

**441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.**

**78.28(1)** Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

*a.* Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

*b.* Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5) “*d.*”

*c.* Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5) “*l.*”

*d.* Rescinded IAB 5/11/05, effective 5/1/05.

*e.* Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5) “*f.*”

*f.* Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

*g.* Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5) “*a.*”

*h.* Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2) “*c.*”)

*i.* Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5) “*m.*”

*j.* Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5) “*c.*”

*k.* Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5) “*e.*”

*l.* Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5) “*n.*”

*m.* Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5) “*g.*”

*n.* Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5) “*h.*”

*o.* Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5) “*i.*”

*p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5) “*j.*”

*q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.

*r.* Customized wheelchairs, subject to the requirements of 78.10(2) “*d.*”

**78.28(2)** Dental services. Dental services which require prior approval are as follows:

*a.* The following periodontal services:

(1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) “*b.*”

(2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) “*d.*”

(3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) “*e.*”

(4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) “*f.*”

(5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)“g.”

*b.* The following prosthetic services:

(1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“b.”

(2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“d.”

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“c.”

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“e.”

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“k.”

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“l.”

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“m.”

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“n.”

*c.* The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)“a.”

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“b.”

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“c.”

*d.* The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)“d”(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)“d”(4).

*e.* Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)“d.”

*f.* Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)“g.”

**78.28(3)** Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

*a.* A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

*b.* Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

*c.* Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

*d.* Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

*e.* Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

**78.28(4)** Hearing aids that must be submitted for prior approval are:

*a.* Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross reference 78.14(7) "d"(1))

*b.* A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7) "d"(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

**78.28(5)** Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

*a.* Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

*b.* All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

*c.* Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

**78.28(6)** Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

*a.* Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

*b.* Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

**78.28(7)** All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

*a.* Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

**78.28(8)** Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

**78.28(9)** Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the

department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

**78.28(10)** Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) "b")

**78.28(11)** High-technology radiology procedures.

a. Except as provided in paragraph 78.28(11) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(11) "a," prior authorization is not required when any of the following applies:

- (1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;
- (2) The member has Medicare coverage;
- (3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member's receipt of such notice (see paragraph 78.28(11) "e"); or
- (4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department's contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member's retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.

2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

This rule is intended to implement Iowa Code section 249A.4.

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