Washington State Health Care Authority

Advanced Imaging Prior Authorization through Qualis Health

Frequently Asked Questions

Updated 05/03/2012:

Q: Advanced imaging prior authorization requests through Qualis Health are not required for Washington State Medicaid patients who belong to a managed care plan. Are there other situations where this is true?

A: An advanced imaging prior authorization through Qualis Health is not required in the following circumstances:

If the patient is eligible for:

- Take Charge/Family Planning Only
- Managed Care
- Detox only

Or, if the patient:

- Has unmet Spend-down
- Is on Medicaid but, another payer is prime, including Medicare
- Is receiving services in the inpatient setting or the emergency department
- Is being evaluated for SSI

There is no edit to stop a questionnaire for a client whose eligibility or circumstances do not require prior authorization through Qualis Health. Questionnaires received by Washington State Medicaid from Qualis Health for patients who are in any of the circumstances listed above will be rejected regardless of the medical necessity recommendation made to HCA by Qualis Health.

You can save valuable staff time by referring to the list above before requesting prior authorization for a patient through Qualis Health. The first question on each questionnaire reiterates these criteria.

Q: What is "ERSO"?

A: "ERSO" means Emergency Related Services Only and is the program formerly known as "Alien Emergency Medical". Answer updated. ERSO is a program for non-citizens who:

- Have a qualifying emergent medical condition;
- Would be eligible for Medicaid if he/she were a citizen; and
- Are ineligible for a full-scope Medicaid program due to immigrant status.

In most cases, cancer is the only qualifying condition under ERSO for which Advanced Imaging will be authorized. The rules around ERSO are specific and complex. If the ERSO client does not have cancer, please call the Medicaid Customer Service Center at 1-800-562-3022 to determine eligibility.

Q: How do I get authorization for an urgent or "ordered-the-same-day" advanced imaging procedure?

A: Washington State Medicaid will allow a provider five (5) business days to complete a prior authorization request through Qualis Health for urgent or "ordered-the-same-day" procedures when the authorization cannot be completed before the procedure is performed. Answer updated.

See also: http://hrsa.dshs.wa.gov/download/Billing_Instructions/Physician-Related_Svcs/Physician-Related_Services_BI.pdf Section, D.33.

Q: How do I submit an urgent or "ordered-the-same-day" prior authorization request to Qualis Health?

A: Submit urgent or "ordered-the-same-day" prior authorization requests just like any other request. Qualis Health follows the same process with all requests. Qualis Health reviews anything that is submitted and forwards their recommendation to Washington State Medicaid. Washington State Medicaid makes the ultimate determination regarding whether services will be authorized.

Q: How does a claim for the "read-only" professional service get paid if the prior authorization was obtained, but the NPI of the professional provider who interprets the image was not added to the PA record in ProviderOne?

A: Please submit the claim with documentation in the comments field "Professional Services only for Pre-authorized Service." Please do not add the authorization number if your NPI is not on the PA record. If you do, the claim will be denied because the billing NPI on your claim is not associated with the services approved on the PA record.

Q: Does imaging ordered by the emergency room physician as part of the emergency room visit or for a client in observation, but performed in a community or free-standing imaging facility require prior authorization?

A: We understand there are communities where once the patient is stable, the attending physician ordered advanced imaging that cannot be performed in the hospital because the facility does not have the equipment. The imaging is performed the same day as the ER visit or as an observation stay by the community imaging or free-standing imaging center. This imaging does not require prior authorization. When billing for the advanced imaging in these situations, please document in the comment field on the claim form "ER Ordered Service" or "Observation Ordered Service." Answer updated 05/03/2012.

Q: Does imaging performed as part of a surgical procedure, e.g. image guided biopsy, require prior authorization?

A: No, these images do not require prior authorization. When billing for the "read- only" in these situations, please document in the comment field on the claim form "Outpatient OR Related Service."

Q: Is the reference number from Qualis the authorization number?

A: No, this number is a Qualis case identification number only. Receiving this number from Qualis does not equate to an approval by HCA for payment. This number does not mean the procedure will be authorized for payment by HCA/Medicaid. Providers should wait until a number is assigned in ProviderOne with a final status of "approved" or until they receive the HCA's written determination.

Q: Can a hospital use the CPT codes to bill for Breast MRIs?

A: No, hospitals must use the appropriate HCPC code(s) that start with a "C" to bill for breast MRIs as required in the agency's billing instructions. Agency staff will create the PA record in ProviderOne with the "C" HCPC code(s) for your convenience and to support payment for these specific procedures.

Q: How do I bill for multiple approved advanced imaging procedures, if each has a different authorization number?

A: Each code with its associated authorization number will need to be submitted on the claim(s). The Agency will not consolidate multiple codes on one authorization. Under HIPPA Version 5010, the electronic UB billing form only has one field for an authorization number. Given these circumstances the billing will be constrained to one advanced imaging code with an authorization number per electronic claim.

Q: What process does Qualis Health offer to providers for reconsideration of a denied request?

A: The physician or practitioner may request a re-review of a denial by completing the Advanced Imaging Request for Review form found on the Qualis Health website: http://www.qualishealth.org/sites/default/files/WA-Medicaid-Advanced-Imagaing-Review-Request-Form.pdf

The requestor will need to:

1. Indicate the Qualis Health reference number (starting with 913…) for which the review is being requested.
2. Fax the form and last three months (if available) of clinical notes and related imaging reports to Qualis Health at (888) 213-7516.

On receipt of a request for re-review, Qualis Health staff will review documentation to determine if the request can be approved. If not, the request will be forwarded to a physician reviewer who will review

the medical information to determine if medical necessity criteria for the procedure are met. More information about reconsideration process is available at: http://www.qualishealth.org/sites/default/files/Physician-Practionioner-Guide-Submitting-WA-Medicaid-Imaging-Requests.pdf

If Qualis Health ultimately recommends the authorization be denied and Washington State Medicaid agrees, the client has the right to appeal.

Q: How does the client appeal a decision by Washington State Medicaid?

A: In the case of a denial, the client will receive a letter from Washington State Medicaid including information about how to appeal through the Administrative Hearings Office. In addition, a client may call the Medicaid Customer Service Center phone line (**1-800-562-3022**) and state he or she wants to appeal a decision. Our phone line hours for clients are from 7:30 a.m. to 5:00 p.m. Our phone staff will direct the client to the Administrative Hearings Office.

Q: Can I extend the dates of service for the authorization?

A: Washington State Medicaid's standard practice is to approve a request for a three-month time span, then extend it up to three additional months if necessary. Contact Washington State Medicaid advanced imaging authorization staff at 1-800-562-3022 ext 52018 between the hours of 1 - 4:30 p.m. to request a date span extension for an approved advanced imaging prior authorization request.

An extension beyond six months will require a new prior authorization as the patient's medical condition may have changed.

Q: If Medicaid is a secondary insurance; do providers still need to request the prior authorization?

A: Advanced imaging prior authorization is not required when another payer, including Medicare, is the primary payer.

Q: Since Medicare does not require prior authorization for imaging, will Medicaid still want a prior authorization for their 20% or will they not pay 20%?

A: Washington State Medicaid coordinates benefits without invoking Medicaid's prior authorization requirements. Washington State Medicaid will not require a prior authorization before paying the 20% in the above scenario.

Q: What if the patient is "on the table" for a MRI/PET SCAN and the provider realizes they need to add contrast to an approved study?

A: Call the advanced imaging authorization staff at 1-800-562-3022 ext 52018 between the hours of 1 - 4:30 p.m. Explain contrast was needed and request a change in the authorized procedure code. The

Washington State Medicaid prior authorization staff can revise the approved prior authorization to add contrast material.

Q: How long will it take for an approval from HCA?

A: Prior authorization requests for advanced imaging submitted through Qualis Health will be approved or denied 72 hours from receipt by HCA.

Qualis Health submits a prior authorization file including all requests recommended for approval or denial on an overnight data transfer to HCA. HCA staff build the authorization, confirm eligibility, and approve or deny the request. The approve/deny decision is faxed to the number provided in the "Comments Box" in iEXCHANGE by the provider or authorized staff member who completes the questionnaire.

Q: What is the time limit for retroactive authorizations for services other than urgent requests ordered on the same day?

A: The Agency considers retroactive authorization when the following applies:

1. Client's eligibility is verifiably approved after the date of service, but retroactive to a date(s) that includes the date the Advanced Imaging procedure was performed; or

2. The primary payer does not pay for the service and Medicaid is identified as the primary payer.

There is no time limit for retroactive authorizations under circumstances 1 and 2 above.

Note: There is a time limit of two business days to complete an authorization request and questionnaire when the procedure is urgent or "ordered-the-same-day."

Q: How do I get copies of billing instructions and other notifications from Washington State Medicaid?

A: Subscribe to a free Listserv for medical providers who work with the Washington State Medicaid program. This Listserv is a major source of information for Washington State Medicaid providers, including updates on rate changes, billing tips, program details, and other issues of provider concern.

The Listserv includes specific provider categories, targeting the information to particular interest areas. To subscribe, follow this link to Washington State Medicaid's Listserv sign up page.
https://fortress.wa.gov/dshs/hrsalistsrvsignup/