



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 the care management organization (CMO) that the member is affiliated with 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

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 Extended Care Facility < 30 days 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

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	Submucous 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

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 SolutionsSM (1-800-784-3981) or MDwise (1-866-440-2449) at least two business days prior to admission. MDwise will provide PA for *Care Select* members who are enrolled with MDwise as their care management organization. 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, page 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:

MDwise Care Select Prior Authorization Unit • P.O. Box 44214 • Indianapolis, Indiana 46244-0214

Providers are encouraged to fax PA requests involving MDwise Care Select members to
1-877-822-7186 or locally to 317-822-7515

Removal of physical, speech, and occupational therapy services limitations as previously published in Indiana Health Coverage Programs (IHCP) provider bulletin BT201058, dated December 7, 2010, the IHCP announced a service limit to physical, speech, and occupational therapy to 25 visits for each type of therapy, per rolling 12-month period, for members age 21 or older, for dates of service on or after January 1, 2011.

These service limitations that were previously announced will be eliminated effective June 30, 2011, but will be applied to any claims submitted with dates of service for January 1, 2011, through June 29, 2011. In addition, prior authorization will be required for all members age 21 or older for physical, speech, and occupational therapy, effective for dates of service on or after June 30, 2011.

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

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