INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Prior Authorization

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of July 1, 2016 Published: October 13, 2016	Semiannual update: • Reorganized and modified text for better flow and clarity • Updated *Prior Authorization Overview* section • Changed ADVANTAGE references to Cooperative Managed Care Services (CMCS) and updated mailing address • Removed *Care Select* information • Updated *Transferring Outstanding Prior Authorizations* section • Added exception information regarding out-of-state providers in the *Prior Authorization Policy Requirements* section • Merged institutional and practitioner lists into the *Institutional and Practitioner Prior Authorization Policy Requirements* section • Added information from the Medical Policy Manual and 405 5-3-13(a) to the *Prior Authorization Policies for Specific Medical Services* section • Included 270/271 electronic transaction as a method of verifying member eligibility in the *Prior Authorization Inquiry and Eligibility Verification* section • Added 278 electronic transaction as a method in the *Methods for Submitting PA Requests* section and in the *Prior Authorization Request Forms* section	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
		• Updated option descriptions in the *Automated Attendant* section • Modified instructions in Table 1 regarding what happens when a PA request is received and the provider is not contracted with the IHCP • Added cross-reference to the Home and Community-Based Services Billing Guidelines module in the *Home and Community-Based Services Waiver Authorizations* section • Added the *1915(i) Home and Community-Based Services Authorizations* section	
1.2	Policies and procedures as of July 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: March 14, 2017	*Core*MMIS update: • Replaced references to Indiana*AIM* with *Core*MMIS • Replaced references to Web interChange with Provider Healthcare Portal (Portal) • Replaced references to RID with Member ID • Replaced references to LPI with Provider ID • Replaced references to Automated Voice Response (AVR) system with Interactive Voice Response (IVR) system and updated the telephone number • Updated text throughout the module to reflect Portal procedures, including the option to upload attachments • Updated the email address and telephone number for the EDI Solutions help desk • Modified the heading and text in *Prior Authorization Policies for Specific Types of Providers or Services* to focus on provider and service types rather than claim types • Updated the *Prior Authorization Inquiry and Eligibility Verification* section to reflect current IVR and Portal processes	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
		• Added information regarding claim submission in the *Medicaid Second Opinion Form* section • Updated the *Prior Authorization Update Requests* section	

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Section 1: Introduction to Prior Authorization

Note:	*The information in this document applies to nonpharmacy services. Pharmacy-related prior authorization for all Indiana Health Coverage Programs (IHCP) members is provided through OptumRx. For information about pharmacy-related prior authorization, including automation of pharmacy prior authorization for fee-for-service claims, see the Pharmacy Services module.*

The Indiana Health Coverage Programs (IHCP) requires prior authorization (PA) based on medical necessity for certain services. Certain services also require submitting PA requests for additional units when normal limits are exhausted.

The *Indiana Administrative Code* (IAC) serves as a comprehensive reference for IHCP covered services and PA procedures and parameters. IHCP providers are responsible for reading the portions of the IAC that apply to their areas of service. Specific PA criteria are found in *405 IAC 5-3* and *407 IAC*.

In addition to the IAC, the *Code of Federal Regulations* (CFR), *Indiana Code* (IC), *Family and Social Services Administration (FSSA) Medical Policy Manual*, and *IHCP Provider Reference Modules*, along with bulletins and banner pages published on indianamedicaid.com, provide a complete resource for PA policy and procedures.

Prior Authorization Overview

Multiple entities provide PA for IHCP services. Determining which entity to contact for PA depends on whether the service is reimbursed through the fee-for-service (FFS) or managed care delivery system. This section provides an overview of FFS PA and managed care PA. It also provides information about transferring existing PAs when a member changes from a managed care program to Traditional Medicaid or other FFS plan.

Fee-for-Service Prior Authorization

The Cooperative Managed Care Services (CMCS) PA Department reviews all IHCP nonpharmacy, FFS PA requests on an individual, case-by-case basis. The department's decisions to authorize, modify, or deny a given request are based on medical reasonableness, necessity, and other criteria in the IAC, as well as FSSA-approved internal criteria.

Providers can obtain applicable sections of the non-MCE internal PA criteria by referring to the *Medical Policy Manual* at indianamedicaid.com, by emailing PolicyConsideration@fssa.in.gov, or by writing to the following address:

MS07
Policy Consideration
Family & Social Services Administration
Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204

Managed Care Prior Authorization

The Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise managed care entities (MCEs) are responsible for processing medical service PA requests for managed care services and notifying members about PA decisions. The MCEs may develop their own internal criteria for *405* and *407 IAC* rule compliance.

The FSSA is responsible for the administration of the MCEs' portion of the HIP, Hoosier Care Connect, and Hoosier Healthwise pharmacy benefits. This responsibility includes processing all outpatient pharmacy claims and managing pharmaceutical services for drugs and some drug-related medical supplies and medical devices provided by enrolled IHCP pharmacy or durable medical equipment (DME) providers. Fee-for-service point-of-sale (POS) prior authorization requests are handled through OptumRx. Fee-for-service DME and home medical equipment (HME) prior authorization requests are processed through CMCS.

All other capitated services remain the responsibility of the HIP, Hoosier Care Connect, and Hoosier Healthwise health plans. These services include:

- Procedure-coded drugs billed by entities other than IHCP-enrolled pharmacy providers
- Medical supplies and medical devices (with the exception, for Hoosier Healthwise, of those medical supplies and devices listed in the *Drug-Related Medical Supplies and Medical Devices Reimbursed as Fee-for-Service* table in the *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com)
- Durable medical equipment
- Enteral or oral nutritional supplements

Prior authorization requests for drug-related medical supplies and medical devices (identified in the *Drug-Related Medical Supplies and Medical Devices Reimbursed as Fee-for-Service* table), when provided by a pharmacy or DME provider, are the responsibility of the CMCS PA Department for all IHCP members.

MCEs are responsible for determining what services require PA for their members, excluding carved-out (FFS-covered) services. However, for self-referral services, MCEs must follow the guidelines for PA in the IAC and outlined within this document. PA requests for services carved out of managed care are processed through CMCS and are subject to the same criteria as FFS requests. See the *Claim Submission and Processing* module for a list of self-referral and carved-out services.

Additional information about MCE authorization procedures can be requested from the MCE at the telephone numbers available from the Provider Healthcare Portal (Portal) at portal.indianamedicaid.com, the Interactive Voice Response (IVR) system at 1-800-457-4584, or the *IHCP Quick Reference Guide* at indianamedicaid.com.

Transferring Outstanding Prior Authorizations

If a member changes from a managed care program (such as HIP, Hoosier Care Connect, or Hoosier Healthwise) to Traditional Medicaid or other FFS plan, all existing PAs are honored for one of the following, depending on which comes first:

- The first 30 calendar days, starting on the member's effective date in the new plan
- The remainder of the PA dates of service
- When approved units of service are exhausted

The PAs may be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home health care. Providers should check eligibility before rendering services. On checking eligibility, providers should notify the new plan of any outstanding PAs and supply documentation to substantiate the PAs.

Plans participating in HIP, Hoosier Care Connect, or Hoosier Healthwise must honor outstanding PAs given within the program for services for one of the following, whichever comes first:

- The first 30 calendar days, starting on the member's effective date in the new plan
- The remainder of the PA dates of service
- When approved units of service are exhausted

This authorization extends to any service or procedure previously authorized within the HIP, Hoosier Care Connect, or Hoosier Healthwise program, including but not limited to surgeries, therapies, pharmacy, home health care, and physician services. MCEs may be required to reimburse out-of-network providers during the 30-day transition period.

The entity that issued the original PA is required to provide the new entity assignment with the following information:

- Member's IHCP Member ID (also known as RID)
- Provider's National Provider Identifier (NPI)
- Procedure codes
- Duration and frequency of authorization
- Other information pertinent to the determination of services provided

The request for PA should be submitted on the *Indiana Health Coverage Programs Prior Authorization Request Form*, which is accessible from the *Forms* page at indianamedicaid.com, or through the Portal or the 278 electronic transaction.

Prior Authorization Policy Requirements

Specific criteria pertaining to PA requirements can be found in *405 IAC 5*. Information about how this code applies to IHCP services is included in the appropriate *IHCP Provider Reference Modules* and the *Medical Policy Manual*, available on the *Provider Reference Materials* page at indianamedicaid.com.

PA is required for all services provided by out-of-state providers, except for the circumstances presented in the *Out-of-State Providers* module.

Prior Authorization Policies for Specific Types of Providers or Services

For additional PA information related to specific provider types or types of service, see the following modules:

- *Chiropractic Services*
- *Dental Services*
- *Diabetes Self-Management Training Services*
- *Durable and Home Medical Equipment and Supplies*

- *Emergency Services*
- *Evaluation and Management Services*
- *Family Planning Services*
- *Genetic Testing*
- *Hearing Services*
- *Home Health Services*
- *Hospice Services*
- *Inpatient Hospital Services*
- *Mental Health and Addiction Services*
- *Obstetrical and Gynecological Services*
- *Pharmacy Services*
- *Podiatry Services*
- *Radiology Services*
- *Surgical Services*
- *Therapy Services*
- *Transportation Services*
- *Vision Services*

Note:	*School corporation services do not require a separate PA procedure, because the individualized education plan (IEP) serves as the PA.*

Inpatient acute care hospital PA requirements are addressed for two distinct areas – substance abuse inpatient care and surgical procedures. Providers must apply appropriate PA policies and procedures to the respective service dates. See the *Mental Health and Addiction Services* module for information about PA for substance abuse inpatient care; see the *Surgical Services* module for information about PA for surgical procedures.

Note:	*Emergency services do not require PA; however, any resulting inpatient stay does require PA, with the exception of inpatient stays for burn care with an admission of type 1 (emergency) or type 5 (trauma). All other emergency admissions must be reported to CMCS PA Department within 48 hours of admission, not including Saturdays, Sundays, or legal holidays, as indicated in the Inpatient Hospital Services module. Providers must continue to follow the guidelines for submission of emergency requests as outlined in of the Emergency Services module.* *Any physician service rendered during an inpatient hospital stay requiring PA and paid for under a level-of-care (LOC) methodology – such as psychiatric, rehabilitation, and burn stays – that did not receive PA is not reimbursed.*

Prior Authorization Policies for Specific Medical Services

Specific PA criteria for medical services are found in *405 IAC 5-25*. These PA requirements provide a guideline for determining procedures that require PA, but the IAC and *Medical Policy Manual* should be referred to as the primary references.

The following medical services require PA as specified in *405 IAC 5-3-13(a)*:

- Reduction mammoplasties
- Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem (PA not required for members receiving rhinoplasty surgery related to a documented, primary diagnosis of cleft lip and/or cleft palate)
- Intersex surgery
- Blepharoplasties for significant obstructive vision problems
- Sliding mandibular osteotomies for prognathism or micrognathism
- Reconstructive or plastic surgery
- Bone marrow or stem-cell transplants
- All organ transplants covered by the Medicaid program
- Home health services
- Maxillofacial surgeries related to diseases of the jaws and contiguous structures
- Temporomandibular joint surgery
- Submucus resection of nasal septum and septoplasty when associated with significant obstruction
- Weight reduction surgery, including gastroplasty and related gastrointestinal surgery
- Procedures ordinarily rendered on an outpatient basis, when rendered on an inpatient basis
- Brand medically necessary drugs
- Psychiatric inpatient admissions, including admissions for substance abuse
- Rehabilitation inpatient admissions
- Orthodontic procedures for members under age 21 years of age for cases of craniofacial deformity or cleft
- Genetic testing for detection of cancer of the breasts or ovaries
- Medicaid Rehabilitation Option (MRO) services, except for crisis intervention
- Partial hospitalization, as provided under *405 IAC 5-20-8*
- Neuropsychological and psychological testing

Prior Authorization Limitations

The IHCP does not reimburse providers for any IHCP service requiring PA unless PA is obtained first. If a PA request qualifies for retroactive eligibility, as defined in the *Retroactive Prior Authorization* section of this document, a determination must be made prior to submitting a claim. PA is monitored by concurrent or postpayment review. Exceptions to this policy are noted later in this document.

Any authorization of a service by CMCS is limited to authorization for payment of IHCP-allowable charges. It is not an authorization of the provider's estimated fees.

PA is not a guarantee of payment. Notwithstanding any PA by the provider's office, the provision of all services and supplies must comply with the following resources:

- *IHCP Provider Agreement*
- *IHCP Provider Reference Modules*
- *IHCP Bulletins*
- *IHCP Banner Pages*
- Remittance Advice (RA) statements or 835 transactions
- PA criteria requested by and issued to providers
- Any applicable state or federal statute or regulation

Section 2: Prior Authorization Procedures

The Indiana Health Coverage Programs (IHCP) requires prior authorization (PA), based on medical necessity, for certain services. Certain services also require submitting PA requests for additional units when normal limits are exhausted. Providers must verify eligibility before delivery of a service and must monitor the number of units of each prior-authorized service.

Prior Authorization Inquiry and Eligibility Verification

The PA department determines whether a PA request is approved, based on medical necessity. Granting PA confirms medical necessity, but is valid only if a member is eligible on the date services are rendered. Providers can verify eligibility by using the Interactive Voice Response (IVR) system, Provider Healthcare Portal (Portal), or 270/271 electronic transaction. See the *Interactive Voice Response System*, *Provider Healthcare Portal*, and *Electronic Data Interchange* modules for details about verifying member eligibility.

> *Note: It is not the responsibility of the PA department to ensure the eligibility status of a member. PA is not a guarantee of payment, and member eligibility should be verified by the provider before services are rendered.*

The eligibility verification process also helps providers determine which entity to contact for PA, based on whether the member's benefits are provided through a managed care program. For managed care members, the eligibility verification provides the name of the managed care program – Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise – and the name and contact information of the managed care entity (MCE) to which the member is assigned. If no managed care information is provided, the member is enrolled in a fee-for-service (FFS) program, such as Traditional Medicaid.

See the *Prior Authorization Overview* section for information about obtaining PA under FFS versus managed care delivery systems. Providers should contact OptumRx at 1-855-577-6317 to obtain information about pharmacy FFS PA requests involving drug and biological services.

Providers should also determine whether the member has third-party liability (TPL) coverage and whether PA from the third-party carrier is necessary. Because the IHCP is the payer of last resort, claims must be submitted to the third-party carrier before they are submitted to the IHCP. The third-party carrier, as well as the IHCP, might require PA. See the *Prior Authorization and Third Party* section for more information.

Provider Requests for Prior Authorization

Providers can request PA on behalf of the IHCP member. After PA is obtained, the member can choose the provider that will render the authorized service, as long as the member is not restricted to a specific provider of service, such as members enrolled in the Right Choices Program (RCP) and members assigned to a primary medical provider (PMP) within a managed care program. It is important to note that the member may have a prior-authorized service performed by a physician other than the one who requested the PA; the approved PA belongs to the member, not to the provider.

PA for managed care members must be requested from the member's MCE, unless the service is carved out of the managed care program. For additional information on carved-out services, see the *Claim Submission and Processing* module.

> *Note: If a member has other health insurance, and a service that is covered by Medicaid requires PA from both payer sources, the provider must obtain PA from both sources before rendering services.*

Methods for Submitting PA Requests

Providers have multiple options for submitting PA requests:

- The Portal, accessible at indianamedicaid.com, allows providers to submit FFS, nonpharmacy PA requests, and to view the status of those requests, online. Attachments can be uploaded electronically, along with the PA request, or they may be submitted separately via fax or mail, using the *Prior Authorization System Update Request Form* as a cover letter. Detailed information about using this web application is available in the *Provider Healthcare Portal* module.

Note:	*To inquire about **existing** PAs via the Portal, providers must have a PA number or be the requesting or rendering provider of the PA to use search options.*

- Another method for submitting PA requests electronically is through the 278 transaction. Attachments to the 278 transaction must be submitted separately, via fax or mail. See the *278 Electronic Transaction* section for more information.

- Providers can also submit PA requests by fax or by mail. For managed care PA requests, see the *IHCP Quick Reference Guide* at indianamedicaid.com for MCE contact information. For FFS, nonpharmacy PA, fax or mail completed request forms to the following fax number or address:

  Prior Authorization Department
  Cooperative Managed Care Services
  P.O. Box 56017
  Indianapolis, IN 46256

  Fax: 1-800-689-2759

  When submitting requests by fax, it is preferred that each PA request be faxed separately. However, if providers must batch PA requests into one fax, they should clearly indicate that the fax contains multiple requests and clearly indicate each separate PA request by adding a separate cover letter between each PA request.

- In some cases, providers can submit PA requests by telephone. See the *Telephone Prior Authorization Requests* section for information on what services can be prior authorized over the telephone.

All necessary forms for FFS, nonpharmacy PA requests are available on the *Forms* page at indianamedicaid.com. See the *Prior Authorization Request Forms* section for more information. To obtain information on PA submission and documentation procedures for services rendered under HIP, Hoosier Care Connect, and Hoosier Healthwise managed care programs, providers should contact the appropriate MCE. Providers are responsible for using these tools to ensure accurate, timely PA review and claim processing.

Provider Types Allowed to Submit PA Requests

In accordance with *Indiana Administrative Code 405 IAC 5-3-10*, PA requests can be submitted and signed by the following provider types:

- Doctor of medicine (MD)
- Doctor of osteopathy (DO)
- Dentist
- Optometrist
- Podiatrist
- Chiropractor

- Psychologist endorsed as a health service provider in psychology (HSPP)
- Home health agency (authorized agent)
- Hospital (authorized agent)
- Transportation provider (authorized agent)

The provider must approve the request by personal signature, or providers and their designees may use signature stamps. Providers that are agencies, corporations, or business entities may authorize one or more representatives to sign requests for PA. If a provider does not fall into one of the groups in the preceding list, the PA is suspended for proof of physician signature.

If a provider type other than those listed previously submits a PA request electronically (via the Portal or 278 transaction), the requester must submit additional documentation indicating that the service or supply is physician-ordered. The additional documentation may be uploaded as an attachment to the Portal request, or else must be sent by fax or by mail. Unless the attachment is submitted via the Portal at the time the request is made, the original request is suspended for documentation of the physician's order. Failure to submit additional documentation within 30 calendar days of the request results in denial of the request.

Signature Stamp and Electronic Signature Policies for PA Requests, Attached Forms, and Supporting Documents

Pursuant to *405 IAC 5-3-5(c)(2)*, it is permissible for providers to use a signature stamp for the *Indiana Health Coverage Programs Prior Authorization Request Form*, which is accessible from the *Forms* page at indianamedicaid.com. The IHCP accepts electronic signatures on supporting documentation submitted with PA requests; however, an original signature or signature stamp is still required on the *Indiana Health Coverage Programs Prior Authorization Request Form* as well as on all State forms attached to the request.

Electronic signatures are accepted on supporting documents as long as the provider's electronic health record system provides the appropriate protection and assurances that the rendering provider signed the document and the signature can be authenticated. If the appropriate controls are in place, electronic signatures are acceptable. Providers using electronic systems need to recognize the potential for misuse or abuse with alternate signature methods. Providers bear the responsibility for the authenticity of the documentation and signatures. Physicians are encouraged to check with their attorneys and malpractice insurers regarding electronic signatures. Any provider using an electronic signature must follow the requirements of *Indiana Code IC 26-2-8-116*.

Time Parameters for Prior Authorization Requests

The decision regarding a PA is made as quickly as possible. For FFS requests, if a decision is not made within **seven business days** after receipt of all required documentation, authorization is deemed to be granted within the coverage and limitations specified *(405 IAC 5-3-14).* The provider must wait until the approved PA decision letter or the 278 response is returned before billing for the service, or until verification can be made that CMCS received the request and did not render a decision within the time parameters listed previously. Verification is accomplished by using the Portal *View Authorization Status* page (available from the Care Management tab) or the IVR system (available at 1-800-457-4584).

Suspension for Requests of Additional Information

For the PA reviewer to determine whether a service or procedure is medically reasonable and necessary, the PA contractor may request more information from the member and provider. Additional clinical information to justify medical necessity or additional information needed for clarification – including, but not limited to, x-rays, ultrasound, lab, and biopsy reports – may be required. Photographs may be necessary in some instances, such as breast reduction surgery or wound management.

When additional information is requested, the time parameters as described previously begin on receipt of the information by the PA Department. The established mechanism to allow time for the provider to supply this information is achieved by *suspending* the first request and having the provider submit the additional information as follows:

- By mail or by fax, using the *Prior Authorization System Update Request Form*, available on the *Forms* page at indianamedicaid.com.
- Through the Portal (for FFS, nonpharmacy PA), by uploading the supporting documentation as a system update to the suspended authorization request. See the *Care Management: View Authorization Status* section of the *Provider Healthcare Portal* module for details.

Note:	*Suspending the request does not mean the request is denied; it gives the provider additional time to provide clinical information that facilitates a more accurate and appropriate determination.*

The PA contractor must receive this information within 30 calendar days of the request or the PA request is systematically denied. If the PA contractor determines medical necessity, the dates authorized are those on the originally suspended PA request.

If documentation is not received within 30 days, the request is denied. Examples of reasons for suspending requests include lack of complete medical history, missing medical clearance forms, or missing plan of treatment. If the determination involves a denial or modification of a continuing service, such as home health care, at least 10 days' notice plus 3 days' additional mailing time must be given before the effective date of the change begins.

New PA Requests for Ongoing Services

The provider is responsible for submitting new PA requests for ongoing services at least 30 calendar days before the current authorization period expires to ensure that services are not interrupted.

Telephone Prior Authorization Requests

PA telephone requests are appropriate to facilitate hospital admission or discharge, to maintain the health and well-being of the member, or when emergency services are required. Examples of services prior authorized by telephone include, but are not limited to, nutritional feedings, extended stays for burn therapy and rehabilitation, and out-of-state requests.

Verbal notification of approval, modification, or denial, with written notification to follow, is given when the call is made for the following services:

- Inpatient hospital admission and concurrent review, when required
- Continuation of retroactive PA for emergency treatment on an inpatient basis
- Surgeries or other treatments that approach or exceed the cost limits or utilization review parameters found in the IAC

- Medically necessary services or supplies that facilitate discharge from a hospital or prevent admission to a hospital
- Equipment repairs necessary for the life support or safe mobility of the patient
- Medical services when a delay in beginning the services could reasonably be expected to result in a serious deterioration of the patient's medical condition

Telephone PAs are not approved for the following:

- Services that can otherwise be authorized in writing, such as routine office visits
- Trend events, such as specialized therapies and continued home health care services
- Elective surgeries
- Retroactive requests for nonemergency services
- Extension of existing PAs

An *Indiana Health Coverage Programs Prior Authorization Request Form* is not necessary for telephone PA services. However, additional written substantiation and documentation may be required.

Telephone Numbers and Staffing

The *IHCP Quick Reference Guide* at indianamedicaid.com is the primary source for prior authorization contact information.

The PA Department telephone number for FFS, nonpharmacy PA requests is:

Cooperative Managed Care Services
1-800-269-5720

This toll-free number is available throughout Indiana and to providers located in designated or contiguous areas of Illinois, Kentucky, Michigan, and Ohio. Telephone lines are staffed from 8 a.m. to 5 p.m. Eastern Time, Monday through Friday, excluding six holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Automated Attendant

CMCS handles all IHCP FFS, nonpharmacy prior authorization calls. The PA telephone lines have an automated attendant to direct calls to the appropriate area. When a call is answered, the automated attendant offers the following options:

- Option 1 – Behavioral Health
- Option 2 – Durable Medical Equipment
- Option 3 – Home Health and Hospice
- Option 4 – Medicaid Rehabilitation Option (MRO)
- Option 5 – Dental or Transportation
- Option 8 – Elective or Urgent Medical or Surgical Hospital Admissions

Providers should access the appropriate option for the PA question; otherwise, if nothing is pressed, the call is transferred to the PA "Other" line.

Prior Authorization Request Forms

All PA requests for services not listed in the *Telephone Prior Authorization Requests* section of this document must be submitted in writing using the *Health Insurance Portability and Accountability Act* (HIPAA)-compliant *Indiana Health Coverage Programs Prior Authorization Request Form* (universal prior authorization form) or *Indiana Prior Review and Authorization Dental Request* form – or their electronic equivalents through the 278 request transaction or (for FFS, nonpharmacy requests) the Portal.

Providers should retain photocopies of the completed *Indiana Health Coverage Programs Prior Authorization Request Form* or *Indiana Prior Review and Authorization Dental Request* form for their records.

Indiana Health Coverage Programs Prior Authorization Request Form

The *Indiana Health Coverage Programs Prior Authorization Request Form*, and instructions for completing the form, are available on the *Forms* page at indianamedicaid.com. Table 1 also includes instructions for completing the form.

Table 1 – *Indiana Health Coverage Programs Prior Authorization Request Form* Instructions

Field	Description
Patient Information: • Medicaid ID/RID# • DOB • Patient Name • Address • City/State/ZIP Code • Patient/Guardian Phone	Enter the information requested for the member who is to receive the requested service. **Required.**
• PMP Name • PMP NPI • PMP Phone	Enter the information requested for the member's primary medical provider (PMP). **Required, if applicable.**
Requesting Provider Information: • Requesting Provider NPI# • Tax ID# • Service Location Code • Provider Name	Enter the information requested for each field. **Required.** Enter the requesting provider's National Provider Identifier (NPI). For atypical providers that do not have an NPI, enter the IHCP-issued Provider ID. The requesting provider NPI must be the billing NPI used by the provider/entity requesting the authorization. For a group/corporate entity, the requesting provider NPI is different from the rendering provider NPI. For a sole proprietor or a dual-status provider, the requesting provider NPI and the rendering provider NPI may be the same. A valid NPI or Provider ID is required. If the requesting provider is not enrolled, the PA request will not be entered and the PA contractor will notify the requesting provider by telephone. The provider's copy of the *Indiana Prior Review and Authorization Request Decision* letter is sent to the mail-to address on file for the requesting provider's NPI and service location code combination.

Field	Description
Rendering Provider Information: • Rendering Provider NPI# • Tax ID# • Name • Address • City/State/ZIP Code • Phone • Fax	Enter the information requested for each field, if the rendering provider is known at the time the request is completed. (The rendering provider is the physician or other IHCP-enrolled practitioner who will be delivering the service to the member.) Enter the rendering provider's NPI or enter the Provider ID for atypical providers that do not have an NPI.
Ordering, Prescribing, or Referring (OPR) Provider Information: • OPR Physician NPI#	Enter the NPI of the OPR provider. (The OPR provider is the practitioner that ordered, prescribed, or referred the member for the requested service.)
Preparer's Information: • Name • Phone • Fax	Enter the requested information about the person preparing the PA request.
Medical Diagnosis • Dx1 • Dx2 • Dx3	Enter the primary, secondary, and tertiary International Classification of Diseases (ICD) diagnosis codes. *Note: ICD-10 diagnosis codes must be used for dates of service on or after October 1, 2015.*
Assignment Category	Check the assignment category for the service you are requesting.
Dates of Service, Start	Enter the requested start date for the service. (For continued services, the start date must be the day after the previous end date.)
Dates of Service, Stop	Enter the requested stop date of service.
Procedure/Service Codes	Enter the service codes, (such as Current Procedural Terminology (CPT®[1]), Healthcare Common Procedure Coding System (HCPCS), revenue code, National Drug Code (NDC), and so forth.
Modifier(s)	Enter any applicable service code modifiers.
Requested Service	Enter a short description (or include an attachment) of the requested services and like services provided by other payers.
Taxonomy	Enter any applicable taxonomy codes.
POS	Enter the requested place-of-service (POS) code.
Units	Enter the requested number of units. Units are equal to days, months, or items, whichever is applicable.
Dollars	Enter the estimated or known IHCP cost of the service. **Required for home health services and durable medical equipment (DME) requests.**

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Field	Description
Notes	Enter clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan-of-treatment dates.
Signature of Qualified Practitioner	Authorized provider, as listed in the *Provider Types Allowed to Submit PA Requests* section and *405 IAC 5-3-10*, must sign and date the form. Signature stamps can be used. **Required.**
Date	

Before submitting the request by fax or mail, complete the following:

- Make sure the PA form has a physician's signature and date. The signature prevents the PA from being suspended and delaying services.
- Ensure that the Member ID (also known as RID) and NPI or Provider ID are correct.
  - For FFS, the *requesting provider* is the billing entity, and the *rendering provider* is the individual provider performing the service. If you are a sole proprietor, or a group or corporate business entity, such as a DME supplier or hospital, you must place your billing NPI or IHCP Provider ID in the Requesting Provider NPI# field on the *Indiana Health Coverage Programs Prior Authorization Request Form*. This action generates a PA decision letter in the IHCP Core Medicaid Management Information System (*Core*MMIS) that is mailed to the billing or requesting provider's mail-to address. The Rendering Provider NPI# field should contain the NPI or Provider ID of the physician or other IHCP-enrolled practitioner within the group or corporate business entity that ordered the services, equipment, or supplies. For sole proprietors or dual-status providers, the requesting provider and the rendering provider may be one and the same.
  - HIP, Hoosier Care Connect, and Hoosier Healthwise MCEs use claim-processing systems other than *Core*MMIS. For this reason, the IHCP recommends that providers contact the appropriate MCE (Anthem, MHS, or MDwise) to determine how to use the Requesting Provider and Rendering Provider fields on the *Indiana Health Coverage Programs Prior Authorization Request Form*.
- Confirm that all other information on the form is correct and complete. Remember that the ICD diagnosis code must be listed and procedure codes must be valid, including modifiers.
- To ensure that response letters are mailed to the appropriate location, verify that the provider's mail-to address is correct in *Core*MMIS. Providers may verify the accuracy of their *mail-to* address by calling Customer Service at 1-800-457-4584 or by using the Provider Maintenance link on the Portal.

Indiana Prior Review and Authorization Dental Request Form

Table 2 contains instructions for the *Indiana Prior Review and Authorization Dental Request* form. This form is available on the *Forms* page at indianamedicaid.com.

Table 2 – *Indiana Prior Review and Authorization Dental Request* Form Instructions

Field	Description
Requesting Provider # Phone Mail to Provider ID Name Address City/State/ZIP Code Service Location Name Address City/State/ZIP Code	Enter the requesting or rendering provider's NPI or IHCP Provider ID and phone number. If the requesting provider is not enrolled, the PA form will be returned to the provider. A valid NPI or Provider ID is required. The provider's copy of the *Indiana Prior Review and Authorization Dental Request Decision* letter is sent to the address that corresponds to the provider information entered in this field, if a separate mailing Provider ID and service location are not identified on the form. If the requesting provider information does not have a valid service location, a PA decision letter will not be generated. Therefore, providers should complete the Mail to Provider ID and Service Location fields to ensure that the PA decision letter is mailed to the correct address. If the Mail to Provider ID and Service Location fields are completed in conjunction with the requesting provider information that has a valid service location, the Mail to Provider ID and Service Location information will be selected as the mailing address for the PA decision letter, instead of the requesting provider number and service location information.
RID NO. DOB	Enter the IHCP Member ID (also known as RID) and date of birth for the member who is to receive the requested service.
Dates of Service, Start	Enter the requested start date for the service. (For continued services, the start date must be the day after the previous end date.)
Dates of Service, Stop	Enter the requested stop date for the service.
Service Code	Enter the requested service code, such as CPT, Current Dental Terminology (CDT®[2]), HCPCS, revenue, or NDC.
Requested Service	Enter a short description (or include an attachment) of the requested service and like services provided by other payers.
Place of Service	Enter the requested place of service.
Units	Enter the number of units desired. Units are equal to days, months, or items, whichever is applicable.
Dollars	Enter the estimated or known IHCP cost of the service. Required for home health services, DME, and pharmacy requests.
Caseworker Phone	Enter the caseworker's name and telephone number.
MCE/590/FFS	Select the appropriate member plan, if applicable: • For managed care, select **MCE**. • For the 590 program, select **590**. • For fee-for-service plans, select **FFS**.

[2] *Current Dental Terminology. CDT copyright 2016 American Dental Association. All rights reserved.*

Field	Description
Is Member Employed?	Select **YES** or **NO**.
Circumstances (Place/Type)	Enter employment information, if applicable.
Is Member in Job Training?	Select **YES** or **NO**.
Type of Job Training	Enter training information, if applicable.
Dental Treatment Plan	
Does the Member have missing teeth?	Select **YES** or **NO**. If yes, indicate which teeth are missing teeth with a checkmark (✓) on the diagram provided.
1. Endodontics	Indicate on the number graph the tooth or teeth to be treated by root canal therapy (1-32).
2. Periodontics	Briefly summarize the periodontal condition.
3. Partial dentures	Use the diagram to indicate the teeth involved. A. Date or dates of extractions of missing teeth. B. Which teeth are to be extracted (tooth #)? C. Which teeth are to be replaced (tooth #)? D. Brief description of materials and design of partial. E. Is member wearing partials now? (**YES** or **NO**) Age of present partials.
4. Dentures	Check one or both: Full upper denture, full lower denture. A. How long edentulous? B. Is member wearing dentures now? (**YES** or **NO**) Age of present dentures.
5. Describe treatment if different from above	Describe any treatment to be provided that was not listed previously on this form.
6. Is the member on parenteral/enteral nutritional supplements?	Check **YES** or **NO**. If Yes, a plan of care to wean the member from the nutritional supplements must be attached. If the plan of care is not provided, dentures, partials, relines, and repairs will be denied.
Brief Dental/Medical History	Enter pertinent information known to the provider about the member's dental and medical history.
Signature of Requesting Dentist	The authorized provider, as listed in the *Provider Types Allowed to Submit PA Requests* section, must sign the form. Signature stamps can be used.
Date of Submission	Enter the date the form was actually submitted.

Medicaid Second Opinion Form

Providers may be required to submit a second or third opinion to substantiate the medical necessity of certain services. If required, the *Medicaid Second Opinion Form* should be completed as directed in the form's narrative and submitted to the appropriate PA department based on the program assignment of the member. This form is available on the *Forms* page at indianamedicaid.com. Completed forms may be submitted by fax or by mail, or uploaded as an attachment to the FFS, nonpharmacy PA request on the Portal.

Medical Clearance Forms for DME or Medical Supplies

Providers must submit medical clearance forms to justify the medical necessity of designated DME or medical supplies when requesting PA. DME or medical supplies that require medical clearance forms when requesting PA include, but are not limited to, the following services:

- Augmentative communication devices – *Augmentative Communication System Selection* form
- Home oxygen therapy – *Certificate of Medical Necessity: CMS-484 – Oxygen* form
- Parenteral or enteral nutrition – *DME Information Form: CMS-10126 – Enteral and Parenteral Nutrition*
- Hearing aids – *Medical Clearance and Audiometric Test Form*
- Hospital and specialty beds – *Medical Clearance Form: Hospital and Specialty Beds*
- Motorized wheelchairs or other power-operated vehicles – *Indiana Health Coverage Programs Medical Clearance for Motorized Wheelchair Purchase form*
- Negative pressure wound therapy – *Indiana Health Coverage Programs Medical Clearance Form: Negative Pressure Wound Therapy*
- Nonmotorized wheelchairs – *Indiana Health Coverage Programs Medical Clearance for Nonmotorized Wheelchair Purchase* form
- Standing equipment – *Medical Clearance Form: Physical Assessment for Standing Equipment*
- Transcutaneous electrical nerve stimulator (TENS) units – *Medical Clearance Form: TENS (Transcutaneous Electrical Nerve Stimulator) Unit*

Each of these forms is available for downloading on the *Forms* page at indianamedicaid.com.

When requesting PA for the DME or medical supplies listed in this section, providers must complete the appropriate clearance form and attach it to a completed *Indiana Health Coverage Programs Prior Authorization Request Form* or upload it as an attachment to the PA request on the Portal. Failing to provide appropriate medical clearance forms with PA request forms results in suspension, not denial, of PA requests. Forms should be completed in sufficient detail to enable a decision about medical reasonableness and necessity.

Providers should retain for their records photocopies of any medical clearance forms included with their submissions. PA contractors can receive the completed medical clearance forms by fax or by mail – or, for FFS, nonpharmacy requests, as attachments uploaded via the Portal.

Prior Authorization Request Decision Letter

After a decision is reached about a nonpharmacy PA request, *Core*MMIS automatically generates an *Indiana Prior Review and Authorization Request Decision* letter. If the PA request is not approved, additional information is included with the decision letter to explain the decision. For example, IAC references and administrative review and appeal rights are included for modified and denied decisions. A suspension is not a denial; rather, it is a request for additional information. Providers must return the additional information within 30 calendar days, or the request is denied. If the PA request is rejected, providers will receive a PA decision letter documenting the rejected status of the PA request, noting that the PA was submitted to the wrong PA contractor based on the assignment of the member to a specific IHCP program.

PA decisions are mailed to the member and the *requesting* provider. The rendering provider, if different from the requesting provider, must contact either the requesting provider or the member to secure a copy of the PA decision.

An explanation of the *Indiana Prior Review and Authorization Request Decision* letter content follows:

- The top-left area of the form provides requesting provider and member information.
- Specific information about the requested service is provided below the provider and member information.
- Space for narrative about the decision is provided below the service information.

Prior Authorization Update Requests

Certain authorization information can be updated on an existing PA request, instead of by submitting another PA request. Authorization updates may be requested by fax, by mail, or, in some cases, by telephone. For FFS, nonpharmacy authorizations, the requesting provider or his or her assigned delegate can perform a system update to the existing request through the *View Authorization Response* page on the Portal. See the *Care Management* section of the *Provider Healthcare Portal* module for details.

The following are examples of appropriate PA update requests:

- A provider that discovers a clerical error in the PA data entered may perform a system update through the Portal or may call or write to request the correction, depending on the complexity of the situation. If the error does not require research or review of the original PA request, the correction can be updated over the telephone. However, some items may be too complicated to resolve with a telephone call and may require additional medical documentation to support the request. Providers may need to send the original request and the system-generated letter for review. An explanatory letter is helpful.
- A request to increase home health services, except in the case of urgent or emergency services, requires a written request with supporting documentation of medical necessity. This request and supporting documentation may be submitted by fax or mail, or as a system update through the Portal.
- Extending the dates on an approved surgery because rescheduling was necessary is appropriate for a telephone update or a system update through the Portal.

*Note: Any request for a **new** service must be submitted as a new PA request.*

Submit written PA update requests on the *Prior Authorization – System Update Request Form*, available on the *Forms* page at indianamedicaid.com. Written PA update requests can also be submitted on the provider's letterhead, with **PRIOR AUTHORIZATION UPDATE** written boldly across the top. Include pertinent information, such as Member ID; PA number; and information to be corrected, changed, or updated. Attach a copy of the original PA request and system-generated letter to verify the item to be updated.

Mail or fax FFS PA update requests to the following address:

Prior Authorization Department
Cooperative Managed Care Services
P.O. Box 56017
Indianapolis, IN 46256

Fax: 1-800-689-2759

When a PA number is updated, a system-generated *Indiana Prior Review and Authorization PA Update Decision* letter is sent automatically to the requesting provider and the member.

Prior Authorization Update Decision Letter

When an existing PA is updated, *Core*MMIS automatically generates an *Indiana Prior Review and Authorization Update Decision* letter. A narrative at the bottom of this letter highlights the information that was changed.

The *Indiana Prior Review and Authorization Update Decision* letter includes the following information:

- Requesting provider information
- Member information
- Specific information about the requested service provided

The *Indiana Prior Review and Authorization Update Decision* letter includes the decision, with one of the following descriptions:

- Approved
- Administrative approval
- Decision overturned by administrative law judge (ALJ)
- Denied
- Rejected
- Evaluation; awaiting final decision; normal cycle
- Approved for continuation of service
- Modified for continuation of service
- Denied for continuation of service
- Noncovered code, denied
- Restored to previous level, awaiting appeal result
- Modified
- No PA required
- No PA required when requested by a PMP
- Pending receipt of required information
- Incorrect PMP
- Suspended
- Appeal dismissed, no hearing, request approved
- Appeal dismissed, no hearing, request modified
- Appeal dismissed, no hearing, request denied
- Decision modified through court action
- Decision upheld by ALJ
- Modified through administrative review
- Approved through administrative review
- Automatically approved after 10 days

Prior Authorization Procedures for Special Programs

This section includes PA requirements and procedures for IHCP special programs. As with any PA request, the requester must have a valid NPI that has been registered with the IHCP or, if an atypical provider, an IHCP Provider ID. The rendering provider must be enrolled in the IHCP to receive reimbursement for providing services to an IHCP member, ensuring that all service requirements are met.

590 Program Authorizations

PA for members of the 590 Program mirrors the IHCP Traditional Medicaid PA system, with the following exceptions:

- Transportation is **not** a covered service for the 590 Program; therefore, PA cannot be granted for 590 Program transportation requests.
- For the 590 Program, PA is required for any service that the provider estimates is $500 or more, regardless of whether the service requires PA in the Traditional Medicaid program. PA requests for pharmacy expenses of more than $500 must be directed to OptumRx.
- For the 590 Program, PA is not required, unless provided by an out-of-state provider, for any service that the provider estimates is less than $500, regardless of whether the service requires PA in the Traditional Medicaid program.

Services for 590 Program members may be prior authorized retroactively. 590 Program services can also be requested using the Portal or 278 electronic transaction.

Home and Community-Based Services Waiver Authorizations

In addition to waiver services, Home and Community-Based Services (HCBS) waiver members also receive Traditional Medicaid benefits, with the same PA requirements and procedures applying to those benefits as apply for other Traditional Medicaid members.

HCBS waiver program services are approved by the member's level of care (LOC) waiver program State administrator: the FSSA Division of Aging, Division of Disability and Rehabilitative Services, or Division of Mental Health and Addiction. The approved waiver services are recorded on a Notice of Action (NOA), and the approved dollars listed on the NOA are transmitted to the member's PA history table to be used during the claim adjudication process. Any discrepancies between approved dollars for waiver services on the NOA and dollars available on the member's PA history table need to be mediated through the member's case manager, who facilitates the resolution of any discrepancies.

Some services may be available through both State Plan (Traditional Medicaid) benefits and waiver program benefits. In this case, the State Plan service benefits, including any that may be available through PA, must be exhausted first before obtaining waiver program services, even if the waiver services are approved.

See the *Home and Community-Based Services Billing Guidelines* module for more information about authorization.

1915(i) Home and Community-Based Services Authorizations

The authorization process for HCBS 1915(i) services varies by program. For more information about authorization, see the *Division of Mental Health and Addiction Adult Mental Health Habilitation Services*, *Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services*, and *Division of Mental Health and Addiction Child Mental Health Wraparound Services* modules.

Retroactive Prior Authorization

PA is given after services have begun or supplies have been delivered only under the following circumstances:

- Pending or retroactive member eligibility
  - The PA request must be submitted within 12 months of the date when the member's caseworker entered the eligibility information. The hospice authorization request must be submitted within one year of the date nursing facility level of care is approved by the office.
- Mechanical or administrative delays or errors by the contractor or county office of the FSSA Division of Family Resources (DFR)
- Services rendered outside Indiana by a provider that had not yet enrolled as an IHCP provider
- Transportation services authorized under *405 IAC 5-30*
  - The PA request must be submitted within 12 months of the date of service.
- The provider was unaware that the member was eligible for services at the time services were rendered; PA is granted in this situation only if the following conditions are met:
  - The provider's records document that the member refused or was physically unable to provide his or her IHCP Member ID.
  - The provider can substantiate that reimbursement was continually pursued from the member until IHCP eligibility was discovered.
  - The provider submitted the request for PA within 60 calendar days of the date that IHCP eligibility was discovered.
- Any situation in which the physician cannot determine the exact procedure to be done until after the service has been performed

Prior Authorization and Third Party

If PA is required for a service, and the member has additional insurance coverage that is primary, PA must be obtained from the appropriate PA contractor, based on the program assignment of the member, to receive payment from the IHCP for the balance of charges not paid by the primary insurance. In addition, if the primary payer requires PA, the provider must follow that plan's requirements for obtaining PA. The provider must also obtain PA from CMCS if the code requires a PA for Indiana Medicaid claim processing.

IHCP PA and Medicare PA are not required for members with Medicare Part A and Part B coverage if the services are covered (in whole or in part) by Medicare. Services not covered by Medicare are subject to normal PA requirements.

Section 3: 278 Electronic Transaction

The 278 transaction provides standard data requirements and content for all users who request and respond to prior authorization (PA) or certification requests. The 278 transaction supports the following information:

- Submission of initial electronic requests
- Submission of updated or revised electronic requests
- Submission of paper attachments for electronic requests
- Submission of retroactive electronic requests
- Submission of out-of-state electronic requests
- Submission of electronic administrative reviews
- Response with approval
- Response with modified approval
- Response with denial of a previous request
- Response with follow-up action code
- Response with action code

Note:	*Requests for administrative review and appeals of PA decisions must be submitted in writing, even if the PA request itself was submitted electronically. See the Prior Authorization Administrative Review and Appeal Procedures section for instructions.*

Providers wanting information about the 278 transaction for submitting electronic PA requests should contact the Electronic Data Interchange (EDI) Solutions Unit at INXIXTradingPartner@hpe.com.

278 Transactions and HIPAA Compliance

Health Insurance Portability and Accountability Act (HIPAA) legislation mandates that many of the major healthcare electronic data exchanges, such as electronic submission of PA requests and the electronic responses, are standardized national formats for all payers, providers, and clearinghouses. All providers who submit affected data electronically to the Indiana Health Coverage Programs (IHCP) must use the mandated HIPAA formats. HIPAA specifically names several electronic standards that must be followed when certain healthcare information is exchanged. These standards are published as *National Electronic Data Interchange Transaction Set Implementation Guides* – commonly called Implementation Guides (IGs). An addendum to each IG was also published and must be used with the IG to properly implement each transaction.

The IHCP has developed technical companion guides to help users understand the IHCP requirements for each new electronic transaction and to assist during the implementation process. In most cases, the existing data exchange format has changed, such as electronic claim submission. In other cases, a new transaction is available, such as the PA request and response transaction. The information contained in the *IHCP Companion Guide* is only intended to supplement the adopted IGs and provide guidance and clarification as it applies to the IHCP. The *IHCP Companion Guide* is never intended to modify, contradict, or reinterpret the rules established by the IGs.

All healthcare organizations exchanging HIPAA transaction data electronically with the IHCP are required to establish an EDI relationship. Entities with this EDI relationship are referred to as trading partners. The IHCP has prepared information to assist entities with becoming IHCP trading partners. Trading partner information is available on the *EDI Solutions* page at indianamedicaid.com. In addition, providers wanting to submit electronic PA requests must follow the testing requirements as outlined by the IHCP. See the *EDI Solutions* page for additional information about the testing process or to obtain copies of testing instructions. Providers may also contact the EDI Solutions help desk by email at INXIXTradingPartner@hpe.com or by telephone at 1-800-457-4584.

Data Elements

The *IHCP Companion Guide* provides detailed information about data elements that are required, situational, or not used by the IHCP for submitting a 278 transaction for PA. Data elements that could require more detailed explanations are discussed in the following sections.

Certification Type Codes

Certification type codes are required data elements used in the 278 transaction to indicate the kind of certification requested. These codes are also found in the 278 IG. When submitting an electronic request for PA, the requester *must* use one of the certification type codes listed in Table 3 to specify the type of request needed.

Table 3 – Certification Type Codes

Code	Description	Usage
1	Appeal – Immediate	Informs the IHCP the request is for an administrative review Use this value only for appeals of review decisions where the level of service required is emergency or urgent.
2	Appeal – Standard	Informs the IHCP the request is for an administrative review
3	Cancel	Indicates the request was previously submitted but is being canceled by the requester
4	Extension	Indicates the request is for an extension request to a previously approved PA
I	Initial	Indicates a new request
R	Renewal	Indicates an update to renew the PA, not extend it
S	Revised	Indicates a request for a change or update to a previously approved PA for which services have not been rendered

Service Type Codes

Service type codes are used in the 278 transaction to identify the classification of service for the PA request. This data element is required if known by the submitting provider. A complete list of service type codes is provided in the 278 IG.

Examples of service type codes are as follows:

- 12 – *Durable medical equipment (DME)*
- 45 – *Hospice*
- 54 – *Long-term care*

Facility Type Codes

Facility type codes identify the type of facility where services were performed. This data element is *required.* The two categories of facility type codes follow:

- Uniform Billing Claim Form Bill Type
- Place of service (POS)

A list of the Uniform Billing Claim Form Bill Type codes is available in the named code sources listed in the 278 IG for the specific facility type code. See the National Uniform Billing Committee (NUBC) website at nubc.org for a current list of type of bill codes.

The provider is responsible for using current codes maintained by the named entity responsible for the code set.

Level-of-Service Codes

Level-of-service codes are used to indicate that the request is for an emergency service and is a situational data element. Emergency services do not require PA; however, any resulting inpatient stay does require PA, with the exception of inpatient stays for burn care with an admission of type 1 (emergency) or type 5 (trauma). Providers must use one of the following level-of-service codes to indicate an emergency request:

- 03 – *Emergency*
- U – *Urgent*

Release of Information Codes

Release of information codes are used to indicate that the provider has a statement on file, signed by the member, authorizing the release of the member's medical information. Providers *must* use one of the current codes listed in Table 4.

Table 4 – Release of Information Codes

Code	Description
A	Appropriate release of information on file at healthcare service provider or utilization review organization
I	Informed consent to release medical information for conditions or diagnoses regulated by federal statutes
M	Provider has limited or restricted ability to release data related to a claim
O	On file at payer or at plan sponsor
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim

Segments

A segment is a unit of information in the electronic transaction. The *IHCP Companion Guide* provides detailed information about segments that are required, situational, or not used by the IHCP for submitting a 278 transaction requesting PA. Segments requiring more explanation are discussed in the following sections.

Diagnosis Segment

This segment of the 278 transaction allows providers to submit up to 12 International Classification of Diseases (ICD) codes for a single patient event. A patient event is defined as: *The service or group of services associated with a single episode of care*. The ICD code is a required data element and must be submitted after the appropriate diagnosis type code.

Previous Certification Identification Segment

This segment is required when a provider submits an additional request associated with a previously approved PA and the provider knows the previous PA request number.

Procedures Segment

This segment of the 278 transaction is used to request specific services and procedures and is required for all IHCP electronic PA requests. There are various procedures on the *Code List Qualifier* listed in the 278 IG used to designate the specific procedure code. However, the IHCP processes only procedure codes defined under the *ABR – Assigned by Reviewer* and *BO – Health Care Common Procedure Coding System (HCPCS)* code sets.

- *Revenue codes* are reported under ABR.
- The American Medical Association (AMA) Current Procedural Terminology (CPT) codes are reported under BO.
- The American Dental Association (ADA) Current Dental Terminology (CDT) codes are considered level II HCPCS codes and are reported under BO.

The IHCP is reviewing the Logical Observation Identifiers, Names, and Codes (LOINC®) for future use. The LOINC identify specific information concerning the patient or services that the utilization management organization (UMO) requires from the provider to complete the medical review. The LOINC are addressed in the 278 5010 Implementation Guide. The LOINC are not to be used with the 278 transaction for processing the IHCP PA requests at this time.

Units

Providers can submit PA requests for service units or for specific dollar amounts. For example, procedure code E8000 – *Gait trainer, pediatric size, posterior support, includes all accessories and components* is used to identify the device. The *Message* segment of the 278 request is used to identify the specific type of device for the PA request. HCPCS code E8000 includes the accessories associated with the device. Providers cannot submit separate codes for the accessories.

Message Segment

The 278 transaction allows providers to submit a free-form message about the request. The *Message (MSG)* segment allows a free-form text field of up to 264 characters. When submitting a PA request that contains a CPT or HCPCS modifier, providers must use the *MSG* segment in the 278 transaction. This format accommodates reporting modifiers for up to 12 procedure codes. The procedure for the reported modifier is identified in the *MSG* segment by the corresponding HI element where the procedure is located. The IHCP *Companion Guide: 278 Prior Authorization Review Request Transaction* provides detailed instructions about billing modifiers. The companion guide also provides information about submitting a request that contains both a modifier and a text message in the *MSG* segment.

Reasons for Rejection of the 278 Request

Providers receive a 278 response for requests that cannot be processed at a system or application level, based on the information submitted. The IHCP *Companion Guide: 278 Prior Authorization Review Response Transaction* or the 278 IG provides a list of *Reject Reason Codes*. Some examples of rejection are as follows:

- Subscriber/Insured not in Group/Plan Identified
- Invalid diagnosis or dates
- Missing service codes and dates
- Exact duplicate of another request

Duplicate Requests or Approval of Nonspecific Codes

The IHCP Core Medicaid Management Information System (*Core*MMIS) rejects duplicate 278 requests for the exact same date of service, exact same procedure, and exact same requesting provider for the same member. Duplicate requests submitted for unspecified procedure or service codes are manually reviewed.

Providers must use the *Message* segment of the 278 transaction to identify the specific procedure or service submitted for the unspecified code to avoid rejection. For example, when submitting HCPCS code E1399 – *Durable medical equipment, miscellaneous,* providers must indicate in the *Message* segment the specific equipment requested.

To avoid rejection as a duplicate of another request, procedures or services that are repeated for the same date of service must be submitted with one of the modifiers in Table 5. These modifiers must be documented in the *Message* segment corresponding to the appropriate procedure code in the corresponding *HI* segment. This requirement does not refer to requests submitted for multiple units for the same procedure or service on the same date of service on the PA service line.

Table 5 – Repeated Services Modifiers

Modifier	Description
76	Repeat procedure by same physician
77	Repeat procedure by another physician
91	Repeat clinical diagnostic laboratory test

Paper Attachments and Electronic PA Requests

The IHCP accepts paper attachments with an electronic PA request. The 278 transaction does not support electronic attachments at this time.

When a 278 request transaction requires submission of additional documentation, the documentation must be submitted as a paper attachment. When a provider elects to send a paper attachment with a 278 transaction, the following information must be included on the 278 transaction in the *Additional Patient Information* segment:

- *Attachment Transmission Code* – Indicates an electronic request has paper documentation to support the requested services. This code defines the timing and transmission method or format of the reports and the method of submission. This value is provided in *Attachment Transmission Code, Data Element 756*, on the 278 transaction. All valid *Attachment Transmission Codes* are accepted for the 278 transactions;

however, the IHCP accepts only paper attachments for electronic or paper PA requests by mail and fax. The IHCP uses the following *Attachment Transmission Codes*:

- BM – *By mail*
- FX – *By fax*

- *Attachment Report Type Code* – Indicates the type of attachment being sent to the IHCP that supports the 278 request data. The code indicates the title or contents of a document, report, or supporting item. This code is used in *Report Type Code, Data Element 755*. For a complete listing of *Attachment Report Type Codes*, see the *National Electronic Data Interchange Transaction Set Implementation Guide: Health Care Services Review—Request for Review and Response: 278: ASC X12N 278 (004010X094)* and *(004010X094A1) Addenda*. Examples include the following codes:
  - B3 – *Physician order*
  - DS – *Discharge summary*
  - OB – *Operative note*
- *Attachment control number (ACN)* – Identifies each attachment. The ACN is created by the provider and must consist of at least two, and no more than 30, characters. The IG allows for 80 characters; however, the IHCP processes only 30 characters. This code is used in *Attachment Control Number, Data Element 67*.

The following instructions are for submitting paper attachments for electronic claims:

- Each paper attachment submitted for a 278 transaction must include a unique ACN. Write the unique ACN on each attachment.
- An attachment with multiple pages must have the ACN on each page.
- A maximum of 10 attachments is allowed per service level and 10 per subscriber level.
- The ACN must be unique per document, and documents cannot be shared between requests.
- Providers must write the ACN, Member ID (also known as RID), provider identification number, and date of service on each attachment to ensure that the attachment is linked to the appropriate request.
- Paper attachments for an electronic request for fee-for-service (FFS) nonpharmacy PA must be mailed or faxed to the Cooperative Managed Care Services (CMCS) at the following address:

  Prior Authorization Department
  Cooperative Managed Care Services
  P.O. Box 56017
  Indianapolis, IN 46256

  Fax: 1-800-689-2759

If the attachments are not received within 30 calendar days of the request submission, the request is denied. If attachments are received, and one specific attachment needed for processing is missing, the provider may receive an electronic response indicating additional information is needed to process the request.

Electronic PA requests are submitted individually or in batch files. Each request must contain the name and number of the UMO. All admission requests for nursing facilities and intermediate care facilities for individuals with intellectual disability (ICFs/IID), specialty 031, are forwarded to the Family and Social Services Administration (FSSA) Long Term Care (LTC) Unit. All other nonpharmacy PA requests are reviewed by the appropriate PA department based on the program assignment of the member. The UMO information listed in Table 6 is required for 278 request submissions.

Table 6 – UMO Information

Data Element	Long-Term Care Requests	All Other Nonpharmacy Requests
UMO Name	LTC Unit	CMCS
UMO Identifier	LTC Unit	CMCS

Retroactive Prior Authorization with 278 Transactions

PA is given after services have begun, or supplies have been delivered, only under the circumstances outlined in the *Retroactive Prior Authorization* section of this document. When a retroactive request is submitted with the 278 transaction, providers must indicate in the *Message* segment of the request that the request is for a retroactive PA.

Request for Transportation Services

When submitting a transportation PA request with the 278 transaction, the following information is required in the *Message* segment of the request. Unlike when submitting a paper request for PA, an attachment is not required when the *Message* segment provides this information:

- Member's condition
- Type of service required, such as wheelchair van, commercial ambulatory service (CAS), or taxi
  - The member's condition must support the level of service requested.
- Reason for and destination of service, such as dialysis or physical therapy treatments
- Frequency of service and treatment per the physician's order, such as twice per week
- Duration of service and treatment per the physician's order, such as three months
- Total mileage for each trip, such as 129 miles
- Total waiting time for each trip, such as two hours

278 Response

A 278 response transaction is communicated to the provider indicating approval, approval with modification, or denial of a request for all electronic PA requests. An electronic response is not provided for paper requests. The *Health Care Services Response* section of the IG allows the payer –the IHCP in this case – to perform the following functions:

- Provide a response to each 278 request received
- Provide a short text message to the provider regarding what is needed, such as missing information needed to process the request
- Provide a reason for rejection
- Provide information indicating the PA status
- Request an attachment
- Return information received on the request to the provider
- Continue to send providers a paper notice

Action Codes

Action codes are assigned by the PA reviewer to identify the type of action taken on the request. Action codes that can appear on a 278 response to the requesting provider are listed in Table 7. Providers receive a 278 response that gives the review outcome information. These action codes are returned only if the appropriate PA department is able to review the request. Providers continue to receive paper notification for PA in addition to an electronic response.

Table 7 – Action Codes

Code	Description
A1	Certified in total
A3	Not certified
A4	Pended
A5	Modified
CT	Contact payer
NA	No action required

Reject Reason Codes

Reject reason codes may be returned to the provider when the system rejects the 278 transaction before PA department review. The provider also receives a *follow-up action code* identifying the action the provider must take to correct the transaction rejection. Providers do not receive paper notification of system-generated rejections. A complete list of reject reason codes is available in the 278 IG.

Section 4: Prior Authorization Administrative Review and Appeal Procedures

Prior authorization (PA) administrative review and appeal procedures are outlined in the following sections of the *Indiana Administrative Code* (IAC):

- *405 IAC 5-7*
- *405 IAC 1.1*

Appeals on PA issues are conducted in accordance with *405 IAC 1.1*. All PA decisions receive a Notice of Appeal Rights with the decision letter, outlining the procedures to be used.

Administrative reviews are completed by the PA contractor that denied the request. If the administrative review is submitted to the incorrect PA contractor, the request will be returned to the provider for submission to the appropriate organization for review. If the member has been assigned to a different program since the request for PA was denied, providers can either appeal to the PA contractor that denied the request *or* submit a new PA request for review to the correct PA contractor.

Note:	*For Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise managed care entity (MCE)-related issues, the member or provider should contact the MCE Member or Provider Services toll-free number to submit a grievance or appeal. See contact information in the IHCP Quick Reference Guide at indianamedicaid.com.* *For information about pharmacy-related appeals, see the Pharmacy Services module.*

Administrative Review of PA Decisions

A provider requesting review of the modification or denial of a PA must request an administrative review within seven working days of the receipt of notification of modification or denial.

- When administrative review is desired but the member continues to be hospitalized, Cooperative Managed Care Services (CMCS) must receive a letter notifying the appropriate PA Hearings and Appeals Department of the *intent to request an administrative review* within seven working days of the receipt of notification of modification or denial. If the provider wants to continue with the appeal, CMCS must receive the entire medical record within 45 calendar days after discharge. If the program assignment of the member has changed since the denial of the initial PA request, a new PA request may be submitted to the PA contractor based on the new program assignment of the member.
- Failure to request a timely administrative review as outlined in *405 IAC 5-7-2(b)* results in the loss of the right to request an administrative hearing.
- The CMCS Indiana Health Coverage Programs (IHCP) medical director or designee renders the administrative review decision of the contractor within seven working days of receipt of all necessary documentation.
- The requesting provider and member receive written notification of the decision containing the following information:
  - The IHCP contractor determination and the rationale for the decision
  - The *Notice of Appeal Rights* through the Indiana Family and Social Services Administration (FSSA)

To initiate an administrative review, providers must include the following information with the request:

- Copy of the original *Indiana Health Coverage Programs Prior Authorization Request Form* (or printout of the electronic PA request)
- Summary letter, including pertinent reasons the services are medically necessary and the following:
  - PA number
  - Member's name
  - IHCP Member ID (also known as RID)
- All documentation including medical records, equipment consultations, progress notes, case histories, and therapy evaluation
  - Documentation should be pertinent to the case and support the medical necessity of the requested service.
- Name, telephone number, and address of the provider submitting the request
  - This information is required in the event it is necessary to contact the provider for additional information or clarification.
- Entire medical record sent with review requests for inpatient hospitalizations

This information should be faxed to CMCS at 1-866-368-2644 or mailed to the following address:

Administrative Review
Prior Authorization Department
Cooperative Managed Care Services
P.O. Box 56017
Indianapolis, IN 46256

Administrative Hearing Appeal Process for PA Decisions

The following subsections address the administrative hearing appeal process for providers and members.

Provider Appeals of Prior Authorization Decisions

Any provider that has submitted a request for prior review and authorization can appeal a denial or modification of the request after exhausting the administrative review process. The appeal request must be in writing and must be signed by the requesting provider or designee. Provider appeals of PA decisions are conducted in accordance with the member appeals regulation, *405 IAC 1.1*.

Provider requests for administrative hearings must be submitted within 33 calendar days of the administrative review decision to the following address:

Hearings and Appeals
Indiana Family and Social Service Administration
402 West Washington Street, Room E034
Indianapolis, IN 46204

For HIP, Hoosier Care Connect, or Hoosier Healthwise MCE-related issues, providers should contact the MCE provider services telephone number to submit a grievance or appeal.

Member Appeals of Prior Authorization Decisions

If a member disagrees with a denial or modification of a PA request, the member can ask for a hearing (pursuant to *Code of Federal Regulations 42 CFR 431.200 et seq*. and *405 IAC 1.1*) by filing an appeal as described in this section. An administrative review by the PA contractor is not required before a member files a request for a hearing with the FSSA.

Members of managed care programs, including HIP, Hoosier Care Connect, and Hoosier Healthwise, must first exhaust their MCE's appeals process before submitting an appeal to the FSSA.

Members can appeal a PA decision by writing a letter explaining why they think the decision is wrong. The letter must be signed and must include the member's name and other important information, such as the date of the decision. Requests for administrative hearings should be sent to the following address:

Hearings and Appeals
Indiana Family and Social Service Administration
402 West Washington Street, Room E034
Indianapolis, IN 46204

If the appellant is not the member, documentation that the appellant has the legal right to act on behalf of the member, such as power of attorney for health care or legal guardianship papers, must accompany the request.

The filing must be within 33 calendar days of the date the adverse decision was received or takes effect, whichever is later. If the request is for a continuing service (for example, home healthcare), at least 10 days' notice plus three days' mailing time must be given before the effective date of the denial or modification, except as permitted under *42 CFR 431.213* and *42 CFR 431.214*.

As required by statute, if the request for a hearing is received before the effective date of the denial or modification of continuing services, services are continued at the authorized level of the previous PA.

For additional information regarding the member appeals process, see the *Member Appeals* section of the *Member Eligibility and Benefit Coverage* module.