2013 IHCP Annual Provider Seminar
Prior Authorization 101
For
Traditional Medicaid and Care Select

This presentation can be downloaded at:

www.advantageplan.com/advcareselect
http://www.mdwise.org/providers-workshops.html
Agenda

- Prior Authorization Overview
  - What Requires PA & Supporting Documentation
  - Universal PA Form Overview
  - Common Reasons for PA Suspension/Denial
  - Elective Inpatient Admission PA
  - PA details for:
    - Medicaid Rehabilitation Option (MRO),
    - Traumatic Brain Injury (TBI),
    - Psychiatric Residential Treatment Facility (PRTF),
    - Physical/Occupational/Speech Therapy, and
    - Diabetic Supplies
    - Hospice
  - Provider Prior Authorization Appeals
- Questions?
There are two Care Management Organizations (CMOs):
  – ADVANTAGE Health Solutions, Inc.™
  – MDwise, Inc.

*Note: ADVANTAGE adjudicates all Traditional Medicaid, Medicaid Rehabilitation Option (MRO), TBI program admissions, and PRTF PA requests*

By contract, the CMOs are responsible for:
  – Processing PA requests
  – Making medical necessity determinations
  – Notifying providers and members of the determination
  – PA decisions based on OMPP approved guidelines
General PA Overview

Determine if a service or item requires PA in Traditional Medicaid and Care Select (CS):

- Use the IHCP fee schedule: [www.indianamedicaid.com](http://www.indianamedicaid.com).

- More information found in the IHCP Provider Manual Ch. 6, Indiana Administrative Code (IAC), bulletins, banner pages, and newsletters.

- Providers can review billing and coverage information in Ch. 8.

- Check PA status using PA inquiry function in Web interChange PRIOR to contacting the CMO.

- Providers must submit PA supporting documentation via fax or mail.
The Program PA Values descriptors are:

1. PA required for Traditional Medicaid and Hoosier Healthwise.
2. PA required for Traditional Medicaid and Hoosier Healthwise, with the exception of Package C.
3. PA only required for Package C.
4. PA not required.
Required forms located at www.indianamedicaid.com in ‘Forms’

- Universal PA for medical and behavioral health (Care Select or Traditional only)
- Prior Review and Authorization Dental Request form
- System Update Form
- Certificate of medical necessity form (i.e. oxygen, hearing aids, hospital beds, etc)
Supporting PA Documentation

- PA must be submitted on the appropriate PA request form and be supported by appropriate medical necessity documentation:

- Examples of Supporting Documentation:
  - certificate of medical necessity clearance form
  - Specific diagnosis related to the service requested
  - treatment plan/plan of care
  - physician order
  - physician notes
  - other documentation supporting medical necessity and reasonableness

Note: The CMOs retain the right to suspend a PA request to request additional information to make medical necessity determinations.
Q. What medical necessity documentation is needed beyond medical clearance forms?

A. Medical necessity requires medical clearance forms are completed and that the reviewer be able to appreciate the functional limitations due to illness or injury that require the necessary equipment

− Thorough documentation outlines not just what the individual “cannot do”, but “what they are capable of doing” as well

− Please document specific functional limitations of the member to demonstrate medical necessity
Important Universal PA Form Instructions

- The requesting and rendering provider’s National Provider Identifier (NPI) or Legacy Provider ID (LPI) are required.

- The provider’s copy of the *Universal Prior Authorization Request Decision* form is sent to the “mail to” address that corresponds to the requesting provider’s NPI or LPI entered in this field.

- If the requesting provider information does not have a valid service location, a PA decision letter is not generated. Therefore, providers must enter the correct NPI or LPI to ensure that the PA decision letter is mailed to the correct “mail to” address.

*Note: Information found in the IHCP Provider Manual Ch 6, Section 2, p. 6-18*
Top 5 PA Suspension/Denial Reasons

- Certificate of medical necessity missing/incomplete
- Home health plan of care missing/incomplete
- Incomplete PA form
- Missing physician orders, signed by physician (Physician Assistant and Advanced Nurse Practitioners are not acceptable per IAC)
- Clinical documentation missing
Helpful Hints to Get Started for all PA Requests

- Always verify eligibility on PA submission date and date of service
- PA decisions made within five (5) business days for CS and ten (10) business days for Traditional Medicaid
- Suspended PA requests must be completed within 30 days by the provider
- Submit PA to the member’s health plan
  - Fax the PA form along with supporting documents together
  - Web InterChange allows providers to submit non-pharmacy PA requests
  - Mail – Submit PA request form along with supporting documents
Elective Inpatient Admissions

- PA required for all non-emergent inpatient hospital admissions
- Including all elective or planned inpatient hospital admissions
- Applies to medical and surgical inpatient admissions
- ER admissions, routine deliveries, and newborn stays will not require PA
- Milliman Guidelines applied as criteria for appropriate admission; exceptions approved based upon medical necessity

NOTE: Required for all Care Select and Traditional Medicaid members effective January 1, 2011 (see BT201060)
Elective Inpatient Admissions

Providers are required to contact ADVANTAGE or MDwise at least

2 business days/ (48 hours) prior to admission.

- All inpatient hospital PA’s will be requested via telephone:
  - ADVANTAGE (1-800-784-3981)
  - MDwise (1-800-356-1204)

Facility must call prior to the admission and provide criteria for medical necessity

- For Non-Emergent ER and urgent care admissions that occur outside normal business hours, including weekends and holidays, providers will have 48 hours from the time of admission to request PA from the member’s CMO.
Retro-Active PA Request

- For dual members if Medicare will not cover the inpatient stay because the member has exhausted Medicare benefit or if the stay is not a Medicare-covered service, providers must request PA.
  
  *You will need to provide documentation of the Medicare denial.*

- For members newly enrolled or re-enrolled in the Medicaid program with a retro-eligibility date assigned by the program, providers should request PA.
Elective Inpatient Admissions

Provide the following information

- Member name and RID number
- Procedure requested, including current CPT code
- Location service is to be performed (facility)
- Medical condition being treated (ICD-9/10-CM) code
- Admitting Physician or surgeon
- Date of Admission
- Estimated length of stay (LOS)
- NPI (Hospital)
- If retro request, due to Medicare denial, provide a copy of Medicare denial documentation
ADVANTAGE reviews only the PA requests for:

- Retroactive eligibility
- Service package not approved by DARMA
- Additional units of service are required before the end of the Service Package
- Services requested, but not contained in initial Service Package

**Key elements of medical necessity determination:**

- Level of Need demonstrated per Adult Needs & Strengths Assessment (ANSA) or Child & Adolescent Needs & Strengths (CANS) Assessment
- Change in condition or severity of condition
- Identified therapeutic benefit
- Services are consistent with MRO policy
- Services are for the direct behavioral impact of the member
PA for Traumatic Brain Injury (TBI) Services

- All PAs managed by ADVANTAGE
- Members converted to FFS upon entry into program for out-of-state neuro-cognitive rehabilitation
- PA requests primarily come from Rehabilitation Facilities, brain injury specialists, and families
- Medical necessity is determined by:
  - Initial services available in Indiana have been utilized (Acute Inpatient and Outpatient services)
  - Services necessary for continued rehabilitation or management of adverse behaviors are not available in Indiana
  - Potential for improvement is identified
  - Mayo-Portland Scale demonstrates functional impairment
Psychiatric Rehabilitation Treatment Facility (PRTF) PA Requests

- PA requests from PRTF and acute behavioral health facilities are processed by ADVANTAGE

- BT200404 guides the admission criteria

- Member transitions to FFS while in program and returns to FFS or RBMC upon dismissal

- Therapeutic benefit of residential treatment is evaluated based upon the member’s condition and proposed treatment interventions

- Response to interventions on risk behaviors determines medical necessity for continued stay
**PRIOR AUTHORIZATION UPDATE**

- **BANNER BR201313**
  - IHCP requires PA for mental health services provided in an outpatient or office setting in excess of **20 units** per member, per rendering provider, per rolling 12-month period.
    
    Providers must submit a **current** plan of treatment and progress notes explaining the necessity and effectiveness of therapy with the PA request and make the plan available for audit purposes;

  - Outpatient mental health services rendered in combination with E&M services; PA requirements for **both** must be met.
    
    PA is required for E&M services in excess of **30 visits** per member, per rendering provider, per rolling 12-month period.

  - Please see Banner BR201313 for a listing of E/M CPT codes subject to mental health services limitations and PA requirements
Physical/Occupational/Speech Therapy PA

IHCP Mandated Physical, Speech, and Occupational Therapy PA changes Effective 6/30/11

- The current therapy guidelines of OMPP indicate approval when medically reasonable and necessary
- All therapy services more than 30 days after a hospital stay require PA
- Members may have Waiver Services that cover additional therapy not usually covered under IHCP benefits
- Medical necessity is determined by the fixed criteria of IAC and also the variable criteria of progress to goals established by the provider
- Please review Provider Bulletin BT201126 for further clarification
Indiana Medicaid has chosen Abbott Diabetes Care and Roche Diagnostics as preferred vendors to supply blood glucose monitors and diabetic test strips for all Indiana Medicaid and HIP members.

- Change affects all claims on or after 1/1/2011.
- See (BT201055) for the Preferred Diabetic Supply List (PDSL).
- Submit PA requests to member’s assigned MCO, CMO or ADVANTAGE (for Traditional Medicaid) for any diabetic item not on the PDSL.

**Effective 2/1/2007 Diabetic supplies require all of the following PA criteria for additional units of A4253 (Diabetic Test Strips)**

- A signed statement of medical necessity.
- A clear medical recommendation of the number of additional units required to meet the patient’s medical need.
- A hemoglobin A1C test dated within 90 days prior to the PA request for additional units of A4253
PA for Hospice

- All PAs managed by ADVANTAGE Health Solutions – FFS PA Dept.
- IHCP hospice providers must submit documentation to ADVANTAGE PA Department within 10 days of the member’s election effective date, and for each benefit period for approval of the hospice benefit.
- Hospice analyst reviews the following documentation for accuracy and completeness to authorize services:
  - *Medicaid Physician Certification* form – Indicates the hospice member’s prognosis and diagnosis that prompted hospice election;
  - *Medicaid Hospice Election* form – Indicates the IHCP member’s willingness to choose the service;
  - *Medicaid Hospice Plan of Care* form – Monitors treatment modalities and processes
PA for Hospice (cont.)

- PA is required for any IHCP-covered service not related to the hospice member’s terminal condition, if PA is otherwise required.
- PA is not required for pharmacy services (for conditions not related to the member’s terminal condition), dental services, vision care services, and emergency services.

Managed Care Members Electing the Hospice Benefit

- Members enrolled in HHW, HIP, or Care Select must dis-enroll from the CMO or MCE before hospice authorization can be completed;
- Members who elect to enroll in the IHCP hospice benefit become eligible for hospice care the day following dis-enrollment from the CMO or MCE;
- The hospice provider may start billing the IHCP the day after the individual is dis-enrolled from the CMO or MCE;
- Hospice provider must fax the hospice election form to the ADVANTAGE Health Solutions-FFS PA Department to initiate the dis-enrollment of the member from the CMO or MCE. ADVANTAGE’s Hospice dis-enrollment fax line is (317) 810-4488.
Submitting PA Requests via Web InterChange

The following provider types can submit PA requests via Web InterChange:

- Chiropractor
- Dentist
- Doctor of Medicine
- Doctor of Osteopathy
- Home Health Agency (authorized agent)
- Hospice
- Hospitals
- Optometrist
- Podiatrist
- Psychologist endorsed as a Health Service Practitioner in Psychology (HSPP)
- Transportation providers

**NOTE:** *ALL provider types can check PA request status via Web InterChange.*
Provider Appeals

• **Administrative Review (1\textsuperscript{st} Level)** – completed by the CMO or FFS PA department that denied the request. *Note: If the member has been assigned to a different program since the PA was denied, providers can either appeal to the PA vendor that denied the original request or submit a new PA request for review to the current CMO or FFS PA vendor.

• **Administrative Hearing (2\textsuperscript{nd} Level)** – after exhausting the administrative review process (1\textsuperscript{st} Level), providers can further appeal the decision by requesting an administrative hearing conducted between the provider, IFSSA, the CMO or FFS PA vendor, and an Administrative Law Judge (ALJ).
Administrative Review (1st Level)

- Administrative review of an adverse PA decision must be submitted within seven (7) working days of the PA decision letter.

- Failure to request a timely administrative review results in the loss of the right to request an administrative hearing.

- The CMO or FFS PA vendor medical directors or designees render the administrative review decision of the health plan within seven (7) working days of receipt of all necessary documentation.
To initiate, providers must include the following information with the request:
- Copy of the original PA form
- Summary letter, including pertinent reasons the services are medically necessary
  - Include the PA number, member’s name, and member RID number
- Include any medical records, equipment consultations, progress notes, case histories, and therapy evaluation that support the medical necessity
- Name, telephone number, and address of the provider submitting the request
- For inpatient hospitalizations please send entire medical record for review
  - CMO or FFS PA vendor must receive entire medical record within forty-five (45) calendar days after discharge.
- Decision letters are mailed to the provider and member
Administrative Hearing (2\textsuperscript{nd} Level)

After exhausting the administrative review process (1\textsuperscript{st} Level), providers can further appeal the decision by requesting an administrative hearing conducted between the provider, IFSSA, the CMO or FFS PA vendor, and an Administrative Law Judge (ALJ).

- Provider requests for administrative hearings must be submitted within 30 calendar days of the administrative review decision to this address:

  Hearings and Appeals Section, MS-04  
  Indiana Family and Social Services Administration  
  402 W. Washington St, Room W392  
  Indianapolis, IN 46204-2773

  \textit{NOTE: The State will schedule a meeting and inform the provider and the CMO or FFS PA vendor of the date, time, and location for the hearing.}
PA Department Contact Information

- ADVANTAGE Health Solutions, Inc.℠
  - www.advantageplan.com/advcareselect
  - 1-800-784-3981 – Care Select PA
  - 1-800-269-5720 – Traditional PA

  Note: ADVANTAGE adjudicates all Traditional Medicaid, Medicaid Rehabilitation Option (MRO), PRTF PA requests, and Traumatic Brain Injury (TBI) Program admissions

- MDwise, Inc.
  - www.mdwise.org
  - 1-800-356-1204 – Care Select PA

  Note: All PA for prescription drugs are processed and adjudicated by Catamaran Corporation and not the CMOs
Questions?

**ADVANTAGE**

Kelvin Orr  
korr@advantageplan.com

Dan Green  
dgreen@advantageplan.com

Katie Tucker  
ktucker@advantageplan.com

**MDwise**

Meredith Edwards  
meedwards@mdwise.org

Matthew McGarry  
mmcgarry@mdwise.org

Marvin Davis  
mdavis@mdwise.org