Chapter 5

Service Authorization

Some IMCare-covered services require authorization. The Service Authorization requirements are to safeguard against inappropriate and unnecessary use of health care services. Some authorization requirements are governed by State law and Federal regulations. When enrollees have private insurance, providers must follow authorization and other rules that apply to the primary insurance.

Providers should submit an *IMCare Service Authorization* request prior to providing a service. The Service Authorization requirements apply when IMCare is the primary payer for the enrollee, or when IMCare is the payer of last resort and the primary payer denies or does not cover any part of a service.

Requests for authorization after the service occurs are subject to the same review criteria as those that are received prior to providing the service.

Receiving an approval for a Service Authorization request does not guarantee payment. Providers must follow IMCare billing policy guidelines, and the IMCare enrollee must be eligible at the time the service is rendered.

All IMCare Utilization Management (UM) determinations are based only on the appropriateness of care and service and coverage. IMCare does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial or other incentives for IMCare representatives who make UM determinations to encourage determinations that result in underutilization.

Definitions

Authorization: The written approval and issuance of an authorization number by IMCare Utilization Management Staff.

Fair Hearing: An administrative proceeding to examine facts concerning the matter in dispute and to advise the Commissioner if the decision to reduce or deny benefits is appropriate. The internal appeal process through IMCare must be exhausted prior to seeking a State Fair Hearing.

Investigative Health Service: A procedure that has limited human application and trial and lacks wide recognition as a safe and effective procedure in clinical medicine. A drug or device the United States Food and Drug Administration (FDA) has not yet declared safe and effective for the use prescribed.

Local Trade Area: The geographic area surrounding an enrollee's residence commonly used by local residents to obtain similar health care services.

Medical Necessity: A health service that is consistent with the enrollee's diagnosis or condition and is:

1. Recognized as the prevailing medical community standard or current practice by the provider's peer group; and
2. Rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or
3. Is a preventive health service as defined in MN Rules part 9505.0355.

Out-of-State Provider: A provider located outside of the State of Minnesota and the enrollee's local trade area.

Referee: A person who conducts fair hearings and provides recommendations to the Commissioner.

IMCare Authorization Criteria

IMCare requires Service Authorization as a condition of IMCare payment for certain services. IMCare may implement service authorization requirements if any of the following apply:

1. The health service is of questionable medical necessity.
2. The health service requires monitoring to control the expenditure of IMCare funds.
3. A less costly, appropriate alternative health service is available.
4. The health service is investigative or experimental.
5. The health service is newly developed or modified.
6. The health service is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial.
7. The health service is comparable to a service provided in a Skilled Nursing Facility (SNF) or hospital but is provided in an enrollee's home.
8. The health service may be considered cosmetic.
9. Authorization is mandated by the State of Minnesota.
10. The service is provided outside the IMCare network.

***Note the above list of authorization requirements are subject to change at any time, for verification of the most up to date information please contact the IMCare Member Services Line at the number or email listed below.**

IMCare Utilization Review staff process requests for Service Authorization. Utilization Review staff accepts requests for Service Authorization by fax, email or telephone. Faxed requests for IMCare Service Authorization are accepted on the IMCare Service Authorization forms, which are available on the IMCare website.

Appropriate documentation for medical necessity is required for all requests. Refer to the appropriate covered services chapter for more information about specific documentation requirements, or contact IMCare Enrollee Services at:

IMCare
1219 SE 2nd Ave.
Grand Rapids, MN 55744
1-800-843-9536 (toll free)
218-327-5545 (fax)
IMCareAuths@co.itasca.mn.us (email)

Per MN Stat. sec. 62M.09, subd. 3, and in compliance with National Committee for Quality Assurance (NCQA) UM standards, a licensed physician reviews all cases in which the utilization review staff has concluded that the authorization criteria are not met. Under these circumstances, subsequent denials can only be made by a physician reviewer based on medical necessity determinations.

*Approval and denial letters will be faxed to the fax number provided on the authorization request form that was submitted by the provider.

Previously Authorized Services for New Enrollees

IMCare follows established procedures for transitioning newly enrolled individuals. During the transitional process, IMCare considers the enrollee's individual health concerns and existing services at the time of enrollment and makes efforts to seamlessly transition new enrollees to contracted network providers for covered services. When considering requests for authorization for continued services from an out-of-plan provider,

IMCare requires that new enrollees transition their health care services to a participating provider, provided that such transition does not create undue hardship on the enrollee and the transition is clinically appropriate.

IMCare provides all enrollees with medically-necessary covered services that an out-of-plan provider, another health plan, or the State had authorized before enrollment in IMCare. IMCare may require the enrollee to receive the services by an IMCare provider, if such a transfer would not create undue hardship on the enrollee and is clinically appropriate.

Documentation Requirements

The criteria listed below are used by IMCare Utilization Review when processing requests for authorization. To merit authorization, the service must be all of the following:

1. Medically necessary, as determined by prevailing medical community standards or customary practice and usage. Medical necessity reviews require supporting clinical documentation from the visit in which the service was ordered.
2. Appropriate and effective for the enrollee's medical needs.
3. Timely, considering the nature and present medical condition of the enrollee.
4. Provided by a provider with appropriate credentials.
5. The least expensive, appropriate alternative available.
6. An effective and appropriate use of IMCare funds.

Modifiers

If a modifier is required for a particular procedure code, the request for Service Authorization submitted to IMCare must include the modifier. Information on the approved authorization, including the procedure code(s) and the modifier(s), must match claim information for the service, or the claim will be denied.

Out-of-Plan Providers

Except for emergency services, out-of-plan providers must obtain prior authorization before providing most IMCare-covered services. Requests for prior authorization of services provided outside of the IMCare network or by non-contracted providers in or out of state must include documentation establishing medical necessity and the unavailability of that service in Minnesota or in the IMCare network. IMCare covered services provided to an IMCare enrollee by an out-of-state, out-of-plan provider will be covered under the following circumstances:

1. The services are medically necessary; and
2. The services are provided in response to an emergency while the enrollee is out of the state and the provider is out of plan; or
3. The services are not available in network or by an out-of-state contracted provider, and the attending physician has determined medical necessity and obtained prior authorization from IMCare. The cost to the enrollee is no greater than it would be if the services were furnished in-network. (The county is responsible for travel expenses associated with obtaining the out-of-state services.); or
4. The services are required because the enrollee's health would be endangered if he/she were required to return to Minnesota or to an in-plan or in-network provider for treatment; or
5. The enrollee has moved out of the plan area, but remains on IMCare; or
6. The service provided is by a specialist and the facility in which the service was provided is closer to the enrollee's home than any network specialist; or
7. The enrollee is new to IMCare, with an enrollment date within 120 days and is engaged in a current course of treatment for one or more of the following conditions:
    - An acute or chronic condition receiving active treatment,
    - A life-threatening mental or physical illness,
    - Pregnancy beyond the first trimester of pregnancy,

- A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death,
- A disabling or chronic condition that is in an acute phase, or
- For the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

There is an exception to the Service Authorization requirement for out-of-plan providers for enrollees with the MSHO/IMCare Classic (HMO SNP) benefit. Non-contracted physician specialists are allowed to provide Medicare-covered services to enrollees in this group without a Service Authorization. This exception for this group of enrollees applies only to clinic or outpatient hospital office visits provided by physician specialists (e.g., cardiologists, pulmonologists, pediatric endocrinologists, neurosurgeons, infectious disease specialists, rheumatologists, oncologists, gastroenterologists, dermatologists, plastic surgeons, etc.) and diagnostic testing or laboratory services ordered by the same physician specialists.

Out-of-Country Care

IMCare does not cover emergency or other health care services received from providers located outside the United States. For the purpose of this section, United States includes the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Notice of Action Taken

IMCare will notify the provider and enrollee in writing of action taken on an authorization request. IMCare Utilization Review staff will notify the provider if additional information is needed to determine medical necessity. If a request is denied, the enrollee and provider will receive notification by telephone and in writing, including a notice of the enrollee's right to Appeal.

Availability of Utilization Management Criteria

The IMCare Utilization Management department uses the most current InterQual™ criteria, adopted clinical practice guidelines, Minnesota Department of Human Services (DHS) policies, State of Minnesota coverage policies, Centers for Medicare & Medicaid Services (CMS) national coverage determinations (dual eligible enrollees only), and other IMCare approved medical policies to make authorization decisions. Criteria are available upon request of the practitioner. The practitioner may request the criteria either by phone, fax, email, or by written request sent via the United States Post Office. The criteria will be provided to the practitioner upon request through any of the distribution methods listed above.

Appeals and Fair Hearings

If a Service Authorization request is denied or reduced, the enrollee may Appeal the decision to IMCare Appeals and Grievances. Once the appeal process has been exhausted, the enrollee may request a fair hearing before a referee from the Minnesota Department of Human Services (DHS). To request a fair hearing, an enrollee must contact the Appeals Unit at DHS.

Providers do not have the right to Appeal a denied request under the Department's fair hearing process. Providers may submit additional documentation and ask IMCare for a reconsideration of a decision. This can be done by submitting an Appeal for Service to the IMCare Compliance Coordinator at 1-800-843-9536 ext. 2183 or Appeal for payment to 1-800-843-9536 ext. 2118. For more information about provider Appeals, please refer to your provider contract.

Authorization List

- ***Applies only to Minnesota Health Care Programs (MA and MNCare).***
- ***Medicare-covered services do not require an authorization.***

New technology, investigative health services, etc., will always require Service Authorization. In addition, please refer to Chapter 13, Inpatient Hospital Notification and Authorization, for authorization requirements for inpatient hospitalizations. General information about certain categories of services is listed below. IMCare follows the DHS policy of requiring authorization for certain services for which no Healthcare Common Procedure Coding System (HCPCS) cases are assigned.

All out-of-network services require prior authorization and referral from a network provider, except for the following services including:

- Allergy Testing
- Most Laboratory Testing
- Radiologic Imaging
- Cardiography, Cardiovascular Monitoring and Noninvasive Cardiovascular Studies
- Endocrinology Testing
- ENT Testing
- Gastroenterology Testing
- Neurology Testing
- Ophthalmology Diagnostic Testing
- Pulmonary Diagnostic Testing
- Noninvasive Vascular Diagnostic Studies
- Dialysis
- Durable Medical Equipment less than $1000
- Emergency Department visits
- Hearing devices dispensed no more than every five years
- Homecare Skilled Nursing Visits up to 9 visits/calendar year
- Hospice Services
- Intravenous Therapy Services
- Mental Health Crisis Intervention
- Mental Health Residential Crisis Intervention up to 10 days
- Mental Health Targeted Case Management
- Open access services (family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases and testing for AIDS or other HIV-related conditions)
- Physical therapy (PT), occupational therapy (OT), speech therapy (ST)
- Provider-administer drugs, vaccines and treatments
- MN Rule 5 Assessments and admissions
- MN Rule 25 Assessments and Comprehensive Assessments
- Substance Use Disorder Services, except for office visits for Buprenorphine treatment
- Transportation Services
- Urgent Care visits

The following services always require prior authorization (both in-network and out-of-network):

Category	Service/Item
Chiropractic	>20 Acupuncture units/calendar year
Cosmetic (potentially)	>24 Spinal Manipulations/calendar year and >6/month
	Abdominoplasty
	Blepharoplasty
	Breast Implant Removal
	Breast Lift (Mastopexy)
	Breast Reconstruction
	Breast Reduction (Reduction Mammoplasty)

Category	Service/Item
Cosmetic (potentially)	Cervicoplasty
	Circumcision
	Dermabrasion
	Excision of excessive skin and subcutaneous tissue
	Lipectomy
	Otoplasty
	Panniculectomy, Abdominal
	Ptosis Repair
	Punch Graft for Hair Transplant
	Rhinoplasty
	Rhytidectomy ("facelift")
	Subcutaneous Injection Filling (collagen)
	Varicose Vein Endovenous Ablation
	Varicose Vein Sclerotherapy
Durable Medical Equipment (DME)	All DME/supplies > $1,000
Experimental/Investigational	All
Genetic Testing	All
Hearing Aides	>1 set/5 years
Home Care	Skilled Nursing Visits >9/calendar year, Home Health Aide Services and Home Care Nursing Visits for enrollees on MSC+ and MSHO.
Inpatient Hospital	Admission and Concurrent Review • In-network: MNCare enrollees only • Out-of-network: MA and MNCare enrollees
Mental Health	All out-of-network care outside of the exceptions listed above.
	>2 Diagnostic Assessments per calendar/year
Personal Care Assistant Services	All PCA services for enrollees on MSC+ & MSHO PCA Services for enrollees on PMAP & MNCare PCA services are managed by DHS.
Screenings	Screening Colonoscopy done out-of-network
	Screening Mammogram for all males, and female enrollees <40yo
Surgeries/Procedures	Neurostimulator Implantation
	Percutaneous Neuroablation (non-spine)
	Gender Confirming Surgeries
	Intersex Surgery, M to F & F to M
	Hysterectomy and Salpingo-Oophorectomy
	Vaginectomy (including colpectomy, metoidioplasty, phalloplasty, urethroplasty, urethromeatoplasty)
	Mastectomy, Breast Reduction, Chest Reconstruction
	Penile Prosthesis
	Orchiectomy
	Vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy)
	Breast Augmentation M to F
	Scrotoplasty, Testicular Expanders, and Testicular Prostheses (F to M)

Category	Service/Item
Surgeries/Procedures	**Spine Surgeries & Procedures**
	Epidural Steroid Injection
	Facet Joint Injection/Medial Branch Block
	Percutaneous Neuroablation/Neurolysis of intraosseous basivertebral nerves (spine)
	Percutaneous Neuroablation/Neurolysis of paravertebral facet joint nerves (spine)
	Sacroiliac (SI) Joint Injection
	Spinal Cord Stimulator (SCS) Insertion
	Spinal Decompression (e.g., discectomy, laminectomy) +/- Fusion
	Spinal Fusion
	Total Disc Arthroplasty/ Replacement (Artificial Disc)
Transplants	All
Vision Services	Contact Lenses - No auth needed for Aphakia (H27.00-H27.03), Bandage Lenses (92071, 92072, S0515), Aniseikonia (H52.32), Keratoconus (H18.601-H18.629)
	>1 Pair of Glasses/2 rolling years >1 Glasses Fitting/30 rolling days
	Industrial/Sport/Educational Glasses
	Tints and Polarized Lenses No auth needed for Albinism E70.3XXX, Achromatopsia H53.51 Aniridia Q13.1, Blue cone monochromatism H53.51 Cystinosis E72.04, Retinitis pigmentosa H35.5

***Note the above list of authorization requirements are subject to change at any time, for verification of the most up to date information please contact the IMCare Member Services Line at the number or email listed above.**

Dental Services
It is essential that requests submitted for Service Authorization consideration be accompanied by adequate case information and appropriate diagnostic materials (e.g., radiographs of patient's current dental condition, prosthesis information, teeth to be replaced, prognosis for remaining dentition, complete six-point periodontal charting for cast metal partials). Refer to Chapter 19, Dental Services, for coverage guidelines and authorization.

Vision Care Services
Refer to Chapter 20, Eyeglass and Vision Care Services.

Contact lenses require Service Authorization before they are provided to enrollees without a diagnosis of Aphakia, Aniseikonia, Keratoconus, or Bandage Lenses.

Tints and polarized lenses require a Service Authorization before being provided to enrollees without a diagnosis of Albinism, Achromatopsia, Aniridia, Blue Cone Monochromatism, Cystinosis, or Retinitis Pigmentosa.

IMCare requires a Service Authorization before obtaining a second pair of eyeglasses in a rolling 24-month dispensing period. Providers are only to dispense a second pair if the replacement criteria of receiving eyeglasses more frequently than every two years are met. Providers need to submit documentation of the reason the second pair of eyeglasses is needed with authorization request. Refer to Chapter 20, Eyeglass and Vision Care Services, for criteria.

Medical Supplies and Equipment
Providers must request authorization for all equipment and supplies listed in Chapter 23, Equipment and Supplies, where authorization is indicated. Authorization is required for the following general areas:
1. DME exceeding $1,000.
2. Repairs (if parts and labor is more than $1000) to equipment: Specify who owns the equipment.

Face-to-Face Encounter for Some Durable Medical Equipment (DME), Effective October 1, 2013
Section 302(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added Section 1834 (a)(1)(E)(iv) to the Act, which provides that payment may not be made for a covered item consisting of a motorized or power wheelchair unless a physician (as defined in Section 1861(r)(1) of the Act, or a physician assistant (PA), nurse practitioner (NP), or Clinical Nurse Specialist (CNS) as the terms are defined in Section 1861(aa)(5) of the Act) has conducted a face-to-face examination of the beneficiary and written a prescription for the item.

The face-to-face encounter must be within six months before ordering or on the date of ordering. The documentation must show that the enrollee was evaluated and/or treated for a condition that supports the DME item(s) ordered. Please refer to Chapter 23, Equipment and Supplies, of the IMCare ***Provider Manual***, for a complete list of the codes for face-to-face encounters.

Prostheses and Orthoses
Providers must request authorization for prostheses and orthoses (orthotics) when the cost exceeds $1,000.

Hearing Aids
Refer to Chapter 17, Rehabilitative Services for specific information. The provision of more than one hearing aid system or hearing aid dispensing fee in a five-year period requires authorization.

Drugs
Refer to Chapter 22, Pharmacy Services, for a complete list of medication and pharmacy services provided through a pharmacy that require authorization. The list includes information regarding the IMCare process for provider notification if a Service Authorization requirement is added to a pharmacy item or medication.

Rehabilitative Services
Refer to Chapter 17, Rehabilitative Services.

All Other Services
The following health services require authorization:
1. All air ambulance transportation that originates from or is to a destination outside of Minnesota and is to and/or from an out-of-network or out-of-plan provider.
2. Investigative health services and procedures that may be considered cosmetic. If staged reconstructive surgery is being proposed for correction of a congenital anomaly, the complete plan for future surgeries must be submitted with the first authorization.
3. Services provided outside of Minnesota. This requirement for prior authorization does not include emergency services. A Service Authorization is required before providing non-emergent services needed because the enrollee's health would be endangered if the enrollee were required to return to Minnesota. A Service Authorization is also required for services provided to children placed outside of Minnesota through the subsidized adoption assistance program under MN Stat. sec. 256B.055, subd. 1 or 2.

Legal References

MN Stat. sec. 62M.09, subd. 3 – Staff and Program Qualifications; Annual Report: Physician reviewer involvement
MN Stat. sec. 256B.02 – Definitions
MN Stat. sec. 256B.04 – Duties of State Agency
MN Stat. sec. 256B.055, subd. 1 – Eligibility Categories: Children eligible for subsidized adoption
MN Stat. sec. 256B.055, subd. 2 – Eligibility Categories: Subsidized foster children
MN Stat. sec. 256B.093 – Services for Persons with Traumatic Brain Injuries
MN Stat. sec. 256B.0625 – Covered Services
MN Rules part 9505.0175 – Definitions
MN Rules part 9505.0215 – Covered Services; Out-of-State Providers
MN Rules parts 9505.0501 – 9505.0540 – Hospital Admissions Certification
MN Rules parts 9505.5000 – 9505.5105 – Conditions for Medical Assistance and General Assistance Medical Care Payment
Title 42 Code of Federal Regulations (CFR) Part 431.52 – Payments for services furnished out of State
42 CFR 440.230 – Sufficiency of amount, duration, and scope
MN Rules parts 9505.5000-9505.5105 – Conditions for Medical Assistance and General Assistance Medical Care Payment
Title 42 Code of Federal Regulations (CFR) Part 431.52 – Payments for services furnished out of State 42 CFR 440.230 – Sufficiency of amount, duration, and scope