

# Hospital Services Prior Authorization

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4042

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Next review date: 11/2026

Policy contains: Hospital services; prior authorization; therapy.

*AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered, on a case by case basis, by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.*

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## **Policy statement**

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**Besides the services found below, AmeriHealth Caritas Louisiana has included a process for emergency authorization of certain equipment, which are considered life threatening should a delay in their receipt occur. These include Apnea monitors, breathing equipment, hyperalimentation therapy aids (parenteral and enteral) and suction machines. In addition to these items for life threatening situations, emergency requests may be made for the temporary rental of wheelchairs for post-operative needs after a hospital discharge. The providers of emergency items must contact the AmeriHealth Caritas Louisiana Utilization Management immediately by telephone and provide the following information:**

- **The recipient's name, age, and AmeriHealth Caritas Louisiana identification number;**
- **The treating physician's name;**
- **The diagnosis;**
- **The time period of need for the item(s);**
- **A complete description of the item(s) requested;**
- **The reason that the request is a medical emergency; and**
- **The cost of the item.**

The decision will be made by AmeriHealth Caritas Louisiana within two working days of the date the completed request is received, and AmeriHealth Caritas Louisiana will contact the provider by telephone and follow up in writing.

### Outpatient Rehabilitation Services

Outpatient rehabilitation is prior authorized and are reimbursed by the Healthcare Common Procedure Coding System (HCPCS) for outpatient rehabilitation services including:

- Physical therapy;
- Occupational therapy; and
- Speech and hearing therapy.

A licensed physician must make the referral. The referral must include the diagnosis, the date of the accident (or onset of illness), the address of the referring physician, his/her specialty (if known), and the date of the referral. The hospital must retain a copy of the physician's referral on file.

The rehabilitation services department must evaluate the recipient. Initial therapy and extended therapy plans require prior authorization. Evaluation codes do not require prior authorization, but are limited to one evaluation per 180 days.

| Description                                   | HCPC         |
|---|--------------|
| <u>Evaluation of Speech Fluency</u>           | <u>92521</u> |
| <u>Evaluation of Speech Production</u>        | <u>92522</u> |
| <u>Speech Sound Lang Comprehension</u>        | <u>92523</u> |
| <u>Behavioral Quality Analysis Voice</u>      | <u>92524</u> |
| <u>Speech/Lang/Hear Therapy – per 15 min</u>  | <u>92507</u> |
| <u>Physical Therapy Evaluation: Low Comp</u>  | <u>97161</u> |
| <u>Physical Therapy Evaluation: Mod Comp</u>  | <u>97162</u> |
| <u>Physical Therapy Evaluation: High Comp</u> | <u>97163</u> |
| <u>Re-Evaluation of Physical Therapy</u>      | <u>97164</u> |
| <u>Therapeutic Exercises – per 15 min</u>     | <u>97110</u> |

| Description                                       | HCPC         |
|---|--------------|
| <u>Occupational Therapy Evaluation: Low Comp</u>  | <u>97165</u> |
| <u>Occupational Therapy Evaluation: Mod Comp</u>  | <u>97166</u> |
| <u>Occupational Therapy Evaluation: High Comp</u> | <u>97167</u> |
| <u>Re-Evaluation of Occupational Therapy</u>      | <u>97168</u> |
| <u>Therapeutic Activities – per 15 min</u>        | <u>97530</u> |

**When requesting PA for outpatient rehabilitation services, the following information must be included, or the request could be delayed or be denied:**

- **A treatment request form Initial therapy and extended therapy plans;**
- **Number of services, visits being requested;**
- **Physician’s referral;**
- **Evaluation results; and**
- **Revenue Code and the HCPCS code.**

**NOTE:CPT codes 97110 and 97530 may be billed with either Physical therapy revenue codes or Occupational therapy revenue codes to best reflect the specific scope of services provided. The request should be sent to AmeriHealth Caritas Louisiana.**

**Extension requests should be submitted at least 25 days prior to the end of the approved period. The requests should have at a minimum the following information attached:**

- **Therapy notes;**
- **Current evaluation results;**
- **Goals and objectives; and**
- **Copy of the physician’s referral.**

**In cases where a delay in therapy would result in deterioration of the medical condition (e.g., burn cases, accidents, or surgery) the treatment may be instituted subject to later approval. The request for therapy should be submitted within the first week of therapy, with an explanation and a request for approval from the start of therapy.**

To expedite the approval process, if it is known that outpatient rehabilitation services will be required upon discharge, a PA request can be submitted using anticipated discharge date as the beginning date of service.

Services may be provided by any enrolled AmeriHealth Caritas Louisiana provider even if furnished as part of an Individual Family Service Plan (IFSP) or Individual Service Plan or provided in a school setting. These services may be received at home from a provider of home services or home health agency.

### Outpatient Surgery Performed On An Inpatient Basis

Certain surgical procedures are covered only when performed as outpatient unless otherwise authorized. These procedures are usually performed on an outpatient basis but can be performed inpatient if it is medically necessary and PA is obtained. A list of outpatient procedures requiring PA to be performed on an inpatient basis may be found on the AmeriHealth Caritas Louisiana website.

NOTE: Refer to Section 25.3 for more information on Outpatient Services and 25.8 for specific billing instructions.

A prior authorization request form should be submitted prior to performance of the surgery. However, post authorization may be requested in emergency situations. See post authorization information below.

Approval for inpatient performance of these procedures will be granted only when one or more of the following exception criteria exists:

- Documented medical conditions exist that make prolonged pre-and/or postoperative observation by a nurse or skilled medical personnel a necessity.
- The procedure is likely to be time consuming or followed by complications.
- An unrelated procedure is being performed simultaneously that requires hospitalization.
- There is a lack of availability of proper post-operative care.
- Another major surgical procedure could likely follow the initial procedure (e.g., mastectomy).
- Technical difficulties as documented by admission or operative notes could exist.
- The procedure carries high recipient risk.

NOTE: Authorization is not required if the procedure is performed in a hospital based ambulatory surgery center.

### Organ Transplants

Transplants must be prior authorized by AmeriHealth Caritas Louisiana. Transplants (other than bone marrow and stem cell) must be performed in a hospital that is a Medicare approved transplant center for the procedure. Hospitals seeking AmeriHealth Caritas Louisiana coverage for transplant procedures must submit documentation verifying that they are a Medicare approved center for each type of transplant other than bone marrow and stem cell transplants. A completed attestation form must be submitted to AmeriHealth Caritas Louisiana. AmeriHealth Caritas Louisiana may grant an exception to a transplant center for a specific procedure if the transplant surgeon can demonstrate experience with

that specific procedure and a history of positive outcomes in another hospital. The other hospital must be a Medicare approved transplant center for that specific procedure.

In addition to the above criteria, transplant centers located in-state shall meet the following criteria for AmeriHealth Caritas Louisiana coverage of transplant services:

- Be a member of the Organ Procurement and Transplant Network (OPTN) or the National Marrow Donor Program (NMDP), if the hospital only performs bone marrow/stem cell transplants;
- Have an organ receiving and tissue typing facility (Centers for Medicare and Medicaid Services (CMS) approved for histocompatibility) or an agreement for such services;
- Maintain a written records tracking mechanism for all grafts and recipients including:
  - Patient and/or graft loss with the reason specified for failure;
  - Date of the procedure; and
  - Source of the graft.
- Have written policy for contacting recipients and appropriate governmental officials when an infectious agent is involved;
- Have a written criteria for acceptable donors for each type of organ for which transplants are performed;
- Have adequate ancillary departments and qualified staff necessary for pre-, intra-, and post-operative care including, but not limited to:
  - Assessment team;
  - Surgical suite;
  - Intensive care;
  - Radiology;
  - Laboratory pathology;
  - Infectious disease;
  - Dialysis; and
  - Therapy (rehabilitation).
- Have minimum designated transplant staff which includes:
  - Transplant surgeon- adopt standards as delineated and updated by the OPTN;
  - Transplant physician - same standards as above;
  - Clinical transplant coordinator:
    - Registered nurse licensed in Louisiana; and
    - Certified by NATCO or in training and certified within 18 months of hire date.
  - Transplant social worker;
  - Transplant dietician;
  - Transplant data coordinator; and
  - Transplant financial coordinator.

**NOTE: For individuals identified in the bullets immediately above this note, continuing education is required to maintain licensure and certification as applicable.**

- **Written recipient selection criteria and an implementation plan for application of criteria;**
- **Facility plan, commitment and resources for a program capable of performing the following minimum number of transplants per year/per organ:**
  - **Heart: 12;**
  - **Liver: 12;**
  - **Kidney: 15;**
  - **Pancreas: 6;**
  - **Bone marrow: 10; and**
  - **Other organs as established per Medicare and/or OPTN.**

**NOTE: If the level falls below the required volume, the hospital shall be evaluated by AmeriHealth Caritas Louisiana for continued recognition as a transplant center.**

**Facility must demonstrate survival rates per organ type per year, which meet or exceed the mean survival rates per organ type per year as published annually by the OPTN. (If rates fall below this level, the hospital shall supply adequate written documentation for evaluation and justification to AmeriHealth Caritas).**

**All organ transplants must be authorized by AmeriHealth Caritas Louisiana prior to the performance of the surgery via a prior authorization letter. The only exception is for recipients with retroactive eligibility.**

**Transplant charges are to be included in the inpatient hospital charges using the revenue codes 300 and 800 range. This includes donor search charges and all procedures involved in harvesting the organ from the donor. Costs associated with the search will not be covered on an outpatient basis. Costs are not covered when the AmeriHealth Caritas Louisiana recipient donates an organ to a non-AmeriHealth Caritas Louisiana recipient.**

#### **Required Documentation for Organ Transplant Authorization Requests**

**All transplants must be prior authorized. The only exception is for recipients with retroactive eligibility. All documentation supporting the performance of the transplant must be attached to the letter.**

#### **Standards for Coverage**

**Requests for transplants are reviewed on a case-by-case basis by applying the following criteria:**

- **Transplant procedure to be performed is compatible with the diagnosis.**
- **All alternative forms of treatment have been tried, and the only viable alternative is the transplant procedure.**
- **Death would be imminent if the procedure were not performed is a reasonable medical probability.**
- **The procedure has met with a reasonable degree of success in the past.**
- **The procedure may be performed out of the state, if the facilities in state are not available.**
- **Services to the organ donor and organ procurement costs are included in the reimbursement methodology.**

#### **Cochlear Implantation**

Louisiana Medicaid covers unilateral or bilateral cochlear implants when deemed medically necessary for the treatment of severe-to-profound, bilateral sensorineural hearing loss in individuals under 21 years of age. All aspects of the cochlear implant (preoperative evaluation, implantation, device, repairs, supplies, therapy) must be prior authorized. For eligibility criteria and prior authorization instructions, please refer to Chapter 5, which is the Professional Services manual chapter. For information on coverage of cochlear implants, equipment, repairs and replacements, please refer to manual Chapter 18, Durable Medical Equipment.

### Reimbursement

Reimbursement will be made to the hospital for both the implant and the per diem. The implant and the implantation surgery must be prior authorized by submitting the PA-01 form. After approval has been granted, the hospital shall bill for the implant(s) by submitting the appropriate HCPCS code on a CMS 1500 claim form. Write the letters DME in bold, black print on the top of the form and the PA number must be written in item 23.

### Medical and Social Criteria

#### General Criteria

The following criteria apply to all candidates:

- Have a profound bilateral sensor-neural hearing loss with pure tone average of 90 dB HL or greater for frequencies of 1000, 2000, and 4000Hz;
- Have no response to Auditory Brainstem Response, Otoacoustic testing or any other special testing or any other special testing that would be required to determine if the hearing loss is valid and severe enough to qualify for cochlear implantation;
- Be a child age one year or older with a profound sensorineural hearing loss or be an adult through the age of twenty years; with a profound post lingual sensorineural hearing loss;
- Receive no significant benefit from hearing aids as validated by the implant team;
- Have a high motivation to be part of the hearing community as validated by the implant team;
- Have appropriate expectations;
- Had radiologic studies that demonstrate no intra cranial anomalies or malformations which contraindicate implanting the receiver-stimulator or the electrode array;
- Have no medical contraindication for undergoing implant surgery or post implant rehabilitation; and
- Show that the recipient and his/her family are well motivated, have appropriate expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) Guidelines.

### Age-Specific Criteria

#### Children One through Nine Years

Children one through nine years must not receive any significant benefit from a hearing aid that was obtained in the best-aided condition as measured by age appropriate speech perception material.

#### Children 10-17 Years

**Children in this age range must meet the following criteria:**

- **Receive no significant benefit from a hearing aid that was obtained in the best aided condition as measured by age and language appropriate speech perception material;**
- **Have received consistent exposure to effective auditory or phonological stimulation in conjunction with the oral method of education and auditory training;**
- **Utilizes spoken language as the primary mode of communication through one of the following: an oral/aural (re) habilitation program or total communications educational program with significant oral/aural; and**
- **Have at least six months' experience with a hearing aid or vibrotactile device in the case of meningitis (in which case the six-month period will be reduced to three months).**

**Adults - 18-20 Years**

**The following criteria must be met:**

- **Have a severe to profound post lingual bilateral sensorineural hearing loss;**
- **Receive no significant benefit from a hearing aid that was obtained in the best-aided condition for speech/sentence recognition material;**
- **Have received consistent exposure to effective auditory or phonological stimulation or auditory communication;**
- **Have no medical contraindication for the undergoing implant surgery or post-implant rehabilitation; and**
- **Show that the recipient and his/her family are well-motivated, have appropriate post-implant expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) guidelines.**

**The criteria utilized must be appropriate for the child's age.**

**Re-Performance of the Surgery**

**Prior Authorization is required for re-performance of the surgery because of infection, extrusion, or other reason. The request should be submitted to AmeriHealth Caritas Louisiana and contain sufficient documentation explaining the reason the surgery must be repeated.**

**Replacement of the External Speech Processor**

**Replacement of the external speech processor will be considered only if the processor is lost, stolen, or damaged beyond repair.**

Upgrades due to cosmetic reasons or technological advances in the hardware do not qualify as reasons for a replacement.

When it is necessary to replace the external speech processor, the multidisciplinary team must initiate the required PA request by submitting a copy of PA's initial approval letter for the implant and documentation of the need for a new processor.

### Non-Covered Expenses

Service contracts and/or extended warranties and insurance to protect against loss and theft are the responsibility of the family.

### Vagus Nerve Stimulator

The vagus nerve stimulator (VNS) is an implantable device used to assist in the control of seizures related to epilepsy and must be prescribed by a physician.

Hospitals should confirm that the surgeon has received an authorization for the procedure prior to submitting their claim in order to prevent denials.

### Intrathecal Baclofen Therapy

Intrathecal Baclofen Therapy (ITB) is for the treatment of severe spasticity of the spinal cord or cerebral origin and for the surgical implantation of the programmable infusion pump by which ITB is delivered. This treatment must be prior authorized before its administration. To obtain pre-certification for the stay, the pre-certification process must be followed.

### Criteria for Recipient Selection

Consideration will be given for reimbursement for implanting an ITB infusion pump if the treatment is considered medically necessary, the recipient is four years of age or older with a body mass sufficient to support the implanted system, and any one or more of the following criteria is met:

- Inclusive criteria for candidates with spasticity of cerebral origin:
  - There is severe spasticity of cerebral origin with no more than mild athetosis;
  - The injury is older than one year;
  - There has been a drop in Ashworth scale of one or more;
  - Spasticity of cerebral origin is resistant to conservative management; or
  - The candidate has a positive response to the test dose of ITB.
- Inclusive criteria for candidates with spasticity of spinal cord origin:
  - Spasticity of spinal cord that is resistant to oral antispasmodics or side effects are unacceptable in effective doses;
  - There has been a drop in Ashworth scale of two or more; or
  - The candidate has a positive response to the test dose of ITB.

Caution should be exercised when considering ITB infusion pump implantation for candidates who:

- Have a history of autonomic dysreflexia;
- Suffer from psychotic disorders;
- Have other implanted devices; or

- Utilize spasticity to increase function such as posture, balance, and locomotion.

#### Exclusion Criteria for Recipients

- Fails to meet any of the inclusion criteria;
- Is pregnant, refuses or fails to use adequate methods of birth control;
- Has a severely impaired renal or hepatic function;
- Has a traumatic brain injury of less than one year pre-existent to the date of the screening dose;
- Has a history of hypersensitivity to oral baclofen;
- Has a systematic or localized infection which could infect the implanted pump; or
- Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of Lioresal during the screening trial procedure.

Prior Authorization for chronic infusion of ITB shall be requested after the screening trial procedure has been completed but prior to the pump implantation.

The request to initiate chronic infusion shall come from the multi-disciplinary team that evaluates the recipient. The multi-disciplinary team should consist of a neurosurgeon or an orthopedic surgeon, a psychiatrist and/or neurologist, the recipient's attending physician, a nurse, a social worker and allied professionals (physical therapists, occupational therapist, etc.).

These professionals shall have expertise in the evaluation, management, and treatment of spasticity of cerebral and spinal cord origin and shall have undergone training in infusion therapy and pump implantation by Medtronic or an equally recognized product supplier with expertise in intrathecal baclofen.

A recent history with documentation of assessments in the following areas must be sent to AmeriHealth Caritas Louisiana:

- Medical and physical;
- Neurological;
- Functional;
- Psychosocial;
- Ashworth scores taken before and after the administration of the IBT test dose(s); and
- Documentation of any other findings about the recipient's condition which would be of interest to or would assist AmeriHealth Caritas Louisiana in making a decision regarding the recipient's need for chronic infusion, i.e., a videotape of the trial dosage.

#### Out-of-State Non-Emergency Hospitalizations

Out-of-state non-emergency hospitalizations require authorization, unless the request for hospitalization is for a dual Medicare/AmeriHealth Caritas Louisiana eligible recipient. Authorization is required for dual eligible recipients only if transportation services are being requested in addition to the hospitalization.

To obtain authorization for out-of-state non-emergency hospitalizations, send a facsimile (fax) of a "Letter of Referral" to the attention of AmeriHealth Caritas Louisiana. The referring physician should sign the "Letter of Referral" and answer the following questions:

- What is the recipient's name and AmeriHealth Caritas Louisiana identification number?
- What is the name and telephone number of the contact person representing the recipient?
- Is the recipient both Medicare and AmeriHealth Caritas Louisiana eligible?
- Does the recipient require transportation services as well?
- Is the facility where the recipient will be hospitalized a AmeriHealth Caritas Louisiana provider with a valid seven-digit provider number?
- Why is the situation so unique that it cannot be provided in Louisiana or in one of the Louisiana trade areas?
- What referrals were made in Louisiana before a referral was made to an out-of-state provider/hospital?

NOTE: Emergency out-of-state hospitalizations do not require PA.

## Positron Emission Tomography Scans

### Positron Emission Tomography Scans for Oncologic Conditions

Positron emission tomography (PET) scans are covered services, which require prior authorization, and must be consistent with AmeriHealth Caritas Louisiana's clinical guidelines and medical necessity criteria for oncologic indications. The medical necessity criteria can be found at [PET Scan Medical Necessity Criteria](#). The procedure must be performed within 30 days of receiving prior authorization.

### Combination Studies PET/Computed Tomography (CT)

The combination of PET and CT scans into a single system (PET/CT) may be considered for oncologic indications where a PET scan is considered medically necessary and specific anatomical identification is required to guide clinical management.

### Prior Authorization

The following documentation is required for prior authorization of PET scans and PET/CT combination studies for oncologic conditions:

- Completed PA request form;
- Documentation of medical necessity includes all of the following;
- The primary diagnosis name and International Classification of Diseases (ICD) code(s) for the condition requiring PET imaging;
- All secondary diagnosis name(s) and ICD code(s) pertinent to comorbid condition(s);

- The most recent medical evaluation, including a summary of the medical history and the last physical exam (clinical information must be submitted by the recipient’s treating oncologist);
- Laboratory and pathology reports pertinent to a diagnosis of malignant neoplasm or carcinoma;
- Risk factors or comorbid conditions;
- The patient’s treatment plan, including a description of the type and dates of any anti-tumor therapy; and
- Any additional clinical information that supports the coverage criteria and that is requested by AmeriHealth Caritas Louisiana.

The payable revenue codes for positron emission tomography scans are 343 and 404. These revenue codes must be billed with the appropriate accompanying CPT codes for PET scans.

### Reconsiderations

1. If a request for PA is denied, a provider may submit the request for reconsideration.

### Instructions for Submitting a Reconsideration

2. Write the word “Reconsideration” across the top of the denial letter, and write the reason the request for reconsideration at the bottom of the page;

3. Attach all of the original documentation, as well as any additional documentation or information, which supports medical necessity, to the letter; and

4. Mail the letter and all documentation to AmeriHealth Caritas.

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## References

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Louisiana Department of Health. 2011. Hospital Services Provider Manual. Prior Authorization. Chapter 25, Section 25.6. Issued 05/12/2025.

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## Policy updates

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