lifts for stairs or vans, wheelchair ramps, generators, or home/bathroom modifications under the DME scope of services. Even though nonmedical equipment may have some remote medically related use, the primary and customary use of such items is a non-medical one and thus they will not be covered.

1.21.6.1.3 When ordering durable medical equipment or supplies, the attending practitioner is required to provide the Medicaid client with a prescription.

In some instances, the practitioner will be required to detail the medical necessity in writing. The attending practitioner is also expected to sign and date a Medicaid Certificate of Medical Necessity (CMN) for the DME supplier. A Medicare CMN is required when requesting prior authorization for durable medical equipment for which there is a specific Medicare CMN. The Medicare CMN is to be submitted for ALL clients not only those who are Medicare eligible. The attending physician, not the DME supplier, is required to complete the Medicare CMN.

1.21.6.2 Supplies

1.21.6.2.1 The DMAP has established an upper limit on the number of each supply used in a three-month period. Practitioners may be requested to further document the medical necessity if the established limit is exceeded.

1.21.6.2.2 Supplies must be purchased economically and the quantity used must be reasonable for the period of time of the request.

1.21.6.2.3 Non-covered supplies include, but are not limited to:

Diapers routinely used for children under four years of age. The DMAP may consider the coverage for diapers that exceed the normal use for children under the age of four years if the attending practitioner details the child's diagnosis, the medical necessity for the diapers, and why the use is outside normal range. This service may be covered through the Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) program. The DME provider will be required to submit a CMN signed and dated by the attending practitioner and the practitioner's letter of medical necessity. The practitioner's letter of medical necessity must address the child's diagnosis and why the excessive usage is medically necessary.

Bandages, Band-Aids, mouthwash, razors, etc. normally purchased for home use.

1.21.7 Positron Emission Tomography (PET) Scans

1.21.7.1 PET Scans will be provided in accordance with Section 50-36 of the Medicare Coverage Issues Manual. Refer to Practitioner Provider Specific Policy Manual for Section 50-36 of the Coverage Issue Manual.

1.21.7.2 All PET Scans must be prior authorized. Prior authorization requests for fee-for-service clients may be mailed or faxed to the Medical Review team located in the Lewis Building (see Index Addresses and Phone Numbers, Delaware Medical Assistance Program State Office in the back of the General Policy).

1.21.7.3 Prior authorization must be requested by the referring physician and must include:

1.21.7.3.1 Patient's name

1.21.7.3.2 Patient's Medicaid number

1.21.7.3.3 Patient's date of birth

1.21.7.3.4 Patient's diagnosis

1.21.7.3.5 Date of scheduled PET Scan

1.21.7.3.6 Results of previous tests (Pathology/biopsy reports, CT Scan, MRI, Ultrasound, X-ray, previous stress tests, etc.)

1.21.7.3.7 Detailed medical history that documents the need for PET Scan.

~~1.21.7.4 In addition, Diamond State Partner (DSP) providers must mail or fax a completed Request Form. Refer to Diamond State Partner section of this manual for policies and forms specific to DSP.~~

~~1.21.8 Home Health Services~~

~~1.21.8.1 Prior authorization is required for the following home health services if:~~

~~1.21.8.1.1 There are multiple clients in the same household requiring home health service from the same agency and/or multiple clients in the same household requiring home health services from multiple agencies.~~

~~1.21.8.1.2 Skilled nursing visits exceed two per day~~

~~1.21.8.1.3 Clients who may require home health aide service for more than two hours per day.~~

~~1.21.8.1.4 Additional home health services are requested for the same client from a second agency.~~

~~1.21.8.1.5 Mentally Retarded Waiver clients require skilled nursing, therapy, or aide services.~~

~~1.21.8.1.6 Skilled nursing visits are in locations other than the client's home~~

~~1.21.8.1.7 Individual resides in an adult foster/residential home~~

~~1.21.8.1.8 Client requires more than one skilled rehabilitation visit per day or more than one hour (4 units) in duration.~~

~~1.21.9 Oral and Facial Prosthetics~~

~~1.21.9.1 The DMAP will cover oral and facial prosthetics for eligible Medicaid clients who are age 21 or older when it is determined to be medically necessary and part of a rehabilitation plan to treat an anatomical deficiency caused by diagnosed conditions.~~

~~1.21.9.2 Refer to the Practitioner Provider Specific Policy Manual, Specific Criteria for Prosthodontists for additional information.~~

~~1.21.10 Bariatric Surgery~~

~~1.21.10.1 The DMAP may cover bariatric surgery for treatment of obesity in adults when the patient's obesity is causing significant illness and incapacitation and when all other more conservative treatment options have failed.~~

~~1.21.10.2 All requests for bariatric surgery must be prior authorized. This includes the surgeon, assistant surgeon (if medically necessary), anesthesiologist, and facility.~~

~~1.21.10.3 Requests for prior authorization of bariatric surgery must be submitted in writing. See Section 8.1 of this manual for the Prior Authorization Request Form for Diamond State Partners recipients and Section 18.2 of this manual for the Prior Authorization Request Form for Medicaid recipients who are not enrolled in managed care.~~

~~1.21.11 Sleep Studies/Polysomnography~~

~~1.21.11.1 The DMAP may cover Sleep Studies/Polysomnography for evaluation of sleep-related disorders.~~

~~1.21.12 Computed Tomographic Colonography~~

~~1.21.12.1 The DMAP may cover computed tomographic colonography in the following instances:~~

~~1.21.12.1.1 For colonic evaluation of symptomatic patients with a known colonic obstruction.~~

~~1.21.12.1.2 For patients with an incomplete colonoscopy due to obstructive or stenosing colonic lesions.~~

~~1.21.12.1.3 For patients who are receiving chronic anticoagulation therapy that cannot be interrupted.~~

1.21 ~~Services Requiring~~ Prior Authorization

1.21.1 The Social Security Act at Section 1902(a)(30)(A) permits the DMAP to require prior authorization.

1.21.2 Providers must obtain prior authorization from the DMAP **before** initiating the service. The DMAP will deny payment for services that require prior authorization yet are initiated before DMAP approval except as specified in section 1.21.3.

1.21.3 Authorization may be granted after the service has been provided in the following circumstances. All other requirements for prior authorization of the service apply.

1.21.3.1 The service has been denied by Medicare or other insurance and the reason for the denial is documented on the EOB.

1.21.3.1.1 The DMAP does not cover services denied by Medicare as not medically necessary and will not authorize these services.

1.21.3.2 The provider was recently enrolled as an out-of-state or out-of-region provider and was required to provide a service to a Medicaid client prior to enrollment.

1.21.3.3 The client has been determined to be eligible for retroactive Medicaid.

1.21.3.4 The client has an urgent medical need for the service defined as:

1.21.3.4.1 A delay in service provision of three business days from the date the rendering provider initiates or receives the order for the service would place the health of the client in serious jeopardy OR

1.21.3.4.2 A delay in service provision of three business days from the date the rendering provider initiates or receives the order for the service would result in institutionalization of the client or prevent discharge of the client from an institution.

1.21.4 The DMAP must approve the treatment plan and services before the provider receives payment for urgent medical services provided prior to obtaining authorization.

1.21.5 Within one business day of the provision of the service, providers requesting authorization for urgent medical services provided prior to obtaining authorization must submit:

1.21.5.1 All documentation normally required for the service being authorized and

1.21.5.2 Patient history/treatment notes that document the urgent nature of the patient's condition or the necessity of the service to prevent institutionalization or to prevent a delay in discharge of the client from an institution. If the urgent medical need for the service is not substantiated, authorization of the service will be denied and no payment will be made.

1.21.5.3 Providers should designate the request as Urgent.

1.21.6 The following services require prior authorization. The list reflects the major categories of services that require prior authorization but is not all-inclusive. Refer to your provider specific policy manual for complete information on services requiring prior authorization. Refer to the designated provider-specific policy manuals for specific information required to support the prior authorization request for the services listed below. Prior authorization is not required if Medicare has paid for the service.

1.21.6.1 Private Duty Nursing Services– Refer to the Private Duty Nursing Provider Specific Policy Manual.

1.21.6.2 Pharmaceuticals – Certain pharmaceuticals require prior authorization. Refer to the Pharmacy Provider Specific Policy Manual.

1.21.6.3 Prescribed Pediatric Extended Care (PPEC) – Refer to the Prescribed Pediatric Extended Care Program Provider Specific Policy Manual.

1.21.6.4 Transplants – Refer to the Inpatient Hospital or Practitioner Provider Specific Policy Manual.

1.21.6.5 Durable Medical Equipment and Supplies – Certain equipment and supplies require prior authorization. Refer to the Durable Medical Equipment Provider Specific Policy Manual.

1.21.6.6 Positron Emission Tomography (PET) Scans – Refer to the Outpatient Hospital or Practitioner Provider Specific Policy Manual.

1.21.6.7 Home Health Services – Certain home health services require prior authorization. Refer to the Home Health Provider Specific Policy Manual.

1.21.6.8 Oral and Facial Prosthetics – Refer to the Specific Criteria for Prosthodontists section of the Practitioner Provider Specific Policy Manual.

1.21.6.9 Bariatric Surgery - Refer to the Inpatient Hospital or Practitioner Provider Specific Policy Manual.

1.21.6.10 Sleep Studies/Polysomnography - Refer to the Outpatient Hospital or Practitioner Provider Specific Policy Manual.

1.21.6.11 Dental and Orthodontic Services – Certain dental and orthodontic services require prior authorization. Refer to the Dental Provider Specific Policy Manual.

1.21.6.12 Elderly and Disabled Waiver Services – Refer to the Elderly and Disabled Waiver Provider Specific Policy Manual.

1.21.6.13 Acquired Brain Injury Waiver Services – Refer to the Acquired Brain Injury Waiver Provider Specific Policy Manual.

1.21.6.14 Extended Pregnancy (Smart Start) Services – Refer to the Extended Pregnancy (Smart Start) Services Provider Specific Policy Manual.

1.21.6.15 Computed Tomographic (CT) Colonography - Refer to the Outpatient Hospital or Practitioner Provider Specific Policy Manual.

1.21.6.16 Out-of-State Services

1.21.6.16.1 All services provided outside of Delaware require prior authorization for payment, except for services from the following providers in New Jersey, Pennsylvania, Maryland, or the District of Columbia: NOTE: DMAP clients are required to receive prior authorization for related travel expenses regardless of where the medical service is provided. Refer to the Related Travel Expenses (Meals/Lodging/Other) section of this manual for details.

1.21.6.16.1.1 Acute Care Hospital (inpatient and outpatient)

1.21.6.16.1.2 DME/Oxygen Supplier

1.21.6.16.1.3 Ground Ambulance

1.21.6.16.1.4 Independent Laboratory

1.21.6.16.1.5 Nurse Midwife

1.21.6.16.1.6 Optician

1.21.6.16.1.7 Optometrist

1.21.6.16.1.8 Podiatrist

1.21.6.16.1.9 Pharmacy

1.21.6.16.1.10 Physician

1.21.6.16.1.11 Ambulatory Surgical Center

1.21.6.16.1.12 Dialysis Center

1.21.6.16.1.13 Certified Nurse Practitioner

1.21.6.16.1.14 Dentist

1.21.6.16.2 All out-of state services not noted above require prior authorization to ensure compliance with DMAP rules and regulations.