Acentra HEALTH

Surgical Justification

Provider Education 2024

Surgical Justification

- SCDHHS contracts with Acentra Health to perform pre-surgical review of select surgical procedures.
- A list of codes requiring prior authorization can be found at Hospital Procedure Codes (scdhhs.gov).
  - Examples include, but not limited to bariatric surgery, hysterectomies, device implants, spine surgery
- Refer to SCDHHS Hospital Services Provider Manual for full details.

Cochlear Implant

- Effective 1/1/2024 SCDHHS expanded coverage for cochlear implants (69930) to include adults, age 21 and over. The procedure requires prior authorization.

- Request must be received before service is performed.
  **Hearing aid trial is not required for members age 21 and over

- InterQual® criteria will be used for medical necessity determination

Endovenous RF

- Effective 10/26/23 SCDHHS requires prior authorization for the following endovenous radiofrequency ablation codes:

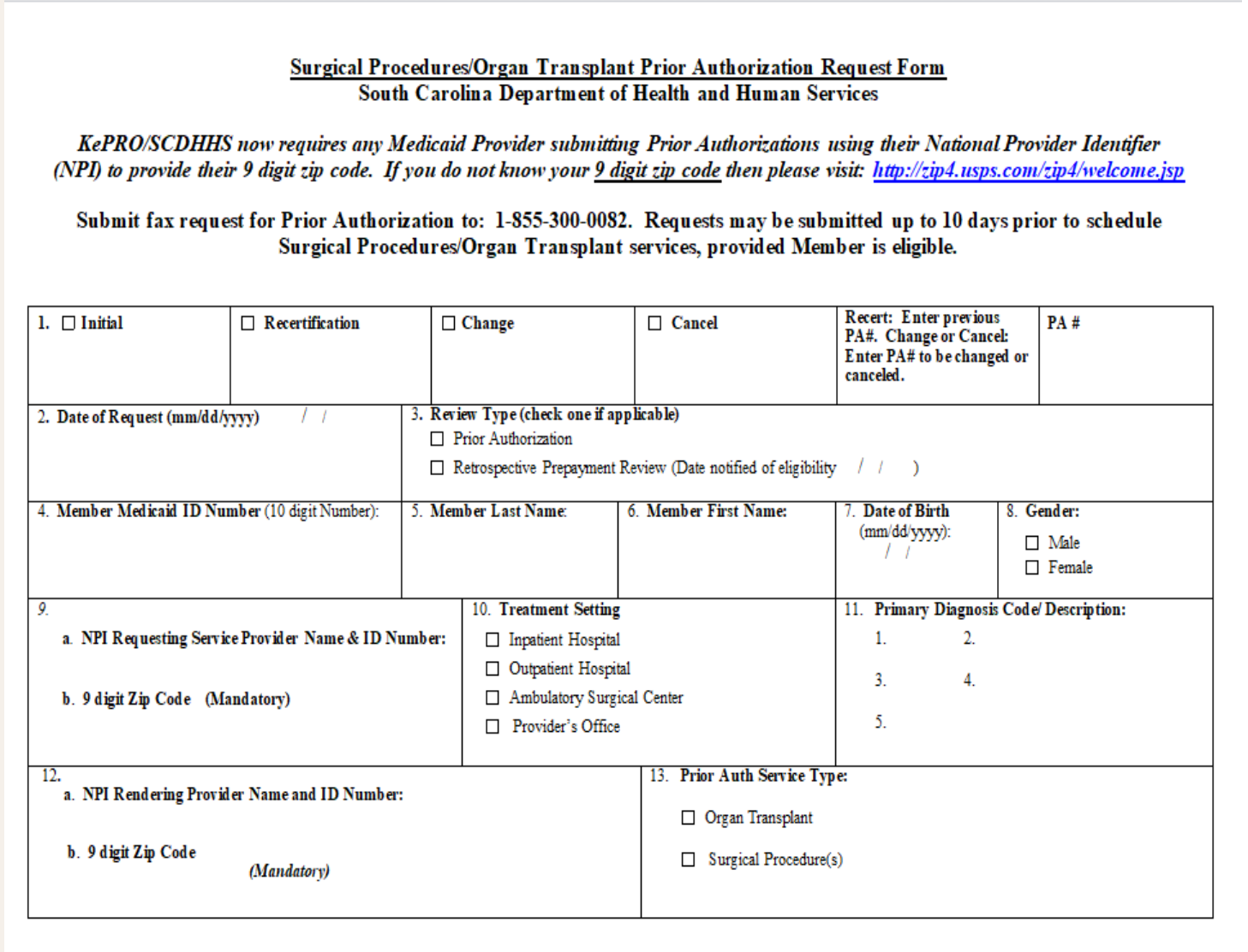
  36475
  36476
  36478
  36479

- Request must be received before service is rendered.

- InterQual® criteria will be used for medical necessity determination

Hysterectomy

- SCDHHS requires pre-admission surgical justification for hysterectomies.
- Prior authorization must be obtained even if the surgery follows a delivery.
- Providers should use the Request for Surgical Justification for Hysterectomy form (if not using the web portal) AND the Consent for Sterilization form with each request.
- A hysterectomy must be medically necessary and not for the sole purpose of rendering a member sterile or incapable of reproducing.



Surgical Procedures/Organ Transplant Prior Authorization Request Form
South Carolina Department of Health and Human Services

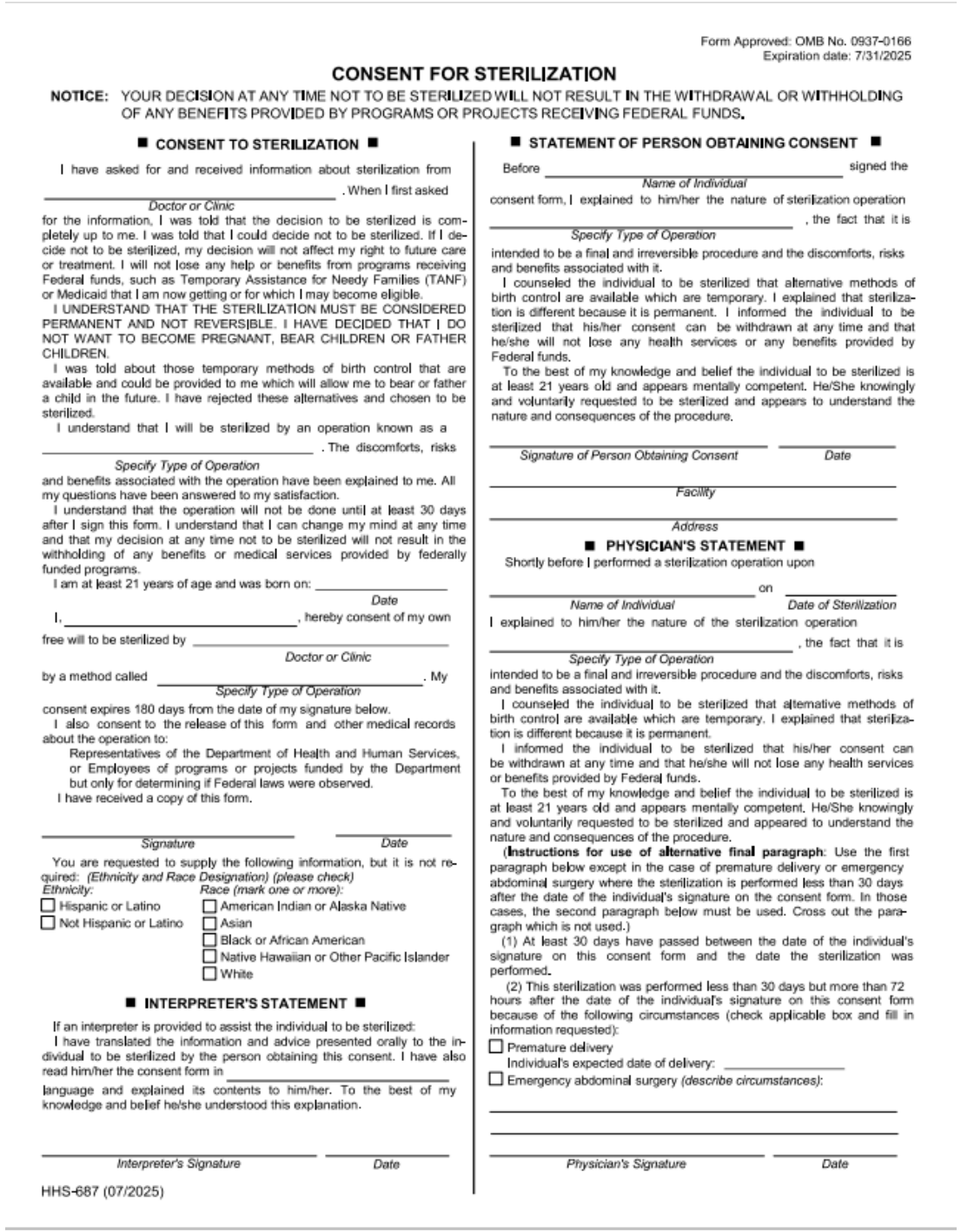
KePRO/SCDHHS now requires any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) to provide their 9 digit zip code. If you do not know your 9 digit zip code then please visit: http://zip4.usps.com/zip4/welcome.jsp

Submit fax request for Prior Authorization to: 1-855-300-0082. Requests may be submitted up to 10 days prior to schedule Surgical Procedures/Organ Transplant services, provided Member is eligible.

1. ☐ Initial	☐ Recertification	☐ Change	☐ Cancel	Recert: Enter previous PA#. Change or Cancel: Enter PA# to be changed or canceled.	PA #
2. Date of Request (mm/dd/yyyy) / /	3. Review Type (check one if applicable) ☐ Prior Authorization ☐ Retrospective Prepayment Review (Date notified of eligibility / /)				
4. Member Medicaid ID Number (10 digit Number):	5. Member Last Name:	6. Member First Name:	7. Date of Birth (mm/dd/yyyy): / /	8. Gender: ☐ Male ☐ Female	
9. a. NPI Requesting Service Provider Name & ID Number: b. 9 digit Zip Code (Mandatory)	10. Treatment Setting ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Ambulatory Surgical Center ☐ Provider's Office		11. Primary Diagnosis Code/ Description: 1. 2. 3. 4. 5.		
12. a. NPI Rendering Provider Name and ID Number: b. 9 digit Zip Code *(Mandatory)*	13. Prior Auth Service Type: ☐ Organ Transplant ☐ Surgical Procedure(s)				

Sterilization Form

- Please use the most current form.
- The physician should submit a **properly completed** consent form that meets all federal requirements associated with elective sterilizations.
- There is a 30-day wait period from the date the consent form is signed by the patient before the surgery is performed, unless it is an urgent or emergent case.
- Exceptions to the 30-day wait period:
  - Premature delivery
  - emergency abdominal surgery
- Please refer to the SCDHHS Hospital Services Provider Manual for more specific details regarding hysterectomy coverage and billing specifications.



Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2025

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (Specify Type of Operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (Date)

I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor or Clinic) by a method called _____ (Specify Type of Operation). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (Signature) _____ (Date)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (Interpreter's Signature) _____ (Date)

HHS-687 (07/2025)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of Individual) signed the consent form, I explained to him/her the nature of sterilization operation _____ (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (Signature of Person Obtaining Consent) _____ (Date)

_____ (Facility)

_____ (Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of Individual) on _____ (Date of Sterilization)

I explained to him/her the nature of the sterilization operation _____ (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

_____ (Physician's Signature) _____ (Date)

Prior Authorization Requests

Authorization requests should be submitted prior to services being rendered.

Authorization requests may be submitted online at https://portal.kepro.com or by fax using the Surgical Justification Request form

Sterilization Consent form must be included if requesting any form of sterilization.

Authorization Types

❑ Prior Authorization

Should always be submitted before the service is rendered.

❑ Retrospective Authorization "Retro"

Needed when services were performed before the member was eligible for Medicaid and the member has since been granted retrospective eligibility covering the date of service.

- A Retro case is NOT one that is submitted late for any reason other than eligibility.
- Untimely requests will be administratively denied.
- Providers must identify a request as RETRO on the fax request form or by request type in Atrezzo.

Processing Timelines

Acentra Health completes requests for services expeditiously and within contractual timeframes. The review completion timeframe is measured from the date Acentra Health receives a request.

- New Request/Admission review – 5 business days
- Retrospective Reviews – 5 business days

Review Process

Administrative Requirements

- Member eligibility verified
- Provider eligibility verified
- Medicaid Guidelines applied

Nurse Review

- InterQual® or State defined criteria applied
- May pend for additional clinical information
- Approve if criteria met
- Refer to physician reviewer if documentation does not support medical necessity.

Physician Review

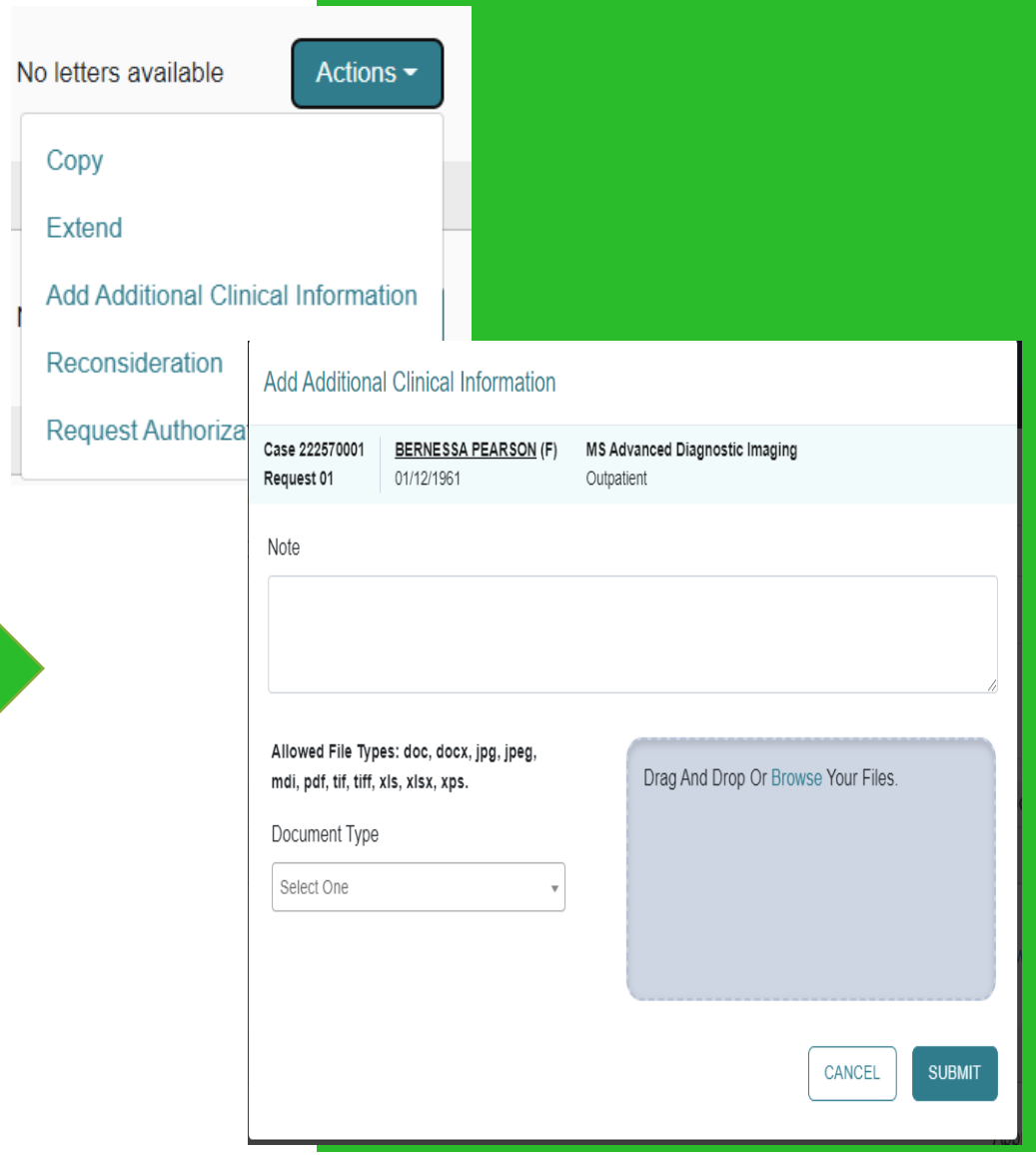
- The medical director, or another qualified physician reviewer will review the case against InterQual® or State defined criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider number
  - Additional information or clarification is needed before a decision can be made
- Notifications are sent via fax or web portal
- A provider has 2 business days to respond to the additional information request
  - If the case contains no clinical information, the case will be administratively denied.
  - If the case has insufficient clinical information and there is no response to the pended, the case will move to the physician reviewer for a determination.
- If a review is administratively denied, the provider may submit a new request once they have all the necessary information.

Responding to Pended Reviews

- If you submitted the request online thru the Portal:
  - Log into the Portal and open the pended case
  - ACTION TAB – additional Clinical Information
  - Upload the requested documents or type the information in the note section.



Denials and Reconsiderations

Administrative Denial

- When any portion of the review is denied because it does not comply with Medicaid regulations
- Example: untimely, insufficient information
- Provider may submit a new case for the service if an administrative denial is received. This does not apply to those cases that were denied for untimely submission.

Clinical Denial

- Occurs when any portion of the requested service is denied by a physician reviewer due to medical necessity
- Does not meet state Medicaid criteria with information submitted or does not meet other national evidence-based criteria

Reconsideration

- May only be requested for clinically denied cases
- Not used for Administrative Denials

Reconsiderations

- May be submitted within 30 calendar days of the **clinical** denial date
  - This is your opportunity to provide more detailed clinicals
- May be submitted via
  - Web portal *preferred
  - Fax
  - phone *least preferred (will still require additional information to be faxed)
- A clinical reviewer will review any additional information submitted. If unable to meet InterQual® or State approved criteria, it will be referred to the physician reviewer.
- A physician reviewer – a different physician from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration
- The physician reviewer may
  - Uphold original decision (no change made)
  - Overturn the original decision (approve the case)
- If original decision is upheld, provider may appeal the decision to SCDHHS.

Appeals

- If a reconsideration is upheld, an appeal may be requested. Specific instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct a Fair hearing.
- Members may request an appeal within 30 calendar days from the reconsideration determination notice:
  - online at www.scdhhs.gov/appeals,
  - Fax 803 255 8206
  - Email appeals@scdhhs.gov
  - Mail Office of Appeals and Hearings

    PO BOX 8206

    Columbia, SC 29202

Resources and Education

- SCDHHS Physician Provider Manual
- Hospital Services Manual - 02-01-2024 (scdhhs.gov)
- Provider Training Resources | SCDHHS
- SC Acentra Health website
- Acentra Health Customer Service
  - 1-855-326-5219