2016 IHCP Annual Provider Seminar:
Prior Authorization 101
for
Medicaid Fee-For-Service
Agenda

- Prior Authorization (PA) Overview
- What Requires PA & Supporting Documentation
- Universal PA Form Overview
- Common Reasons for PA Suspension/Denial
- PA details for:
  - Elective Inpatient Admission
  - Medicaid Rehabilitation Option (MRO)
  - Traumatic Brain Injury (TBI)
  - Psychiatric Residential Treatment Facility (PRTF)
  - Physical/Occupational/Speech Therapy
  - Diabetic Supplies
  - Hospice
  - Transportation
- Provider Prior Authorization Appeals & Hearings
- Questions
Prior Authorization

Cooperative Managed Care Services, LLC (CMCS) adjudicates all Medicaid Fee-For-Service (FFS), Medicaid Rehabilitation Option (MRO), Psychiatric Residential Treatment Facility (PRTF) PA requests and Traumatic Brain Injury (TBI) Program admissions.

By contract, CMCS is responsible for:

• Processing PA requests
• Making medical necessity determinations
• PA decisions based on Office of Medicaid Policy and Planning (OMPP) approved guidelines
• Notifying providers and members of the determination
CMCS adjudicates Medicaid Fee-for-Service (FFS) PA requests, Medicaid Rehabilitation Option (MRO), PRTF PA requests, and Traumatic Brain Injury (TBI) Program admissions.

All PA for prescription drugs are processed and adjudicated by OptumRx for Medicaid Fee-for-Service.
Helpful Hints to Get Started for all PA Requests

• Always verify eligibility on PA submission date and date of service;

• Submit PA to the member’s health plan;

• Fax the PA form along with supporting documents together;

• PA decisions made within five (5) business days for Medicaid FFS;

• Suspended PA requests must be completed within 30 days by the provider.

Fax – Fax PA request form along with supporting documents.
Web InterChange – Allows providers to submit non-pharmacy PA requests.
Mail – Submit PA request form along with supporting documents.
Phone – Urgent PA requests as well as Elective Inpatient Admission PA’s.
General PA Overview

- Indiana Health Coverage Programs (IHCP) Prior Authorization Request Form (universal PA form) is to be used by all providers for all PA requests, except dental, pharmacy, and MCE non-MRO Behavioral Health PA.

- Required forms located at www.indianamedicaid.com in “forms” section;

- Universal PA form for medical and behavioral health (Medicaid FFS only)

- Prior Review and Authorization Dental Request form

- Prior Authorization - System Update Request Form

- Certificate of medical necessity forms (i.e. oxygen, hearing aids, hospital beds, etc)

- Please refer to BT201045 for further information.
General PA Overview

Important Universal PA Form Instructions

- The requesting and rendering provider’s National Provider Identifier (NPI) or Legacy Provider ID (LPI) are required.

- The provider’s copy of the *Universal Prior Authorization Request Decision* form is sent to the “mail to” address that corresponds to the requesting provider’s NPI or LPI entered in this field.

- If the requesting provider information does not have a valid service location, a PA decision letter is not generated. Therefore, providers must enter the correct NPI or LPI to ensure that the PA decision letter is mailed to the correct “mail to” address.

*Note: Information found in the IHCP PROVIDER REFERENCE MODULE Prior Authorization.*
General PA Overview

Determine if a service or item requires PA in Medicaid FFS:

• Use the IHCP fee schedule: www.indianamedicaid.com;

• More information found in the IHCP Provider Reference Module, Indiana Administrative Code (IAC), bulletins, banner pages, and newsletters;

• Providers can review billing and coverage information in the IHCP Eligibility and Benefits Modules and the Claims and Billing Procedures Modules;

• Check PA status using PA inquiry function in Web InterChange;

• Providers must submit PA supporting documentation via fax or mail.
General PA Overview

Supporting PA Documentation

PA must be submitted on the appropriate PA request form and be supported by appropriate medical necessity documentation;

Examples of Supporting Documentation:
- certificate of medical necessity form
- treatment plan/plan of care
- physician order
- physician notes
- other documentation supporting medical necessity

Note: CMCS retains the right to suspend a PA request to request additional information to make medical necessity determinations.
Common PA Suspension/Denial Reasons

• PA form missing required data elements

• Certificate of medical necessity missing/incomplete

• Home health plan of care missing/incomplete

• Missing physician orders: (Physician Assistant and Advanced Nurse Practitioners signed orders are not acceptable per 405 IAC 5-22-6(b)(1))

• Clinical documentation missing
General PA Overview

PA Submission Procedures

When PA is required for services rendered to members as Medicaid FFS, the appropriate forms must be completed and submitted to:

**Cooperative Managed Care Services, LLC or CMCS**
ATTN: Medicaid Prior Authorization Dept.
P.O. Box 56017
Indianapolis, IN 46256
Telephone: 1-800-269-5720
Fax: 1-800-689-2759

Please Note: Our PA staff is more than willing to discuss the outcome of individual PA submissions if the provider needs clarification or further explanation. Please feel free to contact our PA department.
PA for Elective Inpatient Admissions

• PA is required for all non-emergent inpatient hospital admissions;

• Including all elective or planned inpatient hospital admissions;

• Applies to medical and surgical inpatient admissions;

• Medical Emergency (ER) admissions, routine deliveries, and newborn stays will not require PA;
  – Please note all Behavioral Health admissions require PA.

• Milliman Guidelines applied as criteria for appropriate admission; exceptions approved based upon medical necessity;

• NOTE: Required for all Medicaid FFS members effective January 1, 2011 (see BT201060).
PA for Elective Inpatient Admissions

• Providers are required to contact CMCS at least 2 business days prior to admission;

• Inpatient hospital PA’s may be requested via telephone:
  CMCS Medicaid FFS PA (1-800-269-5720)

• Facility must call prior to the admission and provide criteria for medical necessity;

• For Non-Emergent ER and urgent care admissions that occur outside normal business hours, including weekends and holidays, providers will have 2 business days from the time of admission to request PA from CMCS.
PA for Elective Inpatient Admissions

• Retro-Active PA Request
  – For dual members if Medicare will not cover the inpatient stay because the member has exhausted Medicare benefit or if the stay is not a Medicare-covered service, providers must request PA.

  – You will need to provide documentation of the Medicare denial.

  – For members newly enrolled or re-enrolled in the Medicaid program with a retro-eligibility date assigned by the program, providers should request PA.
PA for Medicaid Rehabilitation Option (MRO) Services

CMCS reviews only the PA requests for:

- Retroactive eligibility
- Service package not approved by the Division of Mental Health and Addiction (DMHA)
- Additional units of service are required before the end of the Service Package
- Services requested, but not contained in initial Service Package

Key elements of medical necessity determination:

- Level of Need demonstrated per Adult Needs & Strengths Assessment (ANSA) or Child & Adolescent Needs & Strengths (CANS) Assessment
- Change in condition or severity of condition
- Identified therapeutic benefit
- Services are consistent with MRO policy
- Services are for the direct behavioral impact of the member
PA for Traumatic Brain Injury (TBI) Services

• Members converted to FFS upon entry into program for out-of-state neuro-cognitive rehabilitation;

• PA requests primarily come from Rehabilitation Facilities and brain injury specialists.

• Medical necessity is determined by:
  – Initial services available in Indiana have been utilized (Acute Inpatient and Outpatient services);
  – Services necessary for continued rehabilitation or management of adverse behaviors are not available in Indiana;
  – Potential for improvement is identified;
  – Mayo-Portland Scale demonstrates functional impairment;
Psychiatric Rehabilitation Treatment Facility (PRTF) PA Requests

- BT201314, BT201250, BT200845, and BT200404 guide the admission criteria;

- Member transitions to FFS while in program and returns to FFS or Risk Based Managed Care (RBMC) upon dismissal;

- Therapeutic benefit of residential treatment is evaluated based upon the member’s condition and proposed treatment interventions;

- Response to interventions on risk behaviors determines medical necessity for continued stay;
Reminder: IHCP requires PA for outpatient mental health services exceeding established limits

- IHCP requires PA for mental health services provided in an outpatient or office setting in excess of 20 units per member, per rendering provider, per rolling 12-month period;

- Providers must submit a current plan of treatment and progress notes explaining the necessity and effectiveness of therapy with the PA request and make the plan available for audit purposes;

- Outpatient mental health services rendered in combination with Evaluation & Management (E&M) services; PA requirements for both must be met;

- PA is required for E&M services in excess of 30 visits per member, per rendering provider, per rolling 12-month period;

- Please see Banner BR201313 for a listing of E/M codes subject to mental health services limitations and PA requirements;
The current therapy guidelines of Family and Social Service Administration (FSSA) indicate approval when medically reasonable and necessary;

Prior review and authorization are required for all therapy services, with the following exceptions:
- Initial evaluations;
- Emergency respiratory therapy;
- IHCP no longer allows a PA exemption for 12 hours or visits within 30 calendar days of PT and OT services ordered in writing to treat an acute medical condition provided in an outpatient setting. All other policies and requirements regarding PA for PT or OT services continue to apply. Please refer to BT201627.
- Deductible and co-payment for services covered by Medicare Part B;
- Oxygen equipment and supplies necessary for the delivery of oxygen in nursing facilities included in the facility’s per diem rate;
- Therapy services provided by a nursing facility, or large private or small intermediate care facility for individuals with intellectual disability (ICF/IID), which are included in the facility’s per diem rate.
Physical/Occupational/Speech Therapy PA

• All home health services require PA, except services ordered in writing by a physician before the patient’s discharge from a hospital, and that do not exceed 120 hours within 30 days of discharge. These limits refer to services provided by a registered nurse, licensed practical nurse, and home health aide. Therapies such as occupational, physical, and speech are limited to 30 units of service within 30 days of an inpatient discharge from a hospital.

• Members may have Waiver Services that cover additional therapy not usually covered under IHCP benefits;

• Please review Provider Reference Module for Therapy Services for further information regarding PA for therapy services.
PA for Diabetic Supplies

Indiana Medicaid has chosen Abbott Diabetes Care and Roche Diagnostics as preferred vendors to supply blood glucose monitors and diabetic test strips for all Medicaid FFS members.

- See BT201055 and BT201215 for the Preferred Diabetic Supply List (PDSL).
- Submit PA requests to CMCS for FFS for any diabetic item not on the PDSL.

Diabetic supplies require all of the following PA criteria for additional units of A4253 (Diabetic Test Strips);

- A signed statement of medical necessity.
- A clear medical recommendation of the number of additional units required to meet the patient’s medical need.
- A hemoglobin A1C test dated within 90 days prior to the PA request for additional units of A4253
PA for Hospice

- IHCP hospice providers must submit documentation to the CMCS PA Department within 10 days of the member’s election effective date, and for each benefit period for approval of the hospice benefit;

- Hospice analyst reviews the following documentation:
  - For Dually Eligible members, the Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents State Form
  - Medicaid Hospice Election form – Indicates the IHCP member’s willingness to choose the service;
  - Medicaid Physician Certification form – Indicates the hospice member’s prognosis and diagnosis that prompted hospice election;
  - Medicaid Hospice Plan of Care form – Monitors treatment modalities and processes;

- PA is required for any IHCP-covered service not related to the hospice member’s terminal condition, if PA is otherwise required;
PA for Hospice (cont.)

- PA is not required for pharmacy services (for conditions not related to the member’s terminal condition), dental services, vision care services, and emergency services;

Managed Care Members Electing the Hospice Benefit

- Members enrolled in HHW must dis-enroll from the MCE before hospice authorization can be completed;

- HIP members receiving hospice services will remain enrolled in managed care with their health plan. Please refer to Bulletin BT201626 for details.

- For HCC, if the member is receiving Hospice in an institutional setting only, then the member must be dis-enrolled from the MCE. In home Hospice is covered by the MCE.

- Members who elect to enroll in the IHCP hospice benefit become eligible for hospice care the day following dis-enrollment from the CMO or MCE;

- The hospice provider may start billing the IHCP the day after the individual is dis-enrolled from the CMO or MCE;

- Hospice provider must fax the hospice election form to the CMCS FFS PA Department to initiate the dis-enrollment of the member from the CMO or MCE. CMCS’ Hospice dis-enrollment fax line is (317) 810-4488.
PA for Transportation

Prior authorization (PA) is required for the following transportation services:

• Trips exceeding 20 one-way trips per member, per rolling 12-month period, with certain exceptions;
• Trips of 50 miles or more one way, including all codes associated with the trip (wait time, parent or attendant, additional attendant, and mileage);
• Interstate transportation or transportation services rendered by a provider located out-of-state in a non-designated area;
• Train or bus services;
• Airline or air ambulance services;

Transportation providers may request authorization for members that exceed 20 one-way trips. Examples of situations that require frequent medical intervention include, but are not limited to, prenatal care, chemotherapy, and certain other therapy services.

Per 405 IAC 5-30-1 (3), services must be for transportation to or from (or both) an Indiana Medicaid covered service.
PA may be granted up to one year following the date of service.

PA must include the following information:
• Procedure codes for requested services
• Patients age
• Level of service required (such as wheelchair van, ambulance or taxi)
• Reason for destination of services
• Frequency of services and treatment per the physicians order
• Total mileage for each trip
• Total waiting time for each trip in hours

PA requests MUST include a brief description of the anticipated care and description of the clinical circumstances necessitating the need for transportation.

Please refer to the Provider Reference Module Transportation Service.
Provider PA Appeals

• **Administrative Review (1st Level)** – completed by the FFS PA department that denied the request. *Note: If the member has been assigned to a different program since the PA was denied, providers can either appeal to the PA vendor that denied the original request or submit a new PA request for review to the current FFS PA vendor.

• **Administrative Hearing (2nd Level)** – after exhausting the administrative review process (1st Level), providers can further appeal the decision by requesting an administrative hearing conducted between the provider, Indiana Family and Social Services Administration (IFSSA), or FFS PA vendor, and an Administrative Law Judge (ALJ).
Administrative Review (1st Level)

- Administrative review of an adverse PA decision must be submitted within seven (7) business days of the PA decision letter.

- Failure to request a timely administrative review results in the loss of the right to request an administrative hearing.

- The FFS PA vendor medical directors or designees render the administrative review decision of the health plan within seven (7) business days of receipt of all necessary documentation.
Administrative Review (1st Level)

• To initiate, providers must include the following information with the request in writing:
  – Copy of the original PA form;
  – Summary letter, including pertinent reasons the services are medically necessary;
  – Include the PA number, member’s name, and member RID number;
  – Include any medical records, equipment consultations, progress notes, case histories, and therapy evaluation that support the medical necessity;
  – Name, telephone number, and address of provider submitting the request;
  – For inpatient hospitalizations please send entire medical record for review;
  – FFS PA vendor must receive entire medical record within forty-five (45) calendar days after discharge;

• Decision letters are mailed to the provider and member.
Administrative Hearing (2nd Level)

• After exhausting the administrative review process (1st Level), providers can further appeal the decision by requesting an administrative hearing conducted between the provider, IFSSA, the FFS PA vendor, and an Administrative Law Judge (ALJ).

• Provider requests for administrative hearings must be submitted within 33 calendar days of the administrative review decision to this address:
  Hearings and Appeals
  Indiana Family and Social Service Administration
  402 West Washington Street, Room E034
  Indianapolis, IN 46204

• NOTE: The State will schedule a meeting and inform the provider and the FFS PA vendor of the date, time and location for the hearing.
Questions?