OMPP CHANGE REQUEST

**Title:** Prior Authorization Letter Updates for Care Select and Fee for Service

**Change Request #** CR819  
**Issue Management #** 905

<table>
<thead>
<tr>
<th>Form Completed By:</th>
<th>Date Submitted:</th>
<th>Due Date:</th>
</tr>
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<tbody>
<tr>
<td>Seth Brooke</td>
<td>3/13/2008 3:00:29 PM</td>
<td>4/1/2008</td>
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**Requestor Name:** Seth Brooke

**CHANGE INFORMATION - Please use the Change Request Form - Directional Guide when completing this form.**

1. **Define Change:** State the problem needing resolution. State a suggested solution if one exists. Provide enough information so that the request can be reviewed and prioritized. Include information on a pre-set implementation date if one exists, and how completion will be determined. Identify any related reference, system, or business changes. *If this change could result in a mass adjustment, give the number of providers or claims impacted.*

   The Prior Authorization Letters (Series PAU-9000, PAU-9001, PAU-002, etc) contain two places where the relevant Care Management Organization (CMO) (MDwise Inc., or Advantage Health Solutions) address is listed. OMPP would like to add the CMO’s prior authorization telephone number at the end of each address. The Prior authorization number for MDwise is 1-866-440-2449. The Prior Authorization number for Advantage Health Solutions is 1-800-784-3981.

   The second issue is on the prior authorization rejection letter. The letter's address label at the top and bottom of the letter is populated based on the CMO that the member is currently enrolled. Care Select is using the rejection letter to notify providers that they have submitted the prior authorization to the incorrect CMO and that they should submit it to the other one to be processed. The change that we are requesting is that the top of the letter would be of the CMO that the provider incorrectly submitted the request to and the bottom address would be the CMO to which the prior authorization should truly be going. The intent is to have the letter state: "Provider has submitted the prior authorization to the incorrect vendor (MDwise/Advantage address) and due to this it has been rejected. Please submit the prior authorization to the correct vendor at (MDwise/Advantage address)."

2. **Change Category:** Choose all that apply
   - System (AIM) - Any change to computer software (applications), hardware, and firmware. Check this if there is a system change that includes a reference and/or Business Change.
   - Reference - A change to a reference file data value that does not require a technical (programmer) resource.
   - Business - A change in policy or business operation that does not require a technical (programmer) resource.
   - Mass Adjust/Reprocess - An automated or non automated process by which funds are either recouped by the State or repaid to providers.

3. **Impact Analysis:** Describe, in detail, what the impact, or result, of the completed change will be in the following categories. Include information on a workaround if one exists.
   
   3.a. To other business areas:
   
   The requests would improve the prior authorization process for our vendors and would in no way provide issues for other business areas.

   3.b. To external providers:
   
   The requests would positively impact external providers in that they would have the correct contact information for new prior authorization requests and would have a better understanding of why their prior authorization was rejected and to whom to properly submit.

   3.c. Fiscal impact:
   
   None

   3.d. Number of claims impacted (if reprocessing and/or mass adjustment):
   
   None

4. **Trigger:** Choose all that apply
   - Audit Finding
   - Defect to the system
   - External requirement
   - Federal mandate
   - Money-saving idea
   - New legislation
   - New procedure/technology
   - Provider inquiries
   - System inefficiencies
   - Other, specify

5. **Area Change Originated:**

   **Program Operations:**
   - 590
   - CHIP
   - Disease Management
   - EPSDT
   - First Steps
   - HoosierRx
   - LTC
   - Managed Care
   - MRT
   - PASRR
   - Pharmacy
   - Traditional Medicaid
   - Waiver
   - Other, specify **Care Select**
6. Areas impacted (internal and External): Check all areas that are impacted by this change.

6.a. Program Operations:
- [ ] 590
- [ ] CHIP
- [ ] Disease Management
- [ ] EPSDT
- [ ] First Steps
- [ ] HoosierRx
- [ ] Managed Care
- [x] Traditional Medicaid
- [ ] MRT
- [ ] PASRR
- [x] Other, specify Care Select

6.b. Processes:
- [ ] Change Management
- [ ] Claims
- [ ] Communications
- [ ] Compliance
- [ ] Contract Monitoring
- [ ] Data
- [ ] Documentation
- [ ] Drug rebate
- [ ] Eligibility
- [ ] Financial
- [ ] Medical policy
- [ ] PA
- [ ] Policy
- [ ] Premium Vendor
- [ ] Provider Enrollment
- [ ] Reimbursement
- [ ] Reporting
- [ ] TPL
- [ ] Other, specify

7. Provide Estimates for the following: Describe what it takes to make the change happen for each item.

7.a. System: Order of Magnitude Estimate - Check Very High, High, Medium, Low. (This should be based on the technical portion of the change and is intended to be a high-level estimate only. Additional estimates will be established following requirements determination.)
- [ ] Very High - Greater than 1000 hours
- [ ] High - 501 to 1000 hours
- [ ] Medium - 251 to 500 hours
- [ ] Low - 51 to 250 hours
- [ ] Very Low - Less than 50 hours

Supporting Information:

7.b. Business: Order of Magnitude Estimate - Check Very High, High, Medium, Low. (This should be based on the technical portion of the change and is intended to be a high-level estimate only. Additional estimates will be established following requirements determination.)
- [ ] Very High - Greater than 1000 hours
- [ ] High - 501 to 1000 hours
- [ ] Medium - 251 to 500 hours
- [ ] Low - 51 to 250 hours
- [ ] Very Low - Less than 50 hours

Supporting Information:

7.c. Resources - Describe any specific skill sets, technical resources, or people needed.

7.d. Funding - Describe any needed funding to complete change.

7.e. Durations - Describe amount of time to complete change.
8. **Testing:** Define if testing (test all paper and electronic claims) will be needed. Provide additional information, if available. The coordination plan should include the key areas that need testing, normal outputs tested, Web functionality, vendor testing, or other contractor interfaces as well as requirements for User Acceptance Testing, testers, and EDI coordination.

- [ ] Claims:
  - Crossover:
  - Dental:
  - Home health:
  - Inpatient:
  - Long term care:
  - Medical:
  - Outpatient:
  - Pharmacy:
  - Encounter:

- [ ] EDI - Batch:

- [ ] EVS:

- [ ] Adjustment/reprocess:

- [ ] POS inbound/outbound:

- [ ] Reports:
  - Vendor:
  - Web:
  - Window functionality:
  - Other, specify:

9. **Communication Plan:** Provide a communication plan for how change will be communicated. Check all that apply.

9.a. **Publications:**

- [ ] Banner page
- [ ] Bulletin
- [ ] Member letter
- [ ] Newsletter
- [ ] Project Workbook
- [ ] Provider Manual
- [ ] Web
- [ ] Other, specify:

9.b. **Communication Plan submitted to the OET:**

- [ ] Yes
- [ ] No

9.c. **Training:**

- [ ] EDS Staff
- [ ] External Contractor
- [ ] MCO
- [ ] OMPP/FSSA
- [ ] Provider
- [ ] Other, specify: **CMO**

10. **Follow-up Information:** Provide the following information:

10.a. Information on how the change will be evaluated after it is implemented (monitor claims activity, cost saving, production statistics, etc.). Compare extract data with data in other related reports.

10.b. A plan for how actuals to estimates will be evaluated.
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#### 11. Change/Project Updates:

This information is needed from the requestor as defined below.

Requestor will send status update to the OMPP.changerequest@fssa.in.gov e-mail box.

Subject heading of e-mail will read: CRxxx Status Update MMDDYY

Naming convention for file will be: CRxxx Status Update MMDDYY

- **Routine/Open Change Requests** - monthly updates are required within 7 working days from the end of the month. Information should include changes made during the previous month, any issues, hours required to make those changes. Use the excel file in the Share Point site.

- **Reference file changes** - monthly updates are required within 7 working days from the end of the month. Information should include changes made during the previous month, any issues, hours required to make those changes.

- **System & Business changes** - Update the OET if there are changes to the approved work that impact the original approved change. For example, if it will take longer to complete, resources are not available, risks, or issues have arisen, costs have increased.

  Provide an update after the Design Phase is completed, after the production phase (construction/coding/unit testing) is completed, after Testing (walk through, etc.) is completed and 30 days after Implementation. Updates should include at a minimum: status as compared to estimates, any issues, changes (any child/daughter change orders) or concerns, details regarding any communications needed, a communication plan if it has been written, any follow-up plans.

**OET Review Notes:** *Phone number change in AIM is approved. Cindy Adams will take responsibility to make AIM change. The CMO’s need additional instruction re: modifying their external text. OMPP to communicate to CMO’s.*

#### 12. Actions by the OMPP Operational Effectiveness Team (OET):

- Approve (in Work)
- Approve (Inventory)
- Reject
- In queue
- Return for more information
- Send to Governance Board

#### 13. Actions by the Governance Board:

- Approve
- Reject
- In queue
- Return to OET for more information