

IHCP *bulletin*



INDIANA HEALTH COVERAGE PROGRAMS BT202181 SEPTEMBER 8, 2021

IHCP COVID-19 Response: IHCP reinstates temporary PA changes for managed care SNF admissions

Effective for dates of service (DOS) on or after Sept. 8, 2021, and until further notice, the Indiana Health Coverage Programs (IHCP) is reinstating temporary changes in the skilled nursing facility (SNF) prior authorization (PA) requirements for managed care health plans. This change is in response to the recent increase of coronavirus disease 2019 (COVID-19) cases and hospitalizations across the state of Indiana.



For SNF admission PAs, providers will only be required to submit basic information using the *IHCP Prior Authorization Request Form*, also known as the universal PA form (available from the [Forms](https://www.in.gov/medicaid/providers) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers)) or electronically through the managed care entity (MCE) provider portal.

The following information remains required on the PA form (or electronic equivalent):

- Rendering provider number
- Rendering provider tax ID
- Rendering provider address
- Member ID (also known as RID)
- Member name
- Member date of birth
- Start date of request
- Stop date of request
- Procedure, service or revenue code
- International Classification of Diseases (ICD) diagnosis
- Preparer name
- Preparer phone number
- Number of units
- Signature

For the authorization of the initial admission, clinical documentation is not required with the PA form, but may still be submitted to allow for care coordination support. All documentation must be maintained by the provider to substantiate the services provided and be available for post payment review. Documentation must clearly identify the location of the provider and patient. All services rendered must be medically necessary and within the provider's applicable licensure and scope of practice, including recent changes due to the public health emergency.

Providers must submit the PA request within 72 hours, or three calendar days, of the member's admission. Providers will receive a confirmation response from the MCE with which the member is enrolled.

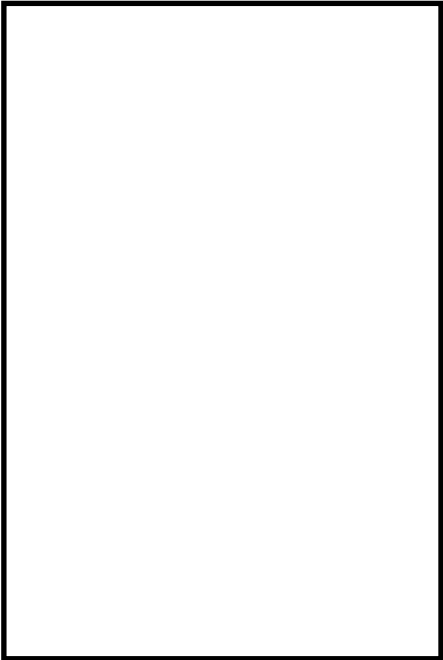
Authorizations will be automatically approved for a period of 14 days, unless fewer days are requested by the provider, or the member has less than 14 days remaining in their skilled nursing benefit limit.

For continuation of services beyond 14 days, a new fully completed authorization form with clinical documentation must be submitted by the provider to the member’s MCE for utilization management review.

Although nursing facilities have up to 30 days to complete a Preadmission Screening and Resident Review (PASRR) Level I and Level II assessments, establishing a level of care (LOC) early into the member’s nursing facility admission is critical for ensuring payment. Claims for nursing facility stays without an appropriate LOC established will be denied, even if the member is discharged from the nursing facility prior to the end of the 30 days.

The Hoosier Care Connect and the Healthy Indiana Plan have limitations on the number of days that can be paid for rehabilitative nursing facility care. Early into the member’s stay, nursing facilities, with the support of the MCE, should prepare plans for discharge or determine whether long-term care is required. Nursing facility stays for longer than the member’s benefit limitation do not automatically guarantee a transition to fee-for-service (FFS). Additional eligibility requirements must be met.

For more information, contact the MCE with which the member is enrolled.



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