MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE

SUBJECT Continuity of Prior Authorized Services Between Fee-For-Service and Managed Care Plans for Individuals Under Age 21	**BY** Darlene C. Collins **Darlene C. Collins, M.Ed., M.P.H.** Deputy Secretary for Medical Assistance Programs
NUMBER:	99-96-01
ISSUE DATE:	February 29, 1996
EFFECTIVE DATE:	February 29, 1996

PURPOSE:

The purpose of this bulletin is to notify providers of the procedures developed to ensure continuity of prior-authorized services whenever a recipient transfers between managed care plans, from a managed care plan to the fee-for-service program, or from the fee-for-service program to managed care.

SCOPE:

This bulletin applies to all providers enrolled in the Medical Assistance Program, including HealthPASS and all managed care plans.

BACKGROUND/DISCUSSION:

On a case-by-case basis, both the fee-for-service program and managed care plans have worked to assure continuity of prior-authorized services for eligible Medical Assistance recipients who move between state-contracted managed care plans or between a managed care plan and fee-for-service. In order to assure uniformity and consistency of approach, the Department has developed a set of procedures designed to avoid a disruption in the delivery of such services to these recipients.

PROCEDURE:

These procedures will be formally implemented in the fee-for-service program effective immediately upon publication of this bulletin. All managed care plans must have these procedures in place by no later than March 1, 1996.

Attached are the procedures which address a:

- Recipient moving from fee-for-service to managed care.
- Recipient moving from managed care to fee-for-service.
- Recipient moving between managed care plans.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free inquiry line for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.

Process for ensuring approval of previously granted Prior Authorization - Fee-for-Service to Managed Care

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***** REMINDER Providers must check EVS prior to providing any service to an eligible M.A. recipient and must listen to the ENTIRE EVS message in order to obtain the correct eligibility information necessary for payment**

1. If the recipient is covered by Medical Assistance fee-for-service and the enrolled treating provider successfully requests from the DPW a prior authorization for services, "from" and "to" dates are assigned by DPW and loaded in the Prior Authorization subsystem.

2. If a provider learns, through EVS or otherwise, that a recipient with an approved fee-for-service prior authorization number has enrolled in a managed care plan, the provider must follow steps 4-8 below. Before the provider treats the recipient at every visit, the provider should verify eligibility via EVS.

3. If the provider does not check the recipient's eligibility with EVS and inappropriately invoices the Department, the invoice will be rejected.

4. The managed care plan, the provider and DPW are responsible for ensuring continuing services that were previously prior authorized by DPW until the end of the time period previously prior authorized by DPW. Neither the managed care plan nor the managed care plan's Primary Care Physician may terminate or reduce previously authorized services through the period that was previously approved.

5. When the provider finds that the recipient has enrolled in a managed care plan, the provider must call the Plan and notify it of the prior authorized services about to be performed.

6. When the managed care plan receives the phone call, if the procedure requires prior authorization, the managed care plan must check DPW's Prior Authorization subsystem to see if the recipient has a prior authorization number on file. If yes, the managed care plan must approve the service at the appropriate rate (either the plan's current rate or the fee-for-service rate, whichever is higher, unless the provider agrees to accept the lower rate) and advise the provider of procedures for billing. The managed care plan must honor the quantity of services, length of time, and scope of services specified by the approved prior authorization.

   6a. If the provider is not a participating provider in the managed care plan, the Plan must pay for all services previously prior authorized by the Department. The Plan may recruit the provider as a participating provider or arrange for the service to be delivered by a participating provider, assuring that services are provided without interruption until the end of the time period previously prior authorized.

7. The provider delivers the service to the recipient, and does not invoice DPW but invoices the managed care plan according to the procedures outlined in Step 6 above.

8. If the Plan receives a request to continue the prior authorized service, the Plan must reassess the need for service and make its own determination of medical necessity before the end of the previously approved period to ensure that services are not terminated or reduced while the Plan makes its decision.

Process for ensuring approval of previously granted Prior Authorization - Managed Care to Fee-for-Service

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***** REMINDER Providers must check EVS prior to providing any service to an eligible M.A. recipient and must listen to the ENTIRE EVS message in order to obtain the correct eligibility information necessary for payment**

1. When a provider is informed via EVS that a recipient is no longer enrolled in a managed care plan but is covered by fee-for-service, the provider and DPW are responsible for ensuring continuing services that were previously prior authorized by the managed care plan until the end of the time period previously authorized by the managed care plan.

2. If the provider is an enrolled M.A. provider, he or she may perform the service and submit to the Department at P.O. Box 8044, Harrisburg, PA 17105, the invoice with the managed care plan's Prior Authorization attached. If there is no formal Prior Authorization form from the managed care plan, a copy of the primary care physician's (PCP's) referral form should be attached to the invoice.

3. If the provider is not an enrolled M.A. provider and wishes to perform the service and receive payment for the service, he or she must enroll by calling the Department and requesting the application forms. The non-enrolled provider may perform the service before becoming enrolled but may not invoice the Department for the service until after completing the enrollment process. The provider who meets all Medical Assistance requirements will be enrolled retroactive to the date the service was first delivered after the recipient disenrolled from managed care. Enrollment forms must be submitted within thirty (30) days of the initial service to avoid extended delays. The invoice with the managed care plan's Prior Authorization (or PCP's referral form) attached must be submitted to the Department at the address listed in Step 2 above.

4. The Prior Authorization Unit will review the invoice and attachment submitted. If the managed care rate for the prior authorization service is higher than the fee-for-service rate, the Department will either negotiate a mutually acceptable rate, identify a qualified and geographically proximate provider who will accept the fee-for-service rate, or approve the managed care rate. Based on that information, the Prior Authorization Unit will issue a DPW Prior Authorization number, forwarding the invoice, with the number, to MAMIS. The Prior Authorization Unit will issue a DPW Prior Authorization Notice to the provider. The quantity of services, length of time, and scope of services prior authorized by the Plan will be honored as initially approved.

5. When MAMIS receives the invoice with the DPW Prior Authorization number the invoice will be paid. Any future invoices must include the DPW Prior Authorization number, which the provider received on the Prior Authorization Notice.

6. A reauthorization request to continue the prior authorized service must be submitted to the Department thirty (30) days before the end of the previously approved period.

Process for ensuring approval of previously granted Prior Authorization - Managed Care to Managed Care

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***** REMINDER Providers must check EVS prior to providing any service to an eligible M.A. recipient and must listen to the ENTIRE EVS message in order to obtain the correct eligibility information necessary for payment**

1. If a provider learns, through EVS or otherwise, that a recipient who was enrolled in Plan A and successfully received a prior authorization for services from Plan A with "from" and "to" dates, disenrolls from Plan A and successfully enrolls in Plan B, then seeks previously prior authorized services from either the same Plan A provider who may or may not be participating with Plan B, or a Plan B provider, the provider must follow steps 3-7 below.

2. The managed care Plans and the provider are responsible for ensuring continuing services that were previously prior authorized by Plan A until the end of the time period previously prior authorized by Plan A. Neither Plan B nor the Plan's Primary Care Physician may terminate or reduce those previously authorized services through the period previously approved.

3. When the provider learns that the recipient has changed Plans, the provider must call Plan B and inform it of existing Plan A prior authorization for services.

4. When Plan B receives the phone call, Plan B will instruct the provider to submit a copy of Plan A's prior authorization (or PCP's referral form) along with the invoice for the service provided. Plan B approves the service at the appropriate rate (either Plan A's current rate or Plan B's current rate, whichever is higher, unless the provider agrees to accept the lower rate) and advises the provider of procedures for billing. Plan B must honor the quantity of services, length of time, and scope of services specified by the approved prior authorization.

   4a. If the provider is not a participating provider in Plan B, Plan B must pay for all services previously prior authorized by Plan A. Plan B may recruit the provider as a participating provider or arrange for the service to be delivered by a participating provider, assuring that services are provided without interruption until the end of the time period previously prior authorized.

5. The provider delivers the service to the recipient, and does not invoice Plan A but invoices Plan B according to the procedures outlined in Step 4 above.

6. If Plan B receives a request to continue the prior authorized service, Plan B must reassess the need for service and make its own determination of medical necessity before the end of the previously approved period to ensure that services are not reduced or terminated while Plan B makes its decision.