MDwise

Improving the health of
Indiana *Care Select* Members

# MDwise *Care Select* Prior Authorization Quick Reference Guide

Certain Indiana Health Coverage Programs (IHCP) services require prior authorization (PA) for members enrolled in the Indiana *Care Select* (ICS) program. Providers should submit PA requests to ADVANTAGE Health Solutions on the date of the request.

This reference document was designed to provide general information for services that require PA in the ICS program. This reference should not be considered all-inclusive. Providers should consult the IHCP fee schedule at www.indianamedicaid.com and use the search engine to search by Current Procedural Terminology (CPT) code or Health Care Procedure Coding System (HCPCS) code to determine if that service requires PA. Certain procedure codes have provider type and specialty specific PA requirements that are mandated by the IHCP. Therefore, all providers should consult the appropriate Indiana Administrative Code (IAC) and/or the IHCP Provider Manual Chapter 6–Prior Authorization for PA guidelines for each provider type and specialty.

## IHCP Services that Require PA in ICS

*Note: Services that require PA in ICS may or may not require PA in Hoosier Healthwise. Providers must consult with the member's assigned managed care entity to determine if a covered IHCP service requires PA.*

### Institutional Services

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| Inpatient Substance Abuse | Inpatient Surgical Services | With the Exception of Emergency Admissions, Prior Authorization is Required for Any Psychiatric Admission, Including Admissions for Substance Abuse |
| Short-Term Nursing Facility Stays < 30 days<br>Extended Care Facility < 30 days<br>no PA is needed | Hospice (Traditional Medicaid only–member must be disenrolled from *Care Select*) | Emergency Services that Require PA in Normal Non-Emergency Situation |
| Rehabilitation Inpatient Admissions | Long-Term Acute Care Hospitalizations | Outpatient Procedures Rendered while Inpatient |
| Non-Emergent Elective Inpatient Admissions | | |

### Non-Institutional Services

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| Bariatric Services | Blepharoplastics | Bone Marrow Transplants |
| Stem Cell Transplants | Brand Name Medically Necessary Drugs (Contact ACS) | Genetic Testing for Detection of Cancer |
| Home Health/Certain Types of Therapy | Intersex Surgeries | Mastectomies for Gynecomastia |
| Reconstructive Surgeries | Maxillo-facial Surgeries | Organ Transplants |
| Reduction Mammoplasties | Chiropractor Services | Rhinoplasty |
| Sliding Mandibular Osteomies | Stress Electrocardiograms | Submucus Resection of Nasal Septum and Septoplasty |
| Surgical Procedures Involving the Foot | Medically Necessary Office Visits > 30 per year | Podiatry Services–Inpatient or Outpatient |
| **Out of State Services Performed in Non-Designated Areas (Non-Emergent) | Certain Durable Medical Equipment (DME) | Certain Home Medical Equipment (HME) |

***Note: PA required for out-of-state inpatient admissions within 48 hours of the admission. Providers in IFSAA designated areas are subject to in-state PA rules.*

## Dental Services

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|---|---|---|
| Dentures | Relines for dentures/partials for Members > Age 21 | Repairs for dentures/partials for Members > Age 21 |
| Dental Services Rendered in a Hospital | Dental Services Rendered in an Ambulatory Surgical Center (ASC) | Facility/Anesthesia Services in an ASC or Hospital |

Effective January 1, 2011, prior authorization (PA) will be required for all non-emergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries and newborn stays will not require PA. Observation does not require PA.

This applies to members of all ages served by traditional Medicaid, those in the *Care Select* program and, in some cases, dually eligible members. A member who is dually eligible for Medicare and Medicaid must ask for Medicaid PA for an inpatient stay that is not covered by Medicare. If a stay is covered by Medicare, in full or in part, the member does not require PA. The effective date of January 1, 2011, will apply to inpatient stays with an admit date on or after January 1, 2011.

Providers are required to call ADVANTAGE Health Solutions (1-800-784-3981) at least two business days prior to admission. All inpatient hospital PAs will be requested via telephone. The facility must call prior to the admission and provide criteria for medical necessity. You may request retroactive PA for dual members if Medicare will not cover the inpatient stay because the member has exhausted his or her Medicare benefit or if the stay is not a Medicare-covered service.

All PA requests must be submitted on the Universal Prior Authorization Request form located at www.indianamedicaid.com unless the provider is submitting the PA request via web interChange (see the IHCP Provider Manual Chapter 6, Section 1, pages 6–8 for a list of providers who may submit PA requests via web interChange). All PA system updates must be submitted on the Prior Authorization System Update Request form also located at www.indianamedicaid.com. New PA requests should not be submitted on a Prior Authorization System Update Request form (i.e. modifying date ranges approved on a PA.) All forms must be complete and signed.

**Submit PA requests for MDwise *Care Select* members to:**
ADVANTAGE Health Solutions–*Care Select*
Attn: Prior Authorization Department
P.O. Box 80068
Indianapolis, IN 46280 46244-0214

**Providers are encouraged to fax PA requests involving MDwise *Care Select* members to:**
1-800-689-2759

On December 10, 2010 the Indiana Health Coverage Program (IHCP) released bulletin BT201058 to announce service limitations to physical, occupational, and speech therapy. Therapy was limited to 25 visits for each therapy type for members age 21 and older, per rolling 12-month period. These service limitations were eliminated on June 30, 2011, but will be applied to any claims submitted with dates of service of January 1, 2011 to June 29, 2011. Effective June 30, 2011, prior authorization will be required for physical, occupational, and speech therapy for members age 21 and older.

Therapy services for members less than 21 years of age remain unchanged, and current prior authorization requirements remain in effect.

**MDwise**
1200 Madison Avenue
Suite 400
Indianapolis, IN 46225

1-800-356-1204
Fax: (317) 630-2835
**MDwise.org**