PREFACE

Health Care Excel, Incorporated, is a private, not-for-profit organization established for the purpose of providing clinically-based objective, and independent monitoring of the quality, appropriateness, and medical necessity of health care services. Our goal is to improve health care processes and outcomes, as well as the health status of target populations. Health Care Excel (HCE) performs effective quality assurance review, utilization review, medical data analysis, and quality improvement.

Health Care Excel, in its role as the Indiana Medical Policy and Review Services contractor, is responsible for the Prior Authorization (PA), Surveillance and Utilization Review (SUR), and Medical Policy (MP) business functions. The Prior Authorization Operations Manual has been developed to ensure the successful functioning of the PA department. Included are procedures, forms, reports, descriptions of the services requiring prior authorization, and other information. The manual also may be used as a reference for the Office of Medicaid Policy and Planning (OMPP), as well as the Surveillance and Utilization Review and Medical Policy departments, and others.

HCE’s goal is to ensure that the Indiana Medical Policy and Review Services contract is managed effectively, is coordinated with other stakeholders and contractors, and provides excellent service to the State of Indiana. The Medical Policy and Review Services contract is under the oversight of the Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration.

Note: Revisions to the Prior Authorization Operations Manual will be identified through the use of shading in the text and exhibits, and the use of a date code in the lower left-hand corner of each page.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Table of Contents</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. OVERVIEW</strong></td>
<td>I-1</td>
</tr>
<tr>
<td><strong>II. ORGANIZATIONAL STRUCTURE, STAFFING, and RESPONSIBILITIES</strong></td>
<td>II-1</td>
</tr>
<tr>
<td>A. Prior Authorization Staff</td>
<td>II-1</td>
</tr>
<tr>
<td>B. Responsibilities of Prior Authorization department</td>
<td>II-2</td>
</tr>
<tr>
<td>C. Primary Coordination with EDS</td>
<td>II-2</td>
</tr>
<tr>
<td>Exhibit II-1: Prior Authorization Contract Responsibilities</td>
<td>II-4</td>
</tr>
<tr>
<td>Exhibit II-2: State Responsibilities</td>
<td>II-8</td>
</tr>
<tr>
<td>Exhibit II-3: Coordination Activities</td>
<td>II-9</td>
</tr>
<tr>
<td><strong>III. PRIOR AUTHORIZATION (PA) PROCEDURES</strong></td>
<td>III-1</td>
</tr>
<tr>
<td>A. Written Requests</td>
<td>III-6</td>
</tr>
<tr>
<td>B. Faxed Requests</td>
<td>III-16</td>
</tr>
<tr>
<td>C. Telephone Requests</td>
<td>III-21</td>
</tr>
<tr>
<td>D. 278 Transaction Process</td>
<td>III-25</td>
</tr>
<tr>
<td>E. Web interChange Process</td>
<td>III-28</td>
</tr>
<tr>
<td>F. Support Staff Processing of Medical Records Received from Providers</td>
<td>III-37</td>
</tr>
<tr>
<td>G. Review of Retroactive PA Requests</td>
<td>III-37</td>
</tr>
<tr>
<td>H. Review Process for Initial PA of Services and Supplies</td>
<td>III-42</td>
</tr>
<tr>
<td>I. Review of PA System Updates</td>
<td>III-66</td>
</tr>
<tr>
<td>J. Internal Grievance Procedure</td>
<td>III-72</td>
</tr>
<tr>
<td>K. Referral to Consultants</td>
<td>III-74</td>
</tr>
<tr>
<td>L. Review of Psychiatric Admissions with the 1261A Certification of Need</td>
<td>III-76</td>
</tr>
<tr>
<td>M. Review of Hospice Services</td>
<td>III-83</td>
</tr>
<tr>
<td>N. Waiver Services and Medicaid Prior Authorization</td>
<td>III-107</td>
</tr>
<tr>
<td>O. Review of Out-of-State Services</td>
<td>III-109</td>
</tr>
<tr>
<td>P. Review of Traumatic Brain Injury Cases</td>
<td>III-112</td>
</tr>
<tr>
<td>Q. Prior Authorization and Third-Party Liability</td>
<td>III-115</td>
</tr>
<tr>
<td>R. Referrals to Surveillance and Utilization Review</td>
<td>III-115</td>
</tr>
<tr>
<td>S. Inpatient Burn Prior Authorization</td>
<td>III-118</td>
</tr>
<tr>
<td>T. Review of Cases Suspended to Location 22</td>
<td>III-118</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.</td>
<td>Review of Long Term Acute Care, Hospital Admissions</td>
<td>III-121</td>
</tr>
<tr>
<td>V.</td>
<td>Review of Psychiatric Residential Treatment Facility Services</td>
<td>III-121</td>
</tr>
<tr>
<td></td>
<td>Exhibit III-1: Telephone Scripts</td>
<td>III-122</td>
</tr>
<tr>
<td></td>
<td>Exhibit III-2: Medical Rationale</td>
<td>III-125</td>
</tr>
<tr>
<td></td>
<td>Exhibit III-3: Consultants Avoiding Common Review Errors</td>
<td>III-126</td>
</tr>
</tbody>
</table>

IV. APPEALS | IV-1

| A.      | Letters of Intent | IV-1 |
| B.      | Administrative Review | IV-2 |
| C.      | Administrative Appeal | IV-9 |
| D.      | Agency Review | IV-17 |
|         | Exhibit IV-1: Administrative Review Letter #1 | IV-18 |
|         | Exhibit IV-2: Administrative Review Letter #2 | IV-20 |
|         | Exhibit IV-3: Administrative Review Letter #3 | IV-21 |
|         | Exhibit IV-4: Administrative Review Letter #4 | IV-23 |
|         | Exhibit IV-5: Administrative Review Letter #5 | IV-26 |
|         | Exhibit IV-6: Administrative Review Letter #6 | IV-28 |
|         | Exhibit IV-7: Administrative Review Letter #7 | IV-29 |
|         | Exhibit IV-8: Administrative Review Letter #8 | IV-31 |
|         | Exhibit IV-9: Administrative Review Letter #9 | IV-33 |
|         | Exhibit IV-10: Administrative Review Letter #10 | IV-35 |
|         | Exhibit IV-11: Administrative Review Letter #11 | IV-36 |
|         | Exhibit IV-12: Administrative Review Letter #12 | IV-37 |
|         | Exhibit IV-13: Administrative Review Letter #13 | IV-38 |
|         | Exhibit IV-14: Administrative Review Letter #14 | IV-40 |
|         | Exhibit IV-15: Administrative Review Letter #15 | IV-41 |
|         | Exhibit IV-16: Administrative Review Letter #16 | IV-42 |
|         | Exhibit IV-17: Administrative Review Letter #17 | IV-43 |
|         | Exhibit IV-18: Administrative Review Letter #18 | IV-45 |
|         | Exhibit IV-19: Administrative Review Letter #19 | IV-46 |
|         | Exhibit IV-20: Administrative Review Letter #20 | IV-48 |
|         | Exhibit IV-21: Administrative Review Letter #21 | IV-50 |
|         | Exhibit IV-22: Administrative Review Letter #22 | IV-51 |
|         | Exhibit IV-23: Administrative Review Letter #23 | IV-53 |
|         | Exhibit IV-24: Administrative Review Letter #24 | IV-55 |
|         | Exhibit IV-25: Letter of Rationale | IV-56 |
## TABLE OF CONTENTS

| V. REPORTING | V-1 |
| VI. SAMPLE FORMS | VI-1 |
| A. Production and Distribution of Prior Authorization Forms | VI-1 |
| Exhibit VI-1: Prior Authorization Request Form | VI-4 |
| Exhibit VI-2: Prior Authorization Request-Dental | VI-5 |
| Exhibit VI-3: Inpatient Psychiatric Fax Form | VI-6 |
| Exhibit VI-4: Rehabilitation Pre-Admission Form | VI-8 |
| Exhibit VI-5: Rehabilitation Concurrent Review Form | VI-13 |
| Exhibit VI-6: OMPP Form 1261A | VI-20 |
| Exhibit VI-7: Hospice Election Form | VI-24 |
| Exhibit VI-8: Hospice Authorization Notice for Dually-Eligible Medicare/Medicaid Nursing Facility Residents | VI-26 |
| Exhibit VI-9: Hospice Physician Certification Form | VI-27 |
| Exhibit VI-10: Hospice Plan of Care | VI-28 |
| Exhibit VI-11: Hospice Discharge Form | VI-30 |
| Exhibit VI-12: Hospice Revocation Form | VI-31 |
| Exhibit VI-13: Hospice Change in Status Form | VI-32 |
| Exhibit VI-14: Hospice Provider Change Request Between Indiana Hospice Providers Form | VI-33 |
| Exhibit VI-15: System Update Request Form | VI-34 |
| Exhibit VI-16: Fax Communication Form | VI-35 |
| Exhibit VI-17 Medicaid Medical Clearance and Audiometric Test | VI-36 |
| Exhibit VI-18: Medical Clearance for Non- Motorized Wheelchair Purchase | VI-38 |
| Exhibit VI-19: Medical Clearance for Motorized Wheelchair Purchase | VI-40 |
### TABLE OF CONTENTS

| Exhibit VI-20: Medical Clearance for TENS Unit (Transcutaneous Electrical Nerve Stimulator) | VI-42 |
| Exhibit VI-21: Medical Clearance for Augmentative Communication Device | VI-43 |
| Exhibit VI-22: Medical Clearance for Parenteral or Enteral Nutrition | VI-45 |
| Exhibit VI-23: Medical Clearance for Oxygen Therapy | VI-46 |
| Exhibit VI-24: Physical Assessment for Standing Equipment Medical Clearance Form | VI-47 |
| Exhibit VI-25: Hospital and Specialty Beds Medical Clearance Form | VI-49 |
| Exhibit VI-26: Negative Pressure Wound Therapy Medical Clearance Form | VI-51 |
| Exhibit VI-27: Internal Referral to Medical Policy | VI-55 |

### VII. PRIOR AUTHORIZATION LETTERS

### VIII. QUALITY MANAGEMENT

A. Training of Prior Authorization Staff

B. Plan for Remedial Training

C. Training of Consultants

D. Performance Management

### IX. PERFORMANCE MEASUREMENT

A. Departmental Internal Quality Control

B. Business Function Performance Standards

### X. CONFIDENTIALITY
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>XI. HIPAA GUIDELINES FOR PRIOR AUTHORIZATION OPERATIONS</th>
<th>XI-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Paper Communication</td>
<td>XI-6</td>
</tr>
<tr>
<td>B. Fax Communication</td>
<td>XI-6</td>
</tr>
<tr>
<td>C. Oral Communication</td>
<td>XI-7</td>
</tr>
<tr>
<td>D. E-mail Communication</td>
<td>XI-7</td>
</tr>
<tr>
<td>E. Computer Safeguards</td>
<td>XI-8</td>
</tr>
<tr>
<td>F. Sanctions</td>
<td>XI-8</td>
</tr>
</tbody>
</table>

**INDEX**

- Index-1
I. Overview

A. Indiana Medicaid Program and Prior Authorization Review Responsibilities for the Medical Policy and Review Services Contractor

The Indiana Family and Social Services Administration (FSSA) is the umbrella agency responsible for administering Indiana’s public assistance program. FSSA is composed of the following agencies: Office of Medicaid Policy and Planning (OMPP); Administrative Services; Office of Information Technology Services; Division of Disability, Aging and Rehabilitation Services (DDARS); Division of Family Resources; and Division of Mental Health and Addiction. The Assistant Secretary for Medicaid Policy and Planning is responsible for administering OMPP. The oversight of the Medical Policy and Review Services contract has been delegated to the Director of Program Operations.

B. Objective of Prior Authorization

The primary objective of Prior Authorization (PA) is to serve as a utilization management measure allowing payment only for those treatments and/or services that are medically necessary, appropriate, cost-effective, and to reduce over-utilization and/or abuse of specified services.

C. Medicaid Management Information System (MMIS) and Systems Support for Prior Authorization

The Indiana Health Coverage Programs (IHCP) Management Information System is referred to as IndianaAIM. Systems support provided by IndianaAIM includes the following functions.

- Maintains all PA requests on-line (the system stores all PA requests regardless of their current status, e.g., under evaluation, approved, denied).
- Decrement PA units during claims processing.
- Maintains an authorization history for all members with a PA on file.
- Links PAs to relevant claims history against the approved PA.
- Maintains all PA administrative review and appeal information on-line.
Produces a variety of daily, monthly, and quarterly reports for use by PA and State staff; reports provide information used to evaluate and improve the PA process and monitor the timeliness of PA processing.

- Produces approval, denial, and other status notifications sent to providers.

- Monitors IHCP approved home health services in coordination with Home and Community-Based Services (HCBS) plans of care (485B). Approved home health services indicate verification of plans of care (485B) which validate coordination with home and community-based services. Report PAU 0008-M is used to report monthly utilization of home health services requested versus approved home health services. The Prior Authorization Director will present statistical reports to OMPP in the PA monthly report.

- Provides an audit trail of changes to the PA file.

- The system supports authorization of dollars, units, or periods of time.

- Supports the 278 transaction for Providers to submit requests electronically.

Health Care Excel (HCE) will coordinate these functions with EDS, the contractor that maintains Indiana AIM. Through an array of meetings, and written communiqués, HCE and EDS will serve the Prior Authorization activities on behalf of the Indiana Medicaid program.

D. Prior Authorization Department

The Program Director for the Medical Policy and Review Services contract will oversee the Manager of Prior Authorization. The Manager of Prior Authorization will work closely with the Medical Director, the Manager of Medical Policy, and the Manager of Surveillance and Utilization Review to coordinate program activities to achieve the objectives of the program (see Exhibit II-3 Coordination Activities). Key management staff will participate in weekly Operations Assessment Committee meetings to discuss issues of mutual interest, formulate actions, and evaluate action plans. This internal quality assurance and improvement function will promote fulfillment of contract responsibilities and responsiveness to the stakeholders.

Information on the department staffing is located in Section II.
E. Confidentiality Plan

Our employees, consultants, and reviewers will be subject to the Confidentiality Plan. All employees will be requested to initially sign, and reaffirm on an annual basis, understanding and compliance with the plan.

F. Consultants and Reviewers

Periodically there will be a need to involve physicians and other health care practitioners in the Prior Authorization program. The Medical Director will support the review activities through the recruitment, training, and ongoing support of physicians and other health care practitioners in the formulation of medical review criteria, case review, and associated activities. Peer reviewers will be consulted to render a medical judgment on the partial or full denial of services or payment resulting from the lack of documented medical necessity. Denials resulting from procedural errors by the provider will not be referred to the Medical Director. The PA Supervisor and/or the PA Manager will review these denials.

G. Prior Authorization Review

The Indiana Administrative Code (IAC), 405 IAC 5, provides the rules under which the Prior Authorization department fulfills its functions. 405 IAC 5-3 sets forth the provisions under which Prior Authorization may be provided. Prior to providing any Indiana Health Coverage Programs (IHCP) service subject to prior authorization, the provider must submit a properly completed IHCP Prior Authorization request form via written, fax, 278 transaction, Web interChange, or telephone, and receive written notice indicating the approval for provision of the service. Approval will be given orally at the time of a telephone request. IHCP will not reimburse any IHCP service requiring prior authorization, which is provided without first receiving prior authorization. The provider is responsible for submitting new requests for prior authorization for ongoing services before the current authorization period expires in order to ensure that services are not interrupted. Prior Authorization is not a guarantee of payment.

Prior Authorization requests may be submitted in writing (via mail or fax), Web interChange, 278 transaction, or by telephone. The PA department staff relies on established criteria at the first level of review. These criteria are utilized as screening guidelines and have been approved by the State. In addition, staff will use the portions of the IAC that delineate guidelines for the approval of services and supplies, and relevant written communiqués or other directives, written or expressed, as approved by the OMPP.
Cases that cannot be approved or modified by the PA reviewer, based upon written criteria, will be referred to a PA Supervisor or the PA Manager for additional review. Professional consultants, who will evaluate cases based upon standards of practice and professional judgment, will perform the second level of review. Providers and members may appeal denials or modifications of services in accordance with 405 IAC 5-7-1.

In addition to the PA function, the department is responsible for processing administrative reviews of denied or modified services. This is an internal appeal process whereby providers may ask for a case to be reviewed by a person other than the original reviewer. Additional documentation may be submitted. The department is also responsible for the processing of appeals that will be heard by an Administrative Law Judge (ALJ).

HCE has developed the Prior Authorization Operations Manual to be used by the Prior Authorization, the Surveillance and Utilization Review, and the Medical Policy departments, and for use as a reference for the OMPP. The manual contains information about the composition of the organization and the department, policies and procedures, information about the supplies and services requiring PA, forms, quality management activities, and HIPAA guidelines. It is intended to be a working document that will facilitate the prior authorization process, ensuring the quality and consistency of decisions.

The criteria to support the review process are provided in a supplemental manual. Other plans, which support PA, include an array of documents, such as provider manuals, Claims Resolution Manual, State IHCP program manuals, HCE Quality Management Plan, Customer Service Plan, contract work plan, Indiana Medical Policy and Review Services (IMPRS) Privacy Manual, annual business plan, and other operations manuals and plans.
II. ORGANIZATIONAL STRUCTURE, STAFFING, AND RESPONSIBILITIES

The Prior Authorization department will coordinate activities with the other business functions within Health Care Excel (Medical Policy and Surveillance and Utilization Review), with EDS, other contractors, and with the State. There will be regular meetings to discuss goals and objectives, evaluate processes, and to work together to make improvements in the program. The figure below represents the flow of information among HCE, EDS and the State, the principal partners in this process.

FIGURE II-1
COMMUNICATION, COOPERATION, AND COORDINATION

A. Prior Authorization Staff

The Prior Authorization (PA) department has been staffed to ensure the fulfillment of its functions and to provide optimal customer service to the State, providers, and IHCP members. The PA department consists of a manager, two supervisors, two specialists, 16 (sixteen) reviewers, and 6.5 support staff. (Refer to Figure II-2.) All staff must achieve and maintain performance standards, and meet or exceed the position qualifications established by the State and HCE. (Refer to Section VIII for Quality Management activities.)
The management and supervision of the department is the responsibility of the **PA Manager**. The PA Manager is accountable for the overall functioning of the department and for the achievement of contractual goals.

**PA Supervisors** conduct the day-to-day oversight for the department staff, and may serve in the absence of the PA Manager on specific issues to ensure department and contract responsibilities are achieved.

**PA Specialists** perform evaluations of PA services and assist in the resolution of complex cases through research and/or consultation with external experts (when appropriate). They are responsible for preparing cases for hearings and appeals, and representing the State at hearings. Specialists may make recommendations for program improvement.

**PA Reviewers** are responsible for reviewing and making determinations on PA requests based on written criteria, the Indiana Administrative Code, and other statutory and program regulations and guidelines. Reviewers also support the hearings and appeals process.

**PA Support** Specialists perform several duties involving written and faxed mail, data entry, organization of files, maintenance of department case files, and maintenance of calendars and tracking tools.

**B. Responsibilities of the Prior Authorization department**

Exhibit II-1 depicts the responsibilities assigned to Prior Authorization.

**C. Primary Coordination with EDS**

EDS holds the contracts for the Claims Processing and Related Services, and the Third-Party Liability. As the Medical Policy and Review Services Contractor, HCE has fundamental coordination responsibilities with EDS.
FIGURE II-2
PRIOR AUTHORIZATION ORGANIZATIONAL CHART

The organization chart depicts the PA department staffing and reporting structure.

Program Director

PA Manager

PA Supervisors (2)

PA Specialists (2)  PA Reviewers (16)  Support Staff (6.5)
EXHIBIT II-1  
RFP-3-45  
Section 4  

PRIOR AUTHORIZATION CONTRACT RESPONSIBILITIES

1. Receive PA requests and approve or deny the requests as appropriate.

2. Enter at least ninety-five percent (95%) of all PA requests into the Indiana AIM PA system on-line within two (2) business days of receipt. Enter the remaining percent within five (5) business days of receipt. The Contractor must develop and submit a report to the State to verify how this standard is being met.

3. Correctly disposition (i.e., approve, deny, or modify) prior authorization requests within ten (10) business days of receipt.

4. Develop and maintain medical criteria used to determine services that require prior authorization and make the criteria available to providers upon request. Criteria shall be provided within five (5) business days of the provider's request. The Contractor may charge providers for copies made of the criteria, but the cost shall not exceed the Contractor's cost to produce the copies.

5. Interface with providers on a regular basis to refine procedures for submission of PA requests to ensure that internal policies agree with changing practices in the provider community.

6. Ensure that non-covered or per diem-reimbursed services are not prior authorized.

7. For services that could potentially be coded with either of the coding systems (i.e., HCPCS or the NDC/UPC/HRI), establish and advise providers of their operant policy and what the requirements will be for assigning codes for such services.

8. Research, analyze, and evaluate all PA requests to ensure all medical facts have been considered prior to rendering a decision to approve or deny the request.

9. Conduct quality assurance reviews to ensure appropriateness of Medicaid PA analyst decisions.

10. Periodically review PA criteria against current practices to ensure appropriateness of PA decisions and to determine if changes to policy are required. Include representatives from the MCOs in the review discussions.

11. Ensure that authorized dollars and/or units are appropriately decremented from the PA file by paid claim.
12. Maintain a sufficient number of toll-free (for Indiana and the contiguous states) PA phone lines and qualified personnel to staff the phone lines so that:

- At least ninety-five percent (95%) of all calls are answered on or before the fourth ring.
- No more than five percent (5%) of incoming calls ring busy.
- At least ninety-five percent (95%) of calls are answered by a live person within two (2) minutes. (Hold time must not exceed two (2) minutes.)
- The average hold time must not exceed thirty (30) seconds.
- Call length is sufficient to ensure adequate information is imparted to the caller.

13. Staff PA phone lines from 7:30 a.m. to 6:00 p.m., local time, Monday through Friday (excluding State holidays).

14. Provide reports to monitor compliance with the above requirements.

15. Proactively assist providers and recipients regarding PA issues.

16. Ensure PA staff utilizes well-defined processes and procedures for analysis and research for PA approvals.

17. Produce monthly reports of PA calls, type of call, and reports regarding line availability, incomplete calls, and disconnects.

18. Receive PA requests via telephone or fax, process requests in accordance with State regulations, enter caller responses on-line, and provide the authorization number or denial reason to the caller.

19. Provide adequate professional medical staff for staffing and managing the PA function, including medically knowledgeable PA analysts for processing requests and availability of licensed medical professionals to provide consultative services regarding all Medicaid-covered service types. The Contractor shall submit to the State a list identifying the individuals responsible for performing PA activities and the types of services for which each individual is responsible.

20. Purge old PA records according to State-specified criteria.
EXHIBIT II-1 (continued)
RFP-3-45
Section 4

PRIOR AUTHORIZATION CONTRACT RESPONSIBILITIES

21. Provide a minimum of three (3) fax machines dedicated to receipt of PA requests, with sufficient memory or buffers to handle multiple incoming transmissions. Statistics for receipt of PAs via fax are included in the monthly reports included in the Procurement Library. See Attachment D for details on how to obtain this information.

22. The Contractor will design PA forms or attachments as needed or define revisions to existing forms if changes are needed. Information should be provided to the core contractor for production of forms or attachments.

23. Prepare and maintain criteria used to make PA decisions. Provide copies of the criteria to providers upon request. The criteria shall be provided within five (5) business days of request. The Contractor may charge the provider no more than the cost of copying and mailing the requested materials.

24. Provide a monthly PA activity report to the State indicating, by type of service, the number of PA requests approved, modified and denied.

25. Prepare an annual work plan for the PA Unit. The plan shall be delivered sixty (60) calendar days before the end of the calendar year. The work plan shall include projects that will be performed and anticipated schedules and resources for the projects and shall specifically address the types of services requiring prior authorization that will be reviewed to evaluate the appropriateness on a quarterly basis. The plan should also include a summary of the activities performed the previous year. Upon completing each quarterly review, the Contractor shall provide the State with a report of progress made to date on the projects, a list of the services reviewed, and the Contractor's recommendations regarding the services that should not continue to require PA, or should be prior authorized and the rationale for its determination. The quarterly report shall be delivered to the State within thirty (30) days after the end of the quarter.

26. On a quarterly basis, the Contractor shall provide a trend analysis to the State to evaluate authorized services, the number of services rejected, the number of appeal requests by PA category, and the number and disposition of appeals. Upon completion of the qualitative and quantitative analysis, the Contractor shall provide recommendations to the State for suggested policy changes. The report shall be delivered within thirty (30) days of the end of the quarter.

27. Research and prepare appropriate, timely, accurate, and thorough responses to inquiries received from the State or providers. Inquiries from government officials require a written response within three (3) business days of receipt. All other inquiries shall be responded to within ten (10) business days of receipt.
EXHIBIT II-1 (continued)
RFP-3-45
Section 4

PRIOR AUTHORIZATION CONTRACT RESPONSIBILITIES

28. Provide staff to represent the State through written and personal testimony in PA appeal matters and court cases.

29. Provide research and documentation to support administrative hearings, appeals, and court cases.

30. On a quarterly basis, initiate a review of administrative reviews, hearings, and appeals from the previous quarter to determine if providers are submitting sufficient information for making appropriate PA decisions. The analysis shall include evaluating administrative reviews to determine how many result in a reversal, denial, or modification. Upon review completion, findings will be provided to the State that includes potential policy change recommendations to correct problems.

31. Attend PA administrative hearings and appeal hearings.

32. Provide necessary staff to attend meetings (provider association meetings, etc.) on an as-needed basis.

33. Refer instances of suspected fraud/abuse to the SUR unit.

34. Meet at least monthly with the SUR Unit and Medical Policy Unit to ensure coordination among the units. Coordinate with the Core Contractor on PA issues at least monthly or as determined to be necessary.

35. Implement a quality assurance process and establish procedures to periodically sample and review dispositioned PA requests to determine if PA policy and procedures are being followed.

36. Review and approve hospice authorization requests in accordance with State instructions and process the required paperwork, assuring the proper completion and that appropriate signatures are present when required.
EXHIBIT II-2
RFP-3-45
Section 4

STATE RESPONSIBILITIES

Note: The State reserves the right to waive the review and approval of Contractor work products.

1. Review and approve all PA error messages and the content of notification letters.

2. Approve the format of all PA request forms and related material.

3. Specify PA record purge criteria.

4. Work with the Contractor to confirm content, format, and expectations for reports prepared by the Contractor.

5. Specify and approve the types of services that may be requested by phone, fax, or other electronic inquiry.

6. Conduct monitoring to ensure that PA decisions are correct and appropriate.

7. Provide policy and procedure research, development, evaluation, and rule promulgation for new rules.

8. Approve prior authorization requests for services not otherwise covered under the State's Medicaid plan but determined to be medically necessary by an EPSDT provider for an EPSDT-eligible child.
COORDINATION ACTIVITIES

1. Develop and maintain coordination methods to provide PA information to the Medical Policy Unit, SUR Unit, the Core Contractor, Waiver Unit staff, and other contractors, including the Managed Care Organizations, as necessary to support the Medicaid program.

2. Coordinate and establish protocols for call transfers.

3. Work with the Core Contractor to resolve claims issues regarding PA.

4. Coordinate activities with the Medical Policy and Review Services Contractor to develop standards regarding PA assignment. Include standards cited to document decision appropriateness.

5. Proactively provide feedback to the Core Contractor and other identified contractors as necessary regarding PA issues.

6. Develop, update, and submit PA information (e.g., appropriate telephone numbers and information on how to obtain hard copies of PA criteria, etc.) to the Core Contractor for inclusion in the provider manual.

7. Review, verify, and deliver to the State, within thirty (30) calendar days of the following month, a report summarizing the Contractor's PA activities performed for the preceding month, including the nature of the PAs (psychiatry, neurology, etc.) and the numbers of each (including which were denied and which were approved).

8. Prepare materials related to PA, subject to State approval, for inclusion in bulletins, newsletters, manuals, etc., prepared and issued by the Core Contractor. The Medical Policy Contractor shall forward the approved materials to the Core Contractor on a mutually agreed-upon schedule. Report findings to the State on a monthly basis.
III. PRIOR AUTHORIZATION PROCEDURES

HCE has established workflow procedures to ensure that PA functions are performed in an efficient, accurate, and timely manner. These include procedures for the flow of work from the mail and fax processing area to the PA reviewers, procedures for the performance of all internal PA functions, and procedures for the communication of decisions to members and providers. In addition, procedures have been established for coordination with other departments within HCE, coordination with EDS and OMPP, and communication with providers and members.

There are also mechanisms for modifying procedures when necessary and for establishing new procedures. These mechanisms will ensure that the State and other partners are involved in the policy and procedure development process.

Policies and procedures will be reviewed annually to ensure they remain up to date. This will be the responsibility of the Medical Policy department in collaboration with the Director of Prior Authorization.

The Indiana Administrative Code (IAC 5-3) outlines the provisions under which prior authorization may be provided. Prior to providing any IHCP service that requires prior authorization, the provider must submit a properly completed IHCP prior authorization request (278 transaction, Web interChange, or telephone request, for certain services) and receive written notice indicating the approval for provision of the service (approval will be given orally during telephone requests). IHCP will not reimburse any IHCP service requiring prior authorization, which is provided without first receiving prior authorization. The provider is responsible for submitting new requests for prior authorization for ongoing services before the current authorization period expires in order to ensure that payment for service is not interrupted.

Prior Authorization of services is not required under the following circumstances (405 IAC 5-3-12).

♦ Prior Authorization is not required when a service is provided to an IHCP member as an emergency service. Emergency means a service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:
  ▶ placing the patient’s health in serious jeopardy;
  ▶ serious impairment to bodily functions; or
  ▶ serious dysfunction of any bodily organ or part.
Continuation of emergency treatment should be authorized by telephone within 48 hours of the emergency admission.

♦ Urgent service is defined as the immediate treatment of a medically urgent condition which usually results from complications of a recent illness or injury, marked temperature, prolonged pain, and similar conditions.

♦ When a member’s physician determines that an inpatient hospital setting is no longer necessary, he or she may determine that IHCP covered services (e.g., home health services) should continue after the member has been discharged or transferred from inpatient hospital care. Those services may continue, without prior authorization, for a period not to exceed 120 (one hundred and twenty) hours within 30 (thirty) calendar days of discharge, if the physician has specifically ordered the services in writing upon discharge or transfer from the hospital. This exemption does not apply to durable medical equipment or out-of-state medical services. Prior review and authorization must be obtained for treatment beyond the 120 (one hundred and twenty) hours within 30 (thirty) calendar days of discharge.

Physical, speech, respiratory, and occupational therapies may continue for a period not to exceed 30 (thirty) hours, sessions, or visits in 30 (thirty) calendar days without prior authorization if the physician has specifically ordered such services in writing upon discharge or transfer from the hospital. Prior review and authorization must be obtained for reimbursement beyond the 30 hours, sessions, or visits in the 30 (thirty) calendar day period for physical, speech, respiratory, and occupational therapies.

Providers may request authorization for medical services and/or supplies in writing via mail, fax, 278 transaction, Web interChange, or by telephone. All requests for prior authorization are reviewed on a case-by-case basis. Prior authorization requests may be submitted by any of the following: doctors of medicine, doctors of osteopathy, dentists, optometrists, podiatrists, chiropractors, and psychologists endorsed as health service providers in psychology (HSPP), home health agencies, hospices, hospitals, or transportation providers.
PA reviewers will rely on established criteria at the first level of review. These criteria are utilized as screening guidelines, and have been approved by the State and formulated through the input of consultants and research of current medical literature. In addition, staff will use the portions of the IAC that delineate guidelines for the approval of services and supplies, and any Bulletins or other directives, written or expressed, approved by the OMPP. Reviewers will be kept informed of any new changes in criteria or rules to enhance the review process.

The review process involves the evaluation of the request utilizing the criteria described above. In the case of procedures, certain services or supplies, the criteria contain indicators that must be present in order for an approval to be made. In the case of ongoing inpatient or outpatient care, the review process involves the evaluation for severity of illness and intensity of service, and for discharge indicators that must be met prior to discharge.

Documentation in the medical records, maintained by the provider, must substantiate the medical necessity for the procedure or service and for the code or description given by the provider. This is subject to post-payment audit and review (405 IAC 5-1-5).

Refer to Figure III-1 for the Prior Authorization Review Process workflow chart.
FIGURE III-1
PRIOR AUTHORIZATION REVIEW PROCESS

Request for PA is received

Reviewer evaluates case while entering into Indiana.AIM

Mail, Fax, Web, or 278 Electronic Transaction Request

Sufficient information?

Yes

Refer to PA Supervisor/Consultant

Refer to PA Supervisor/Consultant

Meets Criteria?

No

Mail Decision Letter

System auto-denial in 30 days.

Yes

Approve Case

Mail Decision Letter

Await Information

Information Received?

Yes

No

No

No

No

Yes

Reviewer evaluates case (utilizing criteria) while entering into AIM

Case suspended, letter sent to provider for more information

Yes

See Consultant Flowchart

Approve Case

Mail Decision Letter

Meets Criteria

Yes

No
FIGURE III-1 (Continued)

PRIOR AUTHORIZATION REVIEW PROCESS

Potential Consultant Referrals

Refer to Supervisor or Director

Complete Consultant Referral Form and attach PA request with documentation for referral and send documentation or schedule telephone consultation

Document decision and rationale on the Physician Referral and Review Form

Enter Decision in IndianaAIM

Case is returned to Specialist or Supervisor

Request Approved?

File with Approved cases

Mail Decision Letter

File with Denials/Modifications awaiting possible Appeal

Appeal Received?

Go to H&A

Yes

No
A. Written Requests

Written requests for prior authorization must meet certain requirements. All requests must be entered into IndianaAIM within two business days of the receipt of the request. All requests not adjudicated (completed) within ten business days are automatically approved.

The requirements include the following (405 IAC 5-3-5).

♦ Written evidence of physician involvement and personal patient evaluation is required to document the acute medical needs. A current plan of treatment and progress notes as to the necessity, effectiveness, and goals of therapy services, must be submitted with the IHCP prior review and authorization request and/or available for audit purposes.

♦ All PA requests that are received via the 278 electronic transaction or Web interChange will need to submit by mail all appropriate attachments for that particular request. This will include all medical clearance forms, a plan of care, proof of physicians’ signature, and any additional requested information in order for the 278 electronic transaction or Web interChange to be completed.

♦ For a service requiring a written request for authorization, a properly completed IHCP prior authorization request must be submitted and approved prior to the service being rendered. The following information must be submitted with the written prior authorization request form:

  ➢ name, address, age, and Medicaid number of the member;
  ➢ name, address, telephone number, provider number, and original or stamped signature of the requesting and/or rendering provider;
  ➢ diagnosis and related information (ICD-9-CM code), except for transportation and dental requests;
  ➢ services or supplies requested, with appropriate CPT, HCPCS, or ADA code;
  ➢ name of suggested provider of services or supplies (optional);
  ➢ date of onset of medical problems;
  ➢ plan of treatment with physician’s signature;
  ➢ treatment goals
rehabilitation potential (where indicated);
- prognosis (where indicated);
- description of previous services or supplies provided, length of such services, or when supply or modality was last provided;
- statement of whether durable medical equipment will be purchased, rented, or repaired, and the duration of need;
- statement of any other pertinent clinical information that the provider deems necessary to justify medical necessity;
- additional information that may be required for clarification, including, but not limited to, x-rays or photographs per 405 IAC 5-3-5 (c) (14); and
- results of laboratory tests.

Written requests can include the following optional information or information specific to the type of request:

- diagnoses for transportation and dental providers;
- previous services such as physical therapy, medication regimen, or outpatient rehabilitation treatment; or
- rehabilitation potential for rehabilitation and TBI requests only.

1. Processing of Mailed (Written) Requests for Prior Authorization. (Refer to Tables III-1 and III-2)

a. Written requests for prior authorization are received via U.S. Mail or may be delivered to HCE by the requesting provider. The HCE mail clerk forwards all written requests to the PA department. The mail clerk is responsible for making sure all mail addressed to the PA department is sorted and delivered to the department at least twice daily.
b. The PA support specialist will open the request and evaluate to ensure that the request contains the necessary information. The support specialist must assess all prior authorization requests for completeness. If required information is missing, the support specialist will return the request to the provider with a letter of explanation. Prior authorization request forms must contain the following information or the request will be returned to the provider.

- Requesting and rendering provider.
- Member number.
- Provider signature.
- Service code.
- Requested dates of service, units or dollars.
- Clinical summary.
- The request must be submitted on the Prior Authorization Request form found in the IHCP Provider Manual.
- Medical clearance form, if applicable. (Refer to c. below.)

If the requesting provider information is present, the rendering provider information is optional. The provider information listed in the first box on the PA form, whether it is the requesting or rendering provider, will be entered on the initial PA screen and the PA Decision letter will be mailed to this provider.

c. Medical clearance forms must be submitted to justify the medical necessity of designated durable medical equipment (DME) or medical supplies when requesting prior authorization. DME or medical supplies that require medical clearance forms when requesting prior authorization include, but are not limited to:

- audiometric DME (hearing aids);
- non-motorized wheelchairs;
- motorized wheelchairs;
♦ transelectrical neurostimulator (TENS) units;
♦ augmentative communication systems;
♦ Certificate of Medical Necessity (CMN): Parenteral or Enteral Nutrition;
♦ Certificate of Medical Necessity (CMN) for Home Oxygen Therapy;
♦ Hospital beds and specialty beds (CMN);
♦ Standers (CMN);
♦ Negative Pressure Wound Therapy (CMN).

d. Properly completed requests are sorted by assignment group (e.g., home health, transportation, DME, etc.).

e. The requests are placed in folders of approximately 50 (fifty) requests per folder. The front cover of the assignment folder is stamped, labeled with the assignment group code, the date received, and the quantity of prior authorization requests in that folder. Any system update requests for an assignment group are added to the front of the folder.

f. The assignment folders are moved to the data entry staging shelves and placed in the coinciding assignment bin. This staging area is divided and labeled into day one and day two staging. A PA supervisor is responsible for monitoring the movement of aging day one assignment folders to day two. This allows for the oldest assignment folder to always be completed first.

g. All requests must be entered into the IndianaAIM system within two business days of receipt.

h. The data entry support specialist will retrieve assignment folders from the staging area always retrieving from the day two staging first and then day one when day two is complete.

i. Each paper request, and all related attachments, will be manually assigned a sequential prior authorization number by the PA support specialist.

j. All 278 transaction or Web interChange attachment forms will be divided into assignment groups and processed with the regular PA inventory. All attachments without an attachment number will be returned to the provider.
k. Telephone and faxed requests will be manually assigned a 10 (ten) digit PA number by the prior authorization reviewer. The PAs received via the 278 electronic transaction or Web interChange will have a PA number automatically assigned to the request. Each support specialist and reviewer will have an assigned range of numbers with which to assign the PA numbers and will maintain a log of each assigned PA number. The logs will be kept for not less than three months.

l. The PA number is made up of a logical sequence of numbers to identify the year, day of the year and delivery mechanism of the request, using numerically sequential digits to monitor the volume of requests on that particular day. For example, the number 6-233-1-02-000 would indicate the following:

- 6 = year (2006) (or 5 =2005),
- 233 = August 21 (the 233rd day of 2006 – this is the Julian Date – most desk calendars are labeled with this date),
- 1 = Paper request,  2 = Telephone request, 3 = Faxed request, and  4 = Web interChange,
- 02 = the PA support specialist or reviewer unique identification number,
- 000 = the first request received for that day, 001 the second request, etc.

This method of number assignment enables the tracking of the exact date and method of transmission of each request, as well as the number of requests processed on a given day.

m. The data entry staff will enter the following information:

- Recipient Identification (RID) Number;
- requesting provider identification number;
- assignment category;
- PA number;
- diagnosis code;
- requested procedure code or revenue code;
- dates of service requested; and
- number of units or dollars requested.
IndianaAIM will automatically populate the names and mailing addresses for both the member and the provider for mailing purposes.

Requests received for members enrolled with Risk-Based Managed Care (RBMC) or Primary Care Case Management (PCCM), including Package C (CHIP) will be identified by the program description field on the initial Prior Authorization window in IndianaAIM (Figure III-11). The program description field will populate with the corresponding initials (RBMC, PCCM, or Package C) indicating the program in which the member is enrolled. All services for members enrolled in the PCCM program, including Package C, will be reviewed for medical necessity by HCE.

When a member switches from RBMC to traditional Medicaid, all services previously authorized by RBMC will be honored by the PA department for 30 (thirty) days. In addition, HCE will process requests for RBMC members for the following services:

- Dental
- Mental Health Services (excluding inpatient admissions to acute hospital facilities)
- Psychiatric Residential Treatment Facilities Services
n. The IndianaAIM system will allow duplicate services to be entered. Once the reviewer enters a decision of approved or modified in the decision line, the system will then direct the reviewer to the duplicated PA request. The PA reviewer will automatically review all miscellaneous unspecified codes for duplicate services. If the duplicate code is for a specific service, the PA reviewer will refer to the PA history to insure the service is not an actual duplicate of the requested service by comparing the dates and internal text.

o. Upon completion of data entry, each folder is numbered with the range of numbers included in the folder (e.g., 6233100001 – 6233100049). The support specialist will enter the range of numbers onto a personal log for verification of contract compliance, and will place the folder in the reviewer staging area assignment shelves. This staging area is divided by assignment group and day two through 10 (ten) aging. This allows for easy visual inventory and assessment of prior authorization aging.

p. Following completion of the review, all written requests for prior authorization are returned to the support specialist for filing numerically for future reference.

q. Decision letters are mailed within 24 (twenty-four) hours (one business day) to the member and the requesting or the rendering provider.
# TABLE III-1

**PROCEDURE/PROCESS: MAILROOM PROCEDURES**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mail is received in the HCE mailroom and delivered to the PA department twice daily.</td>
<td>HCE Mailroom Staff</td>
</tr>
<tr>
<td>2.</td>
<td>Mail is opened and the request is evaluated to ensure the PA contains the necessary information.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>3.</td>
<td>Requests that are incomplete are returned to the provider with a letter of explanation.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>4.</td>
<td>Completed requests are sorted by type of service (e.g., home health, transportation, DME, etc.).</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>5.</td>
<td>The requests are placed in folders of approximately 50 (fifty) requests per folder.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>6.</td>
<td>The folder cover is stamped and labeled with the assignment group code, date received, and quantity of requests in the folder.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>7.</td>
<td>Each request will be entered into the IndianaAIM system within two days of receipt.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>8.</td>
<td>Each paper request and attachment is manually assigned a 10 (ten) digit PA number.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>9.</td>
<td>Each folder is labeled with:</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td></td>
<td>- the range of numbers included in the folder,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- the PA assignment group,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- quantity of PAs contained in the folder,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- date the requests were received, and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- date the requests were entered in IndianaAIM.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>The folder is placed on the shelf in the PA reviewer staging shelves.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>11.</td>
<td>Following review of the entire folder, the PA reviewer will label the folders with the review date.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>12.</td>
<td>Each folder will be labeled with the inventory filing date following completion by the PA reviewer.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>13.</td>
<td>All requests are filed numerically for future reference.</td>
<td>Data Entry Support Specialist</td>
</tr>
</tbody>
</table>
### TABLE III-2

**PROCEDURE/PROCESS: ENTRY OF NEW PRIOR AUTHORIZATION SUBMITTED ON PAPER (MAIL)**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mailed requests are entered into IndianaAIM within two business days of receipt. The information entered includes: RID number, requesting or rendering provider ID number, PA number, diagnosis code, requested procedure code, dates of service requested, number of units requested, and assignment category.</td>
<td>Data Entry Support Specialist</td>
</tr>
<tr>
<td>2.</td>
<td>The PA request and any attached documentation is reviewed and a determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria. Review previous PA history to determine if requested service has been previously requested and decision for that request.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>3.</td>
<td>The approved dates of service, approved units, dollars, if applicable, and the decision are entered on the bottom line of the “line item.”</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>4.</td>
<td>Repeat step 3 for each line item requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>5.</td>
<td>Update the “Internal Text Screen” and enter all pertinent clinical information including signs, symptoms, precipitating factors, progress, regression, previous PA history for the same service, availability of caregivers for home health requests, or most recent authorization(s) for DME requests.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>6.</td>
<td>If intensity of service is being reduced from the last PA request, the internal text is updated with the explanation of why and the “suggested” reduction plan is documented.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>7.</td>
<td>If the requested service is being denied, the internal text is updated with an explanation of why.</td>
<td>PA Reviewer</td>
</tr>
</tbody>
</table>
### TABLE III-2 (Continued)

**PROCEDURE/PROCESS: ENTRY OF A NEW PRIOR AUTHORIZATION SUBMITTED ON PAPER (MAIL)**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>The initials of the reviewer are entered into internal text.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>9.</td>
<td>The external text screen is updated including the appropriate IAC and any other additional information that contributed to making the final decision if the request was not approved as requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>10.</td>
<td>“Batch Print” to generate a decision letter to the requesting or rendering provider and member.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>11.</td>
<td>Mark the PA Request with the appropriate decision such as “A” for approved, “M” for modified, to indicate the request was reviewed and is complete.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>12.</td>
<td>Save and proceed to the next PA request.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>13.</td>
<td>Return the folder of completed PA requests to the top shelf of the metal file cart in the center aisle of the PA department for inventory and filing.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>14.</td>
<td>Supervisor will randomly review requests and decisions for quality improvement purposes.</td>
<td>PA Supervisor</td>
</tr>
</tbody>
</table>
B. Faxed Requests

Inpatient psychiatric facilities, psychiatric units in acute hospitals or inpatient acute care rehabilitation hospitals, long term acute care facilities, transplant services, and hospices approved by HCE, have the opportunity to submit requests for psychiatric, substance abuse, and acute rehabilitation admissions or concurrent reviews via fax. Typically, these facilities treat a high volume of Indiana IHCP members and the request for prior authorization may be quite lengthy and detailed. The facilities have been provided standardized fax forms, approved by the Office of Medicaid Policy and Planning. The forms must be used to provide the specific information needed to perform a comprehensive review of the request. (Refer to Table III-3 for a list of facilities that currently fax requests and Exhibits VI-1 and VI-2, for samples of forms).

### TABLE III-3

**FACILITIES WITH PRIOR AUTHORIZATION FAXING PRIVILEGES**

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>FAX NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ball Memorial</td>
<td>765-741-2982</td>
</tr>
<tr>
<td>Bloomington</td>
<td>812-353-5204</td>
</tr>
<tr>
<td>Clarian Health Partners</td>
<td>317-962-0307</td>
</tr>
<tr>
<td>Columbus Regional</td>
<td>812-376-5443</td>
</tr>
<tr>
<td>Community North</td>
<td>317-621-7868</td>
</tr>
<tr>
<td>Good Samaritan Hospital, Vincennes</td>
<td>812-885-3928</td>
</tr>
<tr>
<td>Parkview</td>
<td>260-373-7653</td>
</tr>
<tr>
<td>Methodist Gary</td>
<td>219-886-5022</td>
</tr>
<tr>
<td>Oaklawn Psychiatric Center</td>
<td>574-534-0157</td>
</tr>
<tr>
<td>St. Catherine</td>
<td>219-392-7470</td>
</tr>
<tr>
<td>St. Francis</td>
<td>317-782-6145</td>
</tr>
<tr>
<td>St. Margaret</td>
<td>219-864-2175</td>
</tr>
<tr>
<td>St. Vincent Stress Center</td>
<td>317-338-4608</td>
</tr>
<tr>
<td>Wishard Health Services</td>
<td>317-630-8006</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REHABILITATION FACILITY</th>
<th>FAX NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ball Memorial Rehab</td>
<td>765-741-2982</td>
</tr>
<tr>
<td>Bennett Rehab</td>
<td>765-646-8391</td>
</tr>
<tr>
<td>Bloomington Rehab</td>
<td>812-353-9947</td>
</tr>
<tr>
<td>Daviess Comm Rehab</td>
<td>812-254-8857</td>
</tr>
<tr>
<td>Elkhart General Rehab</td>
<td>574-523-3465</td>
</tr>
<tr>
<td>Frazier Rehab</td>
<td>502-582-7617</td>
</tr>
<tr>
<td>GSH Rehab</td>
<td>812-885-3609</td>
</tr>
<tr>
<td>Health South Tri-State Rehab</td>
<td>812-479-6794</td>
</tr>
<tr>
<td>REHABILITATION FACILITY</td>
<td>FAX NUMBER</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Hook Rehab – Community Health Network</td>
<td>317-351-7708</td>
</tr>
<tr>
<td>Howard Regional Rehab</td>
<td>800-414-6556</td>
</tr>
<tr>
<td>IU Acute Rehab</td>
<td>317-655-3832</td>
</tr>
<tr>
<td>Methodist Hosp Rehab Southlake</td>
<td>219-738-6617</td>
</tr>
<tr>
<td>Methodist Pediatric Rehab</td>
<td>317-962-6574</td>
</tr>
<tr>
<td>Methodist Rehab Northlake</td>
<td>219-738-6617</td>
</tr>
<tr>
<td>Parkview Rehab</td>
<td>260-373-4548</td>
</tr>
<tr>
<td>Rehab Center @ St. Catherine</td>
<td>219-392-7640</td>
</tr>
<tr>
<td>Rehab @ Memorial Hosp of S. Bend</td>
<td>574-647-3195</td>
</tr>
<tr>
<td>Reid Rehab</td>
<td>765-983-3047</td>
</tr>
<tr>
<td>RHI</td>
<td>317-329-2033</td>
</tr>
<tr>
<td>RHI of Ft. Wayne</td>
<td>260-435-6189</td>
</tr>
<tr>
<td>Riverview Rehab</td>
<td>317-776-7912</td>
</tr>
<tr>
<td>Southern IN Rehab</td>
<td>812-941-6177</td>
</tr>
<tr>
<td>St. Catherine Rehab</td>
<td>219-392-7640</td>
</tr>
<tr>
<td>St. Joseph Rehab</td>
<td>574-472-6070</td>
</tr>
<tr>
<td>St. Margaret Mercy Rehab</td>
<td>219-852-2413</td>
</tr>
<tr>
<td>St. Mary’s Medical Center</td>
<td>219-947-6312</td>
</tr>
<tr>
<td>St. Mary’s Rehab Institute</td>
<td>812-485-7067</td>
</tr>
<tr>
<td>St. Vincent Pediatric Rehab</td>
<td>317-415-5595</td>
</tr>
<tr>
<td>Todd-Aikens Rehab (Johnson Mem. Rehab)</td>
<td>317-346-3186</td>
</tr>
<tr>
<td>Union Hosp Rehab</td>
<td>812-238-7478</td>
</tr>
<tr>
<td>Westview Rehab</td>
<td>317-920-3011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LTAC FACILITY</th>
<th>FAX NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthSouth LTAC</td>
<td>812-238-4193</td>
</tr>
<tr>
<td>Kindred Greenwood</td>
<td>317-881-5938</td>
</tr>
<tr>
<td>Kindred Indianapolis</td>
<td>317-964-0481</td>
</tr>
<tr>
<td>Regency Hosp of NW IN</td>
<td>219-378-1229</td>
</tr>
<tr>
<td>Renaissance Specialty Hospital</td>
<td>765-289-7251</td>
</tr>
<tr>
<td>St. Elizabeth Ann Seton</td>
<td>317-338-6515</td>
</tr>
<tr>
<td>St. Elizabeth Ann Seton</td>
<td>765-236-8116</td>
</tr>
</tbody>
</table>

Faxed requests may be received at any time during the day or night at the HCE office. Faxed requests are scanned and retained on disk as they are received. Faxed requests must be reviewed, decisions made, and the decisions returned to the requesting provider via fax within 48 (forty-eight) hours (two business days) of their receipt. Requests that are received after the close of business (6:00 p.m.) are considered as received on the next business day. For example, a request received at 6:30 p.m. on Friday will be considered as received at 7:30 a.m. on Monday; therefore, the reviewer must render a decision and notify the provider of the decision by 7:30 a.m. on Wednesday.
All requests for prior authorization are reviewed on a case-by-case basis. The decision is rendered based on the submitted documentation and the predetermined rules and criteria approved by the Office of Medicaid Policy and Planning.

Psychiatric facilities have 48 (forty-eight) hours (two business days) from the date of an emergency admission to submit the faxed request form. The faxed form should contain all of the information necessary to establish the necessity of the emergency admission.

Days are entered into the IndianaAIM system as “pending” for both inpatient psychiatric care and for substance abuse admissions, until such time as the provider submits the completed “Certification of Need for Admission” or 1261A. If the completed 1261A is submitted within the stated time and supports the need for the emergency admission, the “pending” days are changed to approved. If the 1261A does not support the need for the admission or is not timely, the “pending” days are denied following the normal review process. (Refer to Section III-K for the procedure for processing the 1261A.)

Rehabilitation hospitals must submit faxed request forms prior to the admission. Admissions most commonly occur when members are transferred from an acute care facility or another rehabilitation facility, thus, are not considered to be “emergency” admissions. The State approved form provides for all information pertinent and necessary to conduct the review and render a decision.

1. Support Staff Processing of Faxed Requests for Prior Authorization

   a. All faxed requests, and any attachments, are collected each morning, and as needed throughout the workday, by a support specialist. Requests are sorted according to the type of service and facility. Faxed requests should be expedited.

   b. A Prior Authorization Fax Communication form must be completed for all psychiatric, rehabilitation and LTAC faxed requests to include facility name, date received, facility fax number, recipient name and RID number, and PA number if applicable.

   c. All faxes must be placed in a folder labeled with the date the faxes are received. (Currently, only inpatient psychiatric facilities, psychiatric units in long term acute care hospitals, hospices, and inpatient rehabilitation facilities have fax privileges.)
d. The folders are placed in the PA fax staging area. The folders are distributed to the appropriate reviewer throughout the day. Each request is assigned a PA number by the PA reviewer utilizing the ten digit numerical assignment procedure described in Section III-A-1-l. The start and stop dates are added to the fax communication forms for psychiatric, rehabilitation, and LTAC requests. A decision must be made within 48 (forty-eight) hours (two business days), so it is important that all faxed requests are forwarded to the reviewers promptly.

e. After the PA reviewer evaluates the documentation and enters the decision into IndianaAIM, the documents are returned to the support specialist, who faxes the decision form to the requesting facility and then files the faxed requests. These files are kept in close proximity to the Prior Authorization department for at least six months from the date of the original request in the event an appeal is filed, then are moved to remote storage and retained in compliance with the Approved Records Retention and Disposition Schedule.

Refer to Table III-4 for a step-by-step process of Entry of New Prior Authorization Submitted on Paper (Fax) and Exhibit VI-16, for PA Fax Communication form.
### TABLE III-4

**PROCEDURE/PROCESS: ENTRY OF NEW PRIOR AUTHORIZATION SUBMITTED ON PAPER (FAX)**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Faxed requests and any attachments are collected each morning and as needed throughout the workday.</td>
<td>Support Specialist</td>
</tr>
<tr>
<td>2.</td>
<td>Requests are sorted by type of service and facility.</td>
<td>Support Specialist</td>
</tr>
<tr>
<td>3.</td>
<td>The PA number, if applicable, is entered in the PA number box.</td>
<td>Support Specialist</td>
</tr>
<tr>
<td>4.</td>
<td>Requests are placed in folders labeled with the date the fax was received and placed in the fax staging area.</td>
<td>Support Specialist</td>
</tr>
<tr>
<td>5.</td>
<td>The folders are distributed to the appropriate reviewer(s) by a supervisor. A decision must be made within 48 (forty-eight) hours.</td>
<td>PA Supervisor</td>
</tr>
<tr>
<td>6.</td>
<td>The rendering provider ID number is entered in the provider ID box.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>7.</td>
<td>The Recipient Identification (RID) number is entered in the RID No. box.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>8.</td>
<td>Each request is assigned a ten digit PA number.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>9.</td>
<td>The requested type of service is entered in the PA assignment box.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>10.</td>
<td>The numeric diagnosis code(s) is entered in the diagnosis box.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>11.</td>
<td>Enter each line item requested including the procedure code(s), dates of service and the number of units requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>12.</td>
<td>The PA request and any attached documentation is reviewed and a determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>13.</td>
<td>Review previous PA history to determine if requested service has been previously requested and decision for that request.</td>
<td>PA Reviewer</td>
</tr>
</tbody>
</table>
TABLE III-4 (Continued)

PROCEDURE/PROCESS: ENTRY OF NEW PRIOR AUTHORIZATION
SUBMITTED ON PAPER (FAX)

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>The approved dates of service, approved units or dollars, and the decision are entered on the bottom line of the line item.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>15.</td>
<td>Repeat step 14 for each line item requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>16.</td>
<td>Update the “Internal Text Screen” and enter all pertinent clinical information including signs, symptoms, precipitating factors, progress, regression, and previous PA history for the same service.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>17.</td>
<td>If intensity of service is being reduced from the last PA request, the internal text is updated with the explanation of why and the “suggested” reduction plan is documented.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>18.</td>
<td>If the requested service is being denied, internal text is updated with an explanation of why.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>19.</td>
<td>The PA decision is entered into the internal text including the number of units and dates of service that are approved or denied.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>20.</td>
<td>The initials of the reviewer are entered into internal text.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>21.</td>
<td>The external text screen is updated including the appropriate IAC and any other additional information that contributed to making the final decision if the request was not approved as requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>22.</td>
<td>“Batch Print” to generate a decision letter to the rendering provider and member.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>23.</td>
<td>Save and proceed to the next PA request.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>24.</td>
<td>Return the folder of completed PA requests to a support specialist for faxing back to the requested provider within the allowed 48 hours. The support specialist files the request by provider and date received.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>25.</td>
<td>Supervisor will randomly review requests and decisions for quality improvement purposes.</td>
<td>PA Supervisor</td>
</tr>
</tbody>
</table>
C. Telephone Requests

Telephone requests for PA may be accepted for selected services if the initiating provider is a Doctor of Medicine, Doctor of Osteopathy, Dentist, Optometrist, Podiatrist, Chiropractor, Psychologist endorsed as a Health Care Provider in Psychology (HSPP), home health agency, hospice, or hospital (405 IAC 5-3-2 and IAC 5-3-10).

Notification of approval or denial will be given at the time the call is made for the following services (405 IAC 5-3).

- Inpatient hospital admissions and concurrent review for services requiring prior authorization (405 IAC 5-3-13).
- Continuation of emergency treatment for those conditions listed in IAC 5-3-13 on an inpatient basis originally without prior authorization, subject to retrospective medical necessity review.

Some services prior authorized by telephone require a properly completed Prior Authorization Request Form to be submitted subsequent to the authorization. These services include:

- medically necessary services or supplies needed to facilitate discharge from, or prevent admission to, a general hospital;
- equipment repairs necessary for life support or safe mobility of the patient; and
- services, when a delay of beginning the services could reasonably be expected to result in a serious deterioration of the patient’s medical condition.

All requests for Prior Authorization are reviewed on a case-by-case basis. The decision is rendered based on the submitted documentation and the predetermined rules and criteria approved by the Office of Medicaid Policy and Planning.

1. All requests for services which are determined to be urgent, emergency, or immediate may be requested by telephone. Telephone authorizations may be granted for a shorter period of time than may normally be given.

   a. The reviewer will request all information necessary in order to render a decision and simultaneously enter the information into the IndianaAIM system.
b. The reviewer will use the Prior Authorization Telephone Script as a guideline for the telephone authorization. (Refer to Exhibit III-1.)

c. The reviewer will be courteous and helpful at all times.

d. Each reviewer will maintain records of all reviews and retain daily log sheets for future reference.

e. A telephone review should include the following (IAC 5-3-6):

- initiation of the telephone request by a provider authorized to request PA (see Section C. above);
- the requesting provider number;
- the name, address, age, and Recipient Identification number (RID);
- diagnosis and related information (ICD-9-CM code);
- services or supplies requested (CPT, HCPCS code, or NDC);
- name of the suggested provider of the services or supplies;
- member-specific clinical information required to establish medical necessity, including the following: prior history, results of diagnostic studies; prior treatment; comorbid conditions; treatment plan and rationale; progress; and date of onset of medical conditions;
- additional information when needed for clarification, including, but not limited to, x-rays, lab test results, and photographs [per 405 IAC 5-3-5 (c) (14)] when appropriate; and
- for emergency admissions, type of accident and accident date, if applicable.
f. A decision is rendered, using the IAC, IHCP bulletins, written directives from OMPP, and internal criteria as guidelines. Clinical information, decision, and rationale for the decision are entered into the internal text, for internal use only. The appropriate IAC citation, and any comments necessary, are entered into the external text, for provider and member notification.

g. Providers receive the prior authorization number and decision immediately via telephone, if approved or modified. Each reviewer keeps an ongoing log tracking the PA numbers assigned to each telephone and faxed request.

h. All telephone requests that cannot be approved or modified (partially approved) are referred to the PA supervisory staff for review. Cases that still cannot be approved or modified are then referred to a physician consultant before the determination may be given to the provider requesting the service(s) or supply(s). Decisions will be entered as “suspended” until the physician review is completed. These referrals must be expedited in order to ensure rapid turnaround and optimal customer service. Documentation of this review, including the name of the physician and the rationale for the denial, is entered into the internal text by the reviewer, and onto the Physician Reviewer Referral and Review Form.

i. Once the decision has been made, the Prior Authorization Decision Form is mailed, within 24 (twenty-four) hours of the decision, to the provider and the member. A Notice of Appeal Rights is included in the mailing.

## TABLE III-5

**PROCEDURE/PROCESS: ENTRY OF NEW PRIOR AUTHORIZATION REQUESTED VIA TELEPHONE**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The phone will be answered on or before the fourth ring.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>2.</td>
<td>The provider number or license number of the requesting provider must be entered.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>3.</td>
<td>The Recipient Identification (RID) number will be entered. The provider must identify member’s name.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>4.</td>
<td>The numeric diagnosis (ICD-9 CM) code(s) will be entered.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>5.</td>
<td>The services or supplies (CPT or HCPCS code) will be entered.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>6.</td>
<td>The name of the rendering provider will be entered, if applicable.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>7.</td>
<td>Member-specific clinical information is requested to establish medical necessity, including prior history, results of diagnostic studies, prior treatment, comorbid conditions, treatment plan and rationale, progress, and date of onset of medical conditions.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>8.</td>
<td>If the request is for an emergency admission, the type of accident and date of accident will be requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>9.</td>
<td>A determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, approved medical criteria and directives from OMPP.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>10.</td>
<td>Clinical information, decision, and rationale for the decision are entered into the internal text.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>11.</td>
<td>The appropriate IAC ruling, and any comments necessary, are entered into the external text for member and provider notification.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>12.</td>
<td>The requesting provider will receive a prior authorization number and decision immediately via telephone if approved or modified.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>13.</td>
<td>The approved dates of service, approved units or dollars, and the decision are entered on the bottom line of the “line item.”</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>14.</td>
<td>Repeat step 13 for each line item requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>15.</td>
<td>Generate a “batch print” to automatically send a decision letter to the provider and member.</td>
<td>PA Reviewer</td>
</tr>
</tbody>
</table>
D. 278 TRANSACTION PROCESS: REVIEW PROCESS FOR ELECTRONIC PRIOR AUTHORIZATION REQUESTS

PA requests can be received electronically via the 278 transaction. This business function has been implemented due to HIPAA requirements. This electronic transmission is an elective process for the provider community and is not considered mandatory.

Electronic requests for PA may be accepted for all service types if the initiating provider is a Doctor of Medicine, Doctor of Osteopathy, Dentist, Optometrist, Podiatrist, Chiropractor, Psychologist endorsed as a Health Care Provider in Psychology (HSPP), home health agency, hospital, hospices, or transportation provider (405 IAC 5-3-2 and IAC 5-3-10).

All requests will be processed in the Indiana AIM system. Notification of approval, denial, suspension, and pending status will be issued in the normal PA business function process. Services that currently require a paper attachment will be followed with a paper attachment submitted by mail. This paper attachment must include the attachment control number, so the attachment can be matched with the original 278 transaction, once received. If the submitting provider is not a provider who is able to submit a PA request independently, that provider will need to mail in proof of the appropriate requesting provider signature. The attachments can include a plan of care, medical clearance form, proof of the requested item by an authorized provider agent, and any other additional documentation that may be requested by the PA reviewer. The PA business function for reviewing PA requests, current medical policies and criteria, apply to the 278 transaction process.
1. The Search for Requests window will be selected for the 278 electronic request transactions.

**FIGURE III-2**

**WINDOW: SEARCH FOR REQUESTS**

2. The PA reviewers will select media type “Electronic” and the assignment category of “Non-processed”, then select the search button. This will display all electronic requests that have not been processed.

3. All electronic requests will include the following information on the Search for Request screen:

   a. Received Date  
   b. Requesting Provider ID  
   c. Recipient Identification (RID) Number  
   d. Processed Indicator  
   e. Certification Type  
   f. Assign Category  
   g. Emergency Indicator  
   h. Certification Number  
   i. PA Number  
   j. Media Type  
   k. User ID
4. The electronic transaction automatically assigns the new request a PA number unless it is a duplicate or appeal request.

5. If the request is a duplicate, the system will ask for the duplicate PA number.

6. The reviewer will highlight a request and press the select button.

7. The PA request is then displayed on the Request for Review Window.

8. The Request for Review Window will display all medical information submitted by the requesting provider.

9. Clicking on the service detail line item will open the IndianaAIM production screens.

10. The normal review process for prior authorization will be followed as described in Section III-1.

11. Once the PA request has been given a decision status, the 278 transaction is automatically completed. An electronic response is transmitted back to the submitting provider indicating the decision status and any additional information necessary for that particular request.

12. A PA decision letter is processed as normal by the IndianaAIM system to the requesting provider and member.
E. **Web interChange: Review process for receiving prior authorization requests through the Web interChange.**

The Web interChange allows providers the ability to submit requests via the internet. Providers must sign up for web administrator abilities through EDS prior to submitting PAs. The Web will allow providers to submit new PAs as well as system updates. Any request requiring signed treatment plans, cost estimates, plan of care, or medical clearance forms will need to be mailed in as system updates. The Web PAs are processed within 10 business days from the date submitted.

Refer to Figures III-3 through Figure III-12 for detailed illustration of processing Web interChange requests submitted through Web interChange.
To access Web interChange requests, click on the Search for Request button.

This window will be displayed after clicking on the Search for Request button.
FIGURE III-5
WINDOW: SEARCH FOR WEB INTERCHANGE REQUESTS

♦ To search for the Web interChange PAs,
1. enter the date received,
2. choose Electronic as the Media Type,
3. then click on the Search button to retrieve requests.
4. The search can further be sorted by Assignment Category; Mental Health, Home Health, Transportation, etc. To sort the requests into an Assignment Category click on the drop down button and select the group.
♦ All PA’s for the Assignment Category chosen will appear on the screen after the search button has been clicked.

♦ When selecting the next PA to work, highlight that request and click on the select button or double click on the highlighted PA.
The Request for Review screen will come up once a PA has been selected. This screen will display all the information the provider entered when submitting the PA request which includes,

- member information
- provider information
- service codes
- dates
- units
FIGURE III-8
WINDOW: REQUEST FOR REVIEW – SERVICE PROVIDERS TAB

Service Providers tab offers additional information about the provider.

FIGURE III-9
WINDOW: REQUEST FOR REVIEW – DIAGNOSIS TAB

Diagnosis tab allows for the provider to enter all of the recipient’s diagnoses.
The Provider/Service Text tab allows the provider to enter free form clinical text for each request.

The Attachments tab is for providers to document what information they will be sending by mail in order for their requests to be approved. The Web interChange currently does not allow electronic submission of attachments so all plan of care forms, cost estimates, treatment plans, and medical clearance forms will still need to be sent in by mail.
FIGURE III-12

WINDOW: REQUEST FOR REVIEW – RECIPIENT ADDITIONAL TAB

The Recipient Additional tab will allow the provider to enter detailed information such as listed below:

♦ patient’s accident date
♦ illness date
♦ menstrual date
♦ and estimated birth date
Table III-6
PROCEDURE/PROCESS: ENTRY OF PRIOR AUTHORIZATION REQUESTS SUBMITTED THROUGH THE WEB INTERCHANGE SYSTEM

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Identify attachments for request submitted through the Web interChange and sort them into the assignment groups. Write the PA number on the request if not given. In AIM, enter the date the additional information was received in the system update box. Then place the requests in the staging area for reviewers to process.</td>
<td>Support Specialist</td>
</tr>
<tr>
<td>2.</td>
<td>On the PA Menu go to Search for Request. Search for not processed request as follows: Enter the date received to correspond with the date HCE is currently working with paper, Media Type is Electronic, Processed Indicator is Not Processed, and Assignment Category.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>3.</td>
<td>The PA request and documentation is reviewed by a PA Reviewer and a determination is made regarding the appropriateness and medical necessity of service or supplies being requested based on IAC, IHCP bulletins, and approved medical criteria.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>4.</td>
<td>The decision with the approved dates of service, approved units, or dollars (if applicable), are entered on the bottom line of the “line item.”</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>5.</td>
<td>Repeat step 3 for each line item requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>6.</td>
<td>In the “Internal Text Screen” enter all pertinent PA reviewer clinical information including; signs, symptoms, precipitating factors, progress, regression, previous PA history for the same service, availability of caregivers for home health requests, or the most recent authorization(s) for DME requests.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>7.</td>
<td>If the information submitted by the Web interChange does not provide enough information for the PA reviewer to make a decision the request will be suspended for additional documentation.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>8.</td>
<td>If the requested service is being suspended for additional documentation, the PA reviewer will enter into the internal and external text an explanation as to what additional information is needed from the provider.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>9.</td>
<td>If the requested service is being modified or denied the internal and external text must contain an explanation of why and include the appropriate IAC.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>10.</td>
<td>Daily counts of all Web PAs that have been received and not processed will be done by the support specialists. To do this support staff will go into the search for request window and search for any request(s) received via the Web interChange not processed.</td>
<td>Support Specialist</td>
</tr>
</tbody>
</table>
F. Support Staff Processing of Medical Records Received from Providers

Entire medical records may be submitted if the provider is requesting a retroactive review for authorization or wishes to appeal a modification or denial of a prior authorization request for hospitalization.

1. The PA support specialist will date-stamp each medical record and any attachments, and will evaluate to determine if the record needs to have a PA number assigned. Retroactive requests for authorization must have a PA number assigned. The provider should include the original PA number when requesting an appeal. If the PA number is not included but the RID and Date of Service (DOS) is provided, the support specialist can find the case in IndianaAIM and the request will be processed.

2. The records are then forwarded to the Prior Authorization reviewer, or to the hearings and appeals staff.

3. Any cover letter or attachments remain with the record.

4. The envelope is attached to any records being forwarded to hearings and appeals.

5. If there are any questions as to the disposition of a record, they are discussed with a supervisor.

G. Review of Retroactive Prior Authorization Requests

1. 405 IAC 5-3-9 provides the conditions under which services or supplies requiring prior authorization may be authorized after the services have been rendered or the supplies provided.

   ♦ Retroactive prior authorization may be given for pending or retroactive member eligibility. The prior authorization request must be submitted within 12 (twelve) months of the date eligibility was established and entered into IndianaAIM.

   ♦ Retroactive prior authorization may be given in the case of mechanical or administrative delays or errors by HCE or the County Office of Family and Children.

   ♦ A provider who has not yet received a provider manual may receive retroactive prior authorization for services rendered outside Indiana.
Retroactive prior authorization may be given for transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within 12 (twelve) months of the date of service.

Services for 590 (five hundred and ninety) members may be authorized retroactively.

Retroactive prior authorization may be given when the provider was unaware the member was eligible for services at the time services were rendered. PA will be granted in this situation only if the following conditions have been met.

⁻ The provider’s records document that the member refused or was physically unable to provide the Recipient Identification (RID or Medicaid) number.

⁻ The provider can substantiate that they continually pursued reimbursement from the patient until IHCP eligibility was discovered.

⁻ The provider submitted the request for prior authorization within 60 (sixty) days of the date IHCP eligibility was discovered.

⁻ Situations where the physician cannot determine the exact procedure to be done until after the service has been performed.

a. These requests can be received either written, via 278 electronic transaction, or Web interChange, and are reviewed as if they had been submitted prior to the provision of services or supplies, following the normal review process.

b. Retroactive requests for members whose eligibility was pending on the date of service will be verified by completing an eligibility audit in IndianaAIM.

c. Appropriate criteria will be utilized, and if the request cannot be approved or modified, the request will be referred to the PA supervisory staff that will refer the request to a physician consultant for a determination of medical necessity.
2. A member, having purchased an item or service, and later learning of IHCP eligibility made retroactive to cover the date the item or service was purchased, may request that the provider submit a claim to IHCP and reimburse the member the IHCP reimbursed amount of the item(s). The provider may wait to receive reimbursement from IHCP prior to refunding the total paid amount to the member.

♦ The reviewer will evaluate the PA request to determine whether it is a covered IHCP service or supply.

♦ If the service or supply is not a covered service by IHCP, the request is denied, and the provider is under no obligation to reimburse the member any portion of the payment.

♦ If the request is approved and the provider is reimbursed, the provider should reimburse the member an amount equal to that paid by the member.
# TABLE III-7

## PROCEDURE/PROCESS: APPROVAL OF A PRIOR AUTHORIZATION

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A prior authorization request and any attached documentation is reviewed and a determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>2.</td>
<td>Review previous PA history to determine if service had been previously requested and the decision for that request.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>3.</td>
<td>The approved dates of service, approved units or dollars, and the decision are entered on the bottom line of the “line item.”</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>4.</td>
<td>Repeat step three for each line item requested.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>5.</td>
<td>Update the “Internal Text Screen” and enter all pertinent clinical information including signs, symptoms, precipitating factors, progress, regression, previous PA history for the same service, availability of caregivers for home health requests, or most recent authorization for DME requests.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>6.</td>
<td>The initials of the reviewer will be entered into internal text.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>7.</td>
<td>“Batch Print” to generate an approval decision letter to the requesting provider and member.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>8.</td>
<td>Save and proceed to the next PA request.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>9.</td>
<td>Return completed PA requests to the top shelf of the metal file cart in the center aisle of the PA department for inventory and filing.</td>
<td>PA Reviewer</td>
</tr>
</tbody>
</table>
### TABLE III-8

**PROCEDURE/PROCESS: DENIAL OF A PRIOR AUTHORIZATION**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A prior authorization request and any attached documentation is reviewed and a determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>2.</td>
<td>Any request that is denied for noncompliance or procedural reasons (e.g., retroactive coverage, non-covered service or supply, etc.) will be documented in the internal text. The external text will cite the appropriate IAC on the decision form that is mailed to the requesting provider and member.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>3.</td>
<td>If the request is unable to be approved or modified based on medical necessity, the request will be suspended and forwarded to the PA supervisory staff.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>4.</td>
<td>The request will be evaluated to ensure that all available documentation and criteria have been assessed.</td>
<td>PA Supervisory Staff</td>
</tr>
<tr>
<td>5.</td>
<td>Any request that cannot be approved or modified will be referred to a Physician Consultant.</td>
<td>PA Manager</td>
</tr>
<tr>
<td>6.</td>
<td>The consultant will be contacted to ensure availability and willingness to evaluate the case.</td>
<td>Support Specialist</td>
</tr>
<tr>
<td>7.</td>
<td>If the service or supply is elective in nature, the case documentation will be mailed or faxed to the consultant for a decision.</td>
<td>Support Specialist</td>
</tr>
<tr>
<td>8.</td>
<td>If the service or supply is considered to be urgent or emergent, the case will be described in detail, via telephone conference with the consultant.</td>
<td>PA Supervisory Staff</td>
</tr>
<tr>
<td>9.</td>
<td>A decision will be made regarding the medical necessity based upon current standards of practice and professional judgement. The physician consultant is constrained by the State of Indiana rules and regulations regarding coverage issues.</td>
<td>Consultant</td>
</tr>
<tr>
<td>10.</td>
<td>The decision is recorded on the Physician Reviewer Referral &amp; Review Form, citing the rationale and mailed back to HCE within five business days.</td>
<td>Consultant</td>
</tr>
<tr>
<td>11.</td>
<td>Urgent and emergent cases that are decided by phone will be documented on the Physician Reviewer Referral &amp; Review Form, including the rationale cited by the consultant.</td>
<td>PA Supervisory Staff</td>
</tr>
<tr>
<td>12.</td>
<td>The consultant decision is entered into the IndianaAIM system and a decision letter is mailed out within 24 (twenty-four) hours.</td>
<td>PA Supervisory Staff</td>
</tr>
<tr>
<td>13.</td>
<td>Requests that do not contain adequate and/or necessary information are entered as suspended.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>14.</td>
<td>The external text is documented with the reason for suspension, requesting the provider resubmit the request with the information listed on the Prior Authorization Decision Form. (If the provider does not respond within 30 (thirty) days with the necessary information to approve the request, the system will automatically deny the request.)</td>
<td>PA Reviewer</td>
</tr>
</tbody>
</table>
H. Review Process for Initial Prior Authorization of Services and Supplies

PA reviewers will perform the initial review utilizing approved criteria, the IAC, IHCP bulletins and other directives of the OMPP. Cases that cannot be approved or modified based upon criteria will be referred to PA supervisory staff for further review.

If the PA supervisory staff determines there is a question of medical necessity, the case will be referred to an appropriate consultant for further review. A decision is rendered based on the submitted documentation and the decision is then entered into the IndianaAIM system.

There are four basic decisions for prior authorization requests. These are approved, modified, denied, or suspended. Any of the additional 20 (twenty) decisions available in IndianaAIM are variations of these four types. Refer to Tables III-9 and III-10, for a brief explanation of each decision code.
### TABLE III-9

**PRIOR AUTHORIZATION DECISION CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved</td>
<td>This decision status is used when the requested service is approved exactly as requested, including service code, the number of units or dollars, and the dates of service.</td>
</tr>
<tr>
<td>Modified</td>
<td>This decision status is used when either the number of units or dollars, or the dates of service, is approved at a lesser level than was requested. A Notice of Appeal Rights must be attached to all modified decisions.  The service code cannot be changed in any way from what was requested.</td>
</tr>
<tr>
<td>Denied</td>
<td>This decision is used when the entire request is denied, or in any situation when a member is refused a requested service. For requests submitted after the services have begun or the supplies provided, the dates of service prior to the receipt of the prior authorization request may be denied, while the remainder of the request may be approved, modified, pended, or denied based on documented medical necessity or lack thereof. Non-covered services are denied, as are services that have met the benefit limit, e.g., 20 (twenty) trips under the transportation services coverage guidelines, without prior authorization. Based on the submitted documentation, medical necessity must be present for any additional trips. All requests lacking documentation supporting medical necessity must be reviewed and signed by a physician designee.  A Notice of Appeal Rights must accompany all notifications of decisions to deny.</td>
</tr>
<tr>
<td>Suspended</td>
<td>A request for prior authorization may only be suspended when the submitted documentation is insufficient to make a decision. The requesting provider and member are notified of the necessary documentation on the PA Decision Form. If the requested documentation is not received within 30 (thirty) days, the PA request is automatically denied.</td>
</tr>
</tbody>
</table>
# TABLE III-10

## DECISION STATUS CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong>&lt;br&gt;(Approved)</td>
<td>All details are approved as requested.</td>
</tr>
<tr>
<td><strong>B</strong>&lt;br&gt;(Non-covered code, PA authorized)</td>
<td>Even though the procedure or supply is not covered by the Indiana Health Coverage Programs, medical necessity is present and the procedure or supply is approved by the OMPP. (May or may not be the result of an appeal decision.)</td>
</tr>
<tr>
<td><strong>C</strong>&lt;br&gt;(Decision overturned by ALJ)</td>
<td>Previously denied or modified decision has been approved by the Administrative Law Judge.</td>
</tr>
<tr>
<td><strong>D</strong>&lt;br&gt;(Denied)</td>
<td>All details of the request are denied.</td>
</tr>
<tr>
<td><strong>E</strong>&lt;br&gt;(Evaluation)</td>
<td>All requests remain in “evaluation” status until reviewed by the PA reviewer. (No decision has yet been made.)</td>
</tr>
<tr>
<td><strong>F</strong>&lt;br&gt;(Approved Continuation of Service)</td>
<td>Request has been approved exactly as approved on previous PA request.</td>
</tr>
<tr>
<td><strong>G</strong>&lt;br&gt;(Modified Continuation of Service)</td>
<td>The request was approved at exactly the same level as was previously approved, not necessarily as requested on this prior authorization request.</td>
</tr>
<tr>
<td><strong>H</strong>&lt;br&gt;(Denied Continuation of Service)</td>
<td>Even though exact services have been previously approved, there is not documentation to warrant approval of this request for prior authorization.</td>
</tr>
<tr>
<td><strong>I</strong>&lt;br&gt;(Non-Covered Code Denied)</td>
<td>The code is not a covered service, therefore, the request is denied.</td>
</tr>
<tr>
<td><strong>K</strong>&lt;br&gt;(Suspended, Awaiting additional information)</td>
<td>Effective 01/1/99 a suspended decision will automatically deny after 30 (thirty) days if the additional information was not received and the decision was not changed in the system (replaced “rejected”).</td>
</tr>
<tr>
<td><strong>L</strong>&lt;br&gt;(PA restored to previous level pending appeal decision)</td>
<td>Previously approved services, that are modified or denied, may be appealed by the member. When this occurs, the services are reinstated at the level previously approved, until the decision is received from the Administrative Law Judge.</td>
</tr>
<tr>
<td><strong>M</strong>&lt;br&gt;(Modified)</td>
<td>Units/dollars or dates of service are approved at a level less than requested.</td>
</tr>
<tr>
<td><strong>N</strong>&lt;br&gt;(No PA required)</td>
<td>The requested service is exempt from prior authorization requirements.</td>
</tr>
</tbody>
</table>
### TABLE III-10 (Continued)

#### DECISION STATUS CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>(No PA required when requested by a PMP) Many services do not need PA when the member is enrolled in a Managed Care Organization and the MCO Primary Medical Physician (PMP) authorizes the service.</td>
</tr>
<tr>
<td>P</td>
<td>(Pending, pays the same as denied) Requests needing written documentation supporting medical necessity will remain “pending” in the IndianaAIM system until such documentation is received and the need for service(s) is verified. For example, inpatient psychiatric services require the Certification of Need document (1261A) be completed and approved before the days can be changed to “approved” status.</td>
</tr>
<tr>
<td>Q</td>
<td>(Incorrect PMP) The provider number indicated on the request is not that of the member’s PMP.</td>
</tr>
<tr>
<td>R</td>
<td>(Rejected request) This requested PA was rejected due to being an exact duplicate submitted via the Web interChange.</td>
</tr>
<tr>
<td>S</td>
<td>(Dismiss/No hearing/Approved) A request for an Administrative Hearing has been filed. Additional review, or submission of additional documentation, confirms medical necessity. The request is approved and the hearing dismissed.</td>
</tr>
<tr>
<td>T</td>
<td>(Dismiss/No hearing/Modified) A request for an Administrative Hearing has been filed. Additional review, or submission of additional documentation, confirms medical necessity for a portion of the services or supplies requested. The appellant is agreeable to the modification. The request is modified and the hearing dismissed.</td>
</tr>
<tr>
<td>U</td>
<td>(Dismiss/No hearing/Denied) A request for an Administrative Hearing has been filed. Medical necessity for the services or supplies is not present or the request was denied because of an error on the part of the provider. For example, the Certification of Need was not submitted within the allowed time limit, causing the requested days to be denied. The appellant is in agreement with the error and will withdraw the appeal.</td>
</tr>
<tr>
<td>V</td>
<td>(Modified through court) Following the Administrative Hearing, the Administrative Law Judge awards the appellant a portion of the services or supplies previously denied. Both the provider and the member are provided with instructions regarding further appeals of this decision issued by the State.</td>
</tr>
</tbody>
</table>
TABLE III-10 (Continued)

DECISION STATUS CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>W</strong></td>
<td>(Decision upheld by ALJ) The Administrative Law Judge is in agreement with the previous modification or denial of services. No additional services or supplies are awarded. Both the provider and the member are provided with instructions regarding further appeals of this decision.</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>(Modified through Administrative Review) A request for Administrative Review has been filed. Additional review or documentation verifies a portion of the requested services or supplies is medically necessary. Both the provider and the member may request an Administrative Hearing, of this modification.</td>
</tr>
<tr>
<td><strong>Y</strong></td>
<td>(Approved through Administrative Review) A request for Administrative Review has been filed. Additional review or documentation verifies medical necessity and the services are approved as requested.</td>
</tr>
<tr>
<td><strong>Z</strong></td>
<td>(Automatic approval after 10 working days) In compliance with 405 IAC 5-3-14, any request for prior authorization that is not adjudicated within 10 (ten) business days of the receipt of all documentation specified in sections 5 and 9 (1) of 405 IAC 5-3, is granted within the coverage and limitations specified.</td>
</tr>
</tbody>
</table>

The decision approves only the number of days or units determined to be necessary to reach the initial goals and/or stabilize the patient. Prior to the end of the approved or pending days, the provider must submit another request if additional days and/or services are believed to be necessary.

Requests not containing adequate and/or necessary information are “suspended” and the provider is advised to resubmit the request with the information listed on the Prior Authorization Decision Form. A suspension is not a denial, and the provider does not need to “appeal” a suspension (405 IAC 5-7-1). The IndianaAIM system automatically denies suspended decisions after 30 days.

Timely adjudication of the request is the responsibility of the PA reviewer. If the reviewer encounters difficulties that will slow the processing of the request, the PA supervisor will be notified.
**Review Process**

1. For written requests, the reviewer removes the “oldest” folder from the shelf for the type(s) of service for which he or she is responsible. The reviewer will record in a log sheet the date, type of service, and PA number range for that folder. The reviewer will initial each entry on the log sheet. This creates a tracking system for paper PA requests in process.

2. Faxed requests are distributed to the reviewers. Faxed requests must be processed within 48 (forty-eight) hours (two business days).

3. PA requests received via 278 electronic transaction or Web interChange, will be processed from oldest date received. All requests received marked emergency, will be reviewed within 48 (forty-eight) hours (two business days).

4. Telephone calls are routed to the PA department by the Automated Call Distribution system. Callers are asked to choose between mental health (1), hospice/home health (2), other medical surgical/DME (3), “other” services (4) or hearings and appeals (8). Reviewers will be cross-trained in all areas, but will specialize in a specific area to facilitate review. Calls will be distributed to the first available reviewer within the queue, but may overflow into other queues to prevent callers from remaining on hold. (See Section III-I, Internal Grievance Procedure, for the handling of complaints.)

The reviewer answers the telephone on or before the fourth ring. (Refer to Exhibit III-1, for the sample Telephone Scripts for telephone reviews.) The information is entered into the IndianaAIM system as the review is conducted.

- Request the provider number or provider license number if the provider calling is not a Medicaid-enrolled provider.
- Inform the caller that the PA decision forms will be mailed to the Provider “A” address showing in IndianaAIM until the provider files are corrected. If corrections are needed, the provider will be directed to notify EDS Provider Enrollment in writing, by mail or fax, of the desired changes.
5. The reviewer enters the case into the Indiana AIM system in accordance with the following procedure.

a. Enter the identification number of the requesting or rendering provider (upper left corner of the PA request form) in the “Provider ID” box.

b. Enter the Recipient Identification (RID) number in the RID No. box.

c. Enter the PA number in the “PA Number” box. For written or faxed requests, use the PA number assigned by the support specialist. For phone requests, assign a PA number using the following procedure.

   ♦ Y = 6 (Year-2006)

   ♦ JJJ = Julian date (247\textsuperscript{th} day of 2006)

   ♦ M = Media type (1=Paper/written, 2=Phone, 3=Fax)

   ♦ 02 = Unique reviewer identification number

   ♦ 000 = Numeric sequence assigned to the individual reviewer(s)

   The result is PA number 6247202000.

d. Click on “PA Assignment” to produce the “pull down box” listing all the types of service. Click on the appropriate type.

e. Enter the primary diagnosis code into the “Diagnosis” box.

f. Click on “Enter” at the bottom of the window. This will automatically populate the remaining information on the window.
NOTE: For telephone reviews, click on “Applications” at the top of the PA screen, and pull up “Member” information. Verify the mailing address with the caller and advise that the decision letter will be mailed to the member address on file.

g. Click on “Applications” at the top of the PA screen.

♦ Click on “LOC” to verify the level of care. If the LOC screen is blank, there is no record of this member having been in a long-term care (LTC) facility during the period of IHCP eligibility; proceed with the review.

♦ If the LOC screen indicates the member is in a LTC facility, DO NOT approve services that are covered as a part of the per diem of a LTC facility.

h. Pull up the “Line item” and enter the first requested procedure code, the dates of service requested, and the requested number of units on the top line.

6. After reviewing the PA request and any attached documentation, make a determination regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria.

7. If approved, or modified due to procedural error, continue with this procedure. If unable to approve or modify, refer the case to the PA Supervisor for consultation with the PA Director as necessary, following the referral procedure.

a. Enter the approved dates of service, the approved units or dollars, and the decision on the bottom line of the “line item.” Repeat the same procedure for each line item requested.

b. Click on “Internal Text” and enter the following information:

♦ time of call, if applicable;
♦ agency or provider requesting the PA;
♦ age and gender of member;
♦ place of member residence (private residence, LTC, ICF/MR, group home, etc.); and
♦ service codes being requested. (If the member is living in a LTC facility, document whether the requested service is included as a part of the per diem.)

c. Click on “Applications” & “PA history” to determine if the requested service has previously been requested, and the decision for that request.

♦ If the previous request was denied, check the internal text of the other PA(s) to see why it was not approved.
♦ If this request is a duplicate of a service already approved, deny the request as a duplicate of services already approved.
♦ Was the service previously appealed? If so, what was the outcome? This information may provide insight regarding previous modifications or denials.

d. Return to the “Internal Text” screen and continue to enter all pertinent clinical information, including, but not limited to the following.

♦ What were the signs, symptoms, and precipitating factors?
♦ Tell about any progress or regression since the last request for PA, if member has been previously approved for the same service(s), (e.g., therapies or home health).
♦ Describe the availability of caregivers in the home, if request is for home health services.
♦ Describe the most recent authorization(s) of DME, and types of DME previously authorized, if request is for DME.
♦ What is the medical status of the member? Is the member capable of participating in the requested regime?
♦ Is the intensity of the requested service being reduced from the level of the last PA request? Explain why, and give the “suggested” reduction plan.

♦ Is the service to be denied? Explain why. Are similar services being provided by any other entity?

♦ Include the decision, including number of units, and clearly state the first and last days approved, or denied.

♦ Include the initials of the reviewer.

e. Pull up “New IAC/Text” and enter the following information that will print on the PA decision form mailed to the provider and the member.

♦ The appropriate IAC, if the request was not approved as requested. To find the IAC, click on the arrow beside the “IAC Codes” box, then on the appropriate code; the system will generate the verbiage of the code.

♦ A listing of any additional information needed to make the final decision if the request was suspended due to lack of information.

♦ An explanation of the reason(s) the request was modified or denied.

f. Proofread the external text and correct any errors. This text is sent to members and providers; it should be clear, concise, accurate, and free of any misspellings or typographical errors. Consult an appropriate dictionary and/or your supervisor for any questions.

g. Click on “batch print” to automatically generate copies for automated mailing to the provider and the member the following day.

h. Decision letters are mailed within 24 (twenty-four) hours to the member and the requesting provider. A notice of appeal rights is included with the decision letter.
i. Click on “save” and proceed to the next PA request.

NOTE: Units/days for inpatient hospitalizations are counted as follows. The day of admission is day one. No units are given for the day of discharge or the last day authorized. For example, a member is hospitalized on 1/1/06 and the hospital stay is approved until 1/5/06. Four days/units would be entered into the computer system for January 1, 2, 3 and 4. No days/units will be given for January 5.

Refer to Figures III-13 through III-25, for a detailed illustration of entry of Prior Authorization requests into the IndianaAIM system.
The system logon window is the first window that will be encountered when accessing the Indiana AIM Medicaid database.

1. Type in the User ID that was issued on the approved security forms.

2. Type in the Password that was issued on the approved security forms.

3. Type in a new password. This is the confidential password that will need to be changed in order to maintain security within the Indiana AIM system. The screen will prompt the user to enter the New Password a second time. This is a cross check to verify the users password. (This password must be kept confidential to ensure the integrity of the user and the Indiana AIM system.)

4. Click on “OK” with the mouse or press the enter key to advance to the next window.
The main menu is the initial window viewed upon entry into the IndianaAIM application. This window is used to gain access to the following windows:

- Adhoc Reporting
- Claims
- Financial
- Managed Care
- MARS
- Prior Authorization
- Provider
- Recipient
- Reference
- Security
- SURS
- Third Party Liability
- Phone Tracking/Project Tracking System

The main menu is the initial window viewed upon entry into the IndianaAIM application. This window is used to gain access to the following windows:

- Adhoc Reporting
- Claims
- Financial
- Managed Care
- MARS
- Prior Authorization
- Provider
- Recipient
- Reference
- Security
- SURS
- Third Party Liability
- Phone Tracking/Project Tracking System
The PA main menu window is used to gain entry to the entire PA database.

1. **PA History:** This window allows the user access to line item detail of all PA requests for a Member. Claims information related to the PA can also be accessed from this area.

2. **Prior Authorization:** The main area for entering requests and for viewing information related to a request once it has been entered.

3. **Table Maintenance:** This window will allow the user to access six areas used within Prior Authorization in order to facilitate data. These areas consist of the following: Assignment Code, Decision Status, IAC Manual, Media Type, Psychiatric Diagnosis, and Holiday Maintenance.

4. **Search for Requests:** The window allows the user to search for all PA requests including 278 electronic transactions and Web interChange. This screen allows the reviewer to search a PA by electronic, paper, and fax. The search can also be sorted by the assignment category.
The PA Table Maintenance Menu is viewed upon entry from the PA Main Menu. This window gains access to one of the following 10 (ten) PA table maintenance selection windows:

- Assignment Code
- Decision Status
- IAC Manual
- Media Type
- Psychiatric Diagnosis
- Holiday Maintenance
- Assignment Crosswalk
- Repeat Modifier
- Status Crosswalk
- Unspecified Procedure

FIGURE III-16

WINDOW: PA TABLE MAINTENANCE MENU
FIGURE III-17

WINDOW: PA ASSIGNMENT CODE SELECTION

The Table Maintenance Menu is used to store the valid assignment codes. These are the 24 (twenty-four) categories of service used in Prior Authorization.

<table>
<thead>
<tr>
<th>Assignment Code</th>
<th>Description</th>
<th>Assignment Group</th>
<th>PA Ind</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>HOMEHEALTH</td>
<td>01</td>
<td>Yes</td>
</tr>
<tr>
<td>02</td>
<td>HOSPITAL</td>
<td>02</td>
<td>Yes</td>
</tr>
<tr>
<td>03</td>
<td>OUTPATIENT</td>
<td>02</td>
<td>Yes</td>
</tr>
<tr>
<td>04</td>
<td>PHYSICIAN</td>
<td>03</td>
<td>Yes</td>
</tr>
<tr>
<td>05</td>
<td>REHAB</td>
<td>10</td>
<td>Yes</td>
</tr>
<tr>
<td>06</td>
<td>TRANSPLANT</td>
<td>10</td>
<td>Yes</td>
</tr>
<tr>
<td>07</td>
<td>TRANS</td>
<td>04</td>
<td>Yes</td>
</tr>
<tr>
<td>08</td>
<td>AUDIOLOGY</td>
<td>06</td>
<td>Yes</td>
</tr>
</tbody>
</table>

01 Home Health  HE Hospice
02 Hospital    LT LTC
03 Outpatient  UN Unknown
04 Physician
05 Rehab
06 Transplant
07 Transportation
08 Audiology
09 Speech
10 Mental HS
11 DME
12 Occupational Therapy (OT)
13 Physical Therapy (PT)
14 Respiratory Therapy (RT)
15 Dental
16 Optometric (OD)
17 Podiatry
18 Chiropractic
19 Pharmaceutical
20 1261A
21 TBI
The PA Table Maintenance Menu is used to store the PA media types. These types are used to identify the various ways to receive a PA request.

1. Paper
2. Telephone
3. Fax
4. Electronic (278 transaction or Web interChange)
5. PAS
6. PROB PA
7. PAS
8. MCO
9. Plan Care
The PA Non-Medicaid Provider window is used to enter a non provider for PA purposes.

The PA Non-Medicaid Provider Selection window is used to view a non-provider information for PA purposes.
FIGURE III-21

WINDOW: PA DECISION STATUS SELECTION

The PA Table Maintenance Menu is used to store PA decision codes. Valid values include:

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>APPROVED</td>
</tr>
<tr>
<td>B</td>
<td>NON-COV CODE APPROV</td>
</tr>
<tr>
<td>C</td>
<td>DEC OVERTURN BY ALJ</td>
</tr>
<tr>
<td>D</td>
<td>DENIED</td>
</tr>
<tr>
<td>E</td>
<td>EVALUATION</td>
</tr>
<tr>
<td>F</td>
<td>APPR/CONTIN OF SERV</td>
</tr>
<tr>
<td>G</td>
<td>MOD/CONTIN OF SERV</td>
</tr>
<tr>
<td>H</td>
<td>DEN/CONTIN OF SERV</td>
</tr>
<tr>
<td>I</td>
<td>NON-COV CODE DENIED</td>
</tr>
<tr>
<td>K</td>
<td>SUSPENDED</td>
</tr>
<tr>
<td>L</td>
<td>RESTORED WAITING ALJ</td>
</tr>
<tr>
<td>M</td>
<td>MODIFIED</td>
</tr>
<tr>
<td>N</td>
<td>NO PA REQUIRED</td>
</tr>
</tbody>
</table>

A      | Approved                                        |
B      | Non-covered code, PA authorized                 |
C      | Decision overturned by ALJ                      |
D      | Denied                                          |
E      | Evaluation                                      |
F      | Approved Continuation of Service                |
G      | Modified Continuation of Service                |
H      | Denied Continuation of Service                  |
I      | Non-Covered Code Denied                         |
K      | Suspended, Awaiting Additional Information (currently not in use) |
L      | PA restored to previous level waiting outcome of appeal |
M      | Modified                                        |
N      | No PA required                                  |
FIGURE III-21 (Continued)

WINDOW: PA DECISION STATUS SELECTION

O  No PA required when requested by a PMP
P  Pending pays the same as denied
Q  Incorrect PMP
R  Rejected, PA – due to exact duplicate submitted via the Web interChange.
S  Dismiss – No Hearing Approve
T  Dismiss – No Hearing Modified
U  Dismiss – No Hearing Denied
V  Modified through Court
W  Decision Upheld by ALJ
X  Modified Through Administrative Review
Y  Approved Through Administrative Review
Z  Automatic approval after 10 working days
The prior authorization window is used to view, add, or update a prior authorization request. Clicking on the “New” button retrieves a blank Prior Authorization Window to allow entry of a new PA.

1. **Provider ID:** The nine character numeric of the Requesting Provider (also referred to as the requesting provider).

2. **Service Provider ID:** The nine character numeric of the Provider of Service. (This number may or may not be included on the request. This number is referred to as the rendering provider.)

3. **RID No.:** The 12 (twelve) character numeric of the member.

4. **PA Number:** The 10 (ten) character PA number. This must be a unique number.

5. **PA Assignment:** The two digit number utilized to categorize the PA’s received. When an assignment code of 10 (ten) is entered, the psychiatric button at the bottom of the screen will be available to enter data into the 1261A drop down list box. This box is accessed by clicking on the Psychiatric button with your mouse or by pressing the Alt + P buttons on your keyboard.
FIGURE III-23

WINDOW: PA LINE ITEM SELECTION

The PA Line Item Selection window is used to view the detailed line items for per PA request. If further inquiry into a specific line item is desired, highlight the line item and click on the select button.
The PA Line Item window is used to enter, and work a PA request.

1. Line Item: The numeric character distinguishing each line item on a PA request.
2. Service Code: The correct five character HCPC, CPT, ADA or NDC code.
3. Modifier: Enter the alphanumeric characters as supplied by the requesting provider.
4. Taxonomy is optional for the provider.
5. Service Code Description (auto populates).
6. Status: The correct status selected from the drop down list box.
7. Second Opinion: Change from “No” to “Yes” if this is an IHCP-required second opinion request.
8. Action: Auto populates based on HIPAA-required language
9. Reject Reason: Select the appropriate code from the drop down list box
10. Requested Effective Date: The requested start date is CCYYMMDD format.
11. Requested End Date: The requested end date in CCYYMMDD format.
12. Requested Units: The number of requested units.
13. Requested Dollars: The number of requested dollars, if applicable.
14. Authorized Effective Date: The authorized start date in CCYYMMDD format.
15. Authorized End Date: The authorized end date in CCYYMMDD format.
16. Authorized Units: The number of authorized units.
17. Authorized Dollars: The number of authorized dollars, if applicable.
18. Quantity Used: These fields are populated from claims paid.

**FIGURE III-25**

**WINDOW: PA IAC CODE SELECTION**

The PA Table Maintenance Menu is used to store frequently used IAC references. Each code is listed along with the written narrative. By double clicking, the desired text can be brought into the external text, and will print on the PA decision form.
Review of Prior Authorization System Updates

A system update is any alteration of an existing prior authorization. The provider is responsible for submitting new requests for prior authorization for ongoing services before the current authorization period expires, in order to ensure that services are not interrupted (405 IAC 5-3-1).

♦ Requests for system updates may be received in writing, by telephone, via 278 electronic transaction, or the Web interChange from the requesting provider. Each request must contain information sufficient to support the requested change, and that information must be entered into the “Internal Text” screen as verification of the change. Providers must be instructed to clearly indicate the assigned PA number when submitting the requested documentation. This will alert the PA support specialist that the request need not be assigned a new number.

♦ System updates may include, but not be limited to, the following.

- Extension of dates, limited to no more than six months beyond the original ending date of the existing PA.
- Changed or incorrect procedure code(s), dates of service, decision code, or Recipient Identification (RID) number.
- Administrative Review or Administrative Hearing decisions.
- Change in the number of units based on a change in the condition or needs of the member.

Following are examples of possible system update scenarios.

- An IHCP member is receiving 10 (ten) hours of home health care five days a week while the primary caregiver works outside the home. The primary caregiver has emergency surgery and is unable to care for the member. The provider requests increased home health hours for four to six weeks until the primary caregiver can resume these responsibilities.
A member has round trip transportation approved weekly to see the physician for treatment of a tenuous medical condition. The condition worsens, and the physician needs to see him or her twice weekly for three weeks, or until the condition stabilizes. The provider requests three additional round trips added to the PA.

A member is approved for outpatient psychotherapy every two weeks. The patient’s condition worsens, and the therapist feels it is necessary to see him or her twice weekly for two weeks or until the crisis subsides. The provider requests six additional units of outpatient psychotherapy added to the PA.

1. The following procedures should be followed by the PA support specialists for processing the request.

   a. System update requests are date stamped, sorted by type of service, and placed in the front of the folder for the same assignment group.

   b. The PA number the system update is referencing is retrieved in IndianaAIM. Click on System Update and enter the date the system update was received.

   c. These are placed directly on the shelves and a decision regarding the update is made and entered by the PA reviewer. A click on “system update” will cause the generation of a new decision letter once the PA is updated.

2. The following procedures should be followed by the PA reviewers for processing the request. Home health requests require specific suspension rule policy and the processing of these types of requests are outlined in item three.

   a. Review the request for sufficient information to support the requested change.

   b. Determine the appropriate original PA (from the System Update Request Form) and select.

   c. Review the request following the PA review process and utilizing the appropriate criteria.

   d. Select “System Update” and enter appropriate date in “Update Reviewed.”
e. If unable to approve or modify (partially approve) due to a lack of medical necessity, the system update is referred to the PA Supervisory Staff and PA Director for review. If the request cannot be approved, refer the case to a physician consultant for review.

f. Select “Line Item” and make desired changes in codes, units, dates, or decision fields.

g. Select “External Text”, then “External Text Maintenance” and “New.” (A clean screen will appear.) Enter the information provided supporting the system update request. Repeat this procedure for “Internal Text.”

h. Proofread any text that will appear on the Decision Letter.

i. Be sure to select the “Batch Print” option before exiting the PA to ensure the system update decision will be batch printed and mailed to the requesting provider and the member.

3. The following procedures should be followed by the PA reviewer for processing home health requests.

a. Review the request for sufficient information to support the requested change.

b. Determine the appropriate original PA (from the System Update Request Form) and select.

c. Review the request following the PA review process and utilizing the appropriate criteria.

d. Select “System Update” and enter appropriate date in “Update Reviewed.”

♦ If unable to approve or modify a home health request based on lack of documentation received through a system update within the 30 (thirty) day suspension limit, suspend for an additional 30 (thirty) days to allow for the documentation to arrive.

♦ The external text must include a detailed description of the required documentation necessary to make the decision.
e. If unable to approve or modify (partially approve) due to a lack of medical necessity, the system update is referred to the PA Supervisory Staff and PA Director for review. If the request cannot be approved, refer the case to a physician consultant for review.

f. Select “Line Item” and make desired changes in codes, units, dates, or decision fields.

g. Select “External Text”, then “External Text Maintenance” and “New.” (A clean screen will appear.) Enter the information provided supporting the system update request. Repeat this procedure for “Internal Text.”

h. Proofread any text that will appear on the Decision Letter.

i. Be sure to select the “Batch Print” option before exiting the PA to ensure the system update decision will be batch printed and mailed to the requesting provider and the member.

Any reduction or denial of ongoing services by the PA reviewer requires that the member receive notification of the reduction or denial at least 30 (thirty) calendar days from the date of the decision.

If the member has not been given proper notice of the proposed reduction, and files an appeal within 10 (ten) days of the mailing of the notice, services must be restored to their previous level, pending the results of the appeal. Refer to the Section IV concerning Hearings and Appeals. Notice is not required if the request is a first request for those services, or the previous PA expired prior to the receipt of the current prior authorization request.

Refer to Table III-12, for the step-by-step procedure for Modification of an Approved Prior Authorization (System Update) and Exhibit VI-15, for a copy of the Prior Authorization System Update Request Form.
FIGURE III-1
PRIOR AUTHORIZATION REVIEW PROCESS
HOME HEALTH PA FOR SUSPENSIONS

PA home health request is received

Sufficient information?  

Yes

Reviewer evaluates case (utilizing criteria) while entering into Indiana M

Meets Criteria

No

Request denied

Yes

Approve request

Mail Decision Letter

 Documentation received after 30 days, and not within the PA dates of service

System auto-denies

Request denied

Mail Decision Letter

 Documentation requested received after 30 days, but within the PA dates of service

Request approved

Request approved with modified dates based on documentation received date

Mail Decision Letter

 Documentation requested received within 30 days

Request denied based on criteria

Mail Decision Letter

 Documentation received within 30 days is incomplete

Reviewer suspends PA for 30 days to allow time for documentation to arrive

PA suspended for 30 days to allow time for documentation to arrive
### TABLE III-11

**PROCEDURE/PROCESS: MODIFICATION OF AN APPROVED PRIOR AUTHORIZATION (SYSTEM UPDATE)**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Request to modify an approved authorization can be received in writing, by telephone, via 278 electronic transaction, or Web interChange, from the requesting provider.</td>
<td>Provider</td>
</tr>
<tr>
<td>2.</td>
<td>Requests that are received by mail are date stamped and sorted by type of service.</td>
<td>PA Support Specialist</td>
</tr>
<tr>
<td>3.</td>
<td>Requests are placed in the front of the same assignment group folders.</td>
<td>PA Support Specialist</td>
</tr>
<tr>
<td>4.</td>
<td>The PA number the system update is referencing is retrieved in IndianaAIM. Click on “System Update” and enter the date the request was received.</td>
<td>PA Support Specialist</td>
</tr>
<tr>
<td>5.</td>
<td>The folders are placed on the appropriate shelf in the reviewer staging area to be retrieved for review.</td>
<td>PA Support Specialist</td>
</tr>
<tr>
<td>6.</td>
<td>Determine the appropriate original PA from the System Update Request Form and select the request to be modified.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>7.</td>
<td>Review the request for sufficient information to support the requested change.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>8.</td>
<td>Review the request following the PA review process and utilizing the appropriate criteria.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>9.</td>
<td>Select “System Update” and enter appropriate date in the “Update Reviewed” field.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>10.</td>
<td>If unable to approve or modify the request based on medical necessity, refer the case to a PA supervisor for a denial review through the appropriate chain of command.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>11.</td>
<td>If able to approve or modify the request, select the appropriate line item and make the desired changes in codes, units, dates, or decision fields.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>12.</td>
<td>Select “External Text”, then “External Text Maintenance” and “New.” (A clean screen will appear.) Enter the information provided supporting the system update request. Repeat this procedure for “Internal Text.”</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>13.</td>
<td>Select “Batch Print” to generate a new decision letter to the provider and member.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>14.</td>
<td>Any reduction or denial of ongoing services requires the member receive notification of the reduction or denial at least 10 business days prior to the implementation of the denial or modification. Therefore the mailing of the decision must occur 13 days prior to the proposed reduction.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>15.</td>
<td>Return the written System Update Request Forms to the top shelf of the metal file cart in the center aisle of the PA department for inventory and filing.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>16.</td>
<td>Services must be restored to their original level pending the results of an appeal, if the member is not given proper notice of the proposed reduction.</td>
<td>PA Hearings and Appeal Specialist</td>
</tr>
</tbody>
</table>
I. Internal Grievance Procedure

Definition

When the requesting provider/agency believes the reviewer rendering the prior authorization decision has made an error AND the member will suffer harm if time lapses in order to follow the Administrative Review/Appeals process, he or she may utilize the internal grievance process. When providers call with individual problems, they will be informed of this internal grievance process and the procedure will be explained at that time.

The internal grievance process is available on a very limited basis whether the request was submitted in writing, by telephone or faxed. The following sequence must be followed for reconsideration of a prior authorization request.

Procedures

1. The requesting provider/agency must contact the reviewer who originally reviewed the request and provide any additional information omitted during the initial review. A provider choosing to initiate the internal grievance procedure can request their call be transferred to this reviewer. If it is agreed that the additional information warrants a change of the original decision, a system update may be completed.

   If the reviewer does not believe the additional information is sufficient to change the decision nor does the member’s health and safety seem in jeopardy nor does the situation appear to necessitate immediate review, the provider will be requested to submit a written request for Administrative Review. The prior authorization decision remains unchanged (The reviewer may wish to review the case with the PA supervisor.)

2. If the requesting provider/agency still believes the decision may jeopardize the health and safety of the member, he or she may request to speak with the reviewer’s supervisor. Upon hearing the facts of the case, the supervisor must determine if the situation warrants immediate review or a change of the prior authorization decision (The supervisor may wish to review the case with the PA director.)

   If the supervisor does not believe the additional information is sufficient to change the decision, nor does the member’s health and safety seem in jeopardy or the situation appear to necessitate immediate review, the provider is requested to submit a request for
Administrative Review. The prior authorization decision remains unchanged.

3. If the requesting provider/agency is still dissatisfied, he or she may request to speak with the Prior Authorization Manager. The manager renders the final decision. All the available information, including laws, rules, criteria and other resources utilized to make determinations, will be considered. Clinical validation will be sought as needed from other medical professionals within or outside the prior authorization department. Interpretation of the IAC or a final decision may be requested from the appropriate person(s) in the Office of Medicaid Policy and Planning.

Ample opportunity has been afforded, to this point, to safeguard possible errors that may jeopardize the well-being of the member.

At NO time will this process be circumvented by any party. Consistency creates protection from liability and the assurance that all applicable rules and criteria are followed accurately.
J. Referral to Consultants

Requests for services or supplies which PA reviewers are unable to approve or modify because they are not within the established guidelines by the IAC, established criteria, IHCP bulletins, or other directives of the Office of Medicaid Policy and Planning, will be referred by the PA reviewer to the PA supervisory staff.

The PA supervisory staff will evaluate the case to ensure that all available documentation and criteria have been assessed. If the request cannot be approved or modified, it will be referred to the Medical Director or a consultant by the PA manager for further review according to the following procedure.

1. The PA reviewer will determine the appropriate medical specialist such as neurologist, psychiatrist, dentist, etc.
   a. Cases, in which the reason for denial is noncompliance with the IAC or other rules, will not be referred to a physician consultant. The PA supervisory staff will address these cases. Only denials related to medical necessity may be referred to a consultant.
   b. Peer reviewers will be used to render a medical judgment on the partial or full denial of services or payment. For instance, a physical therapist may be consulted in a case in which physical therapy services are requested; or, a plastic surgeon may be consulted in cases in which plastic or reconstructive surgery is requested. If a consultant is not available, the PA manager will refer the case to the Medical Director for assistance in securing the services of a peer reviewer.

2. The support specialist will contact the selected consultant to ensure availability and willingness to evaluate the case.

3. If the supply or service is elective in nature, the PA support specialist will mail the case documentation to the consultant. The consultant must complete and return the decision within 10 (ten) days from the original request received date. If the supply or service is considered to be an emergency, the case will be described, in detail, via telephone conference with the consultant, or the Medical Director will be consulted, if necessary, to expedite the process.
4. The consultant will make the decision regarding medical necessity based upon current standards of practice and professional judgment, rather than upon the criteria guidelines, which are utilized by the PA reviewers and PA specialists. (Refer to Exhibit III-2, Medical Rationale and Exhibit III-3, Consultants Avoiding Common Review Errors.) However, these professionals are still constrained by State of Indiana rules and regulations regarding coverage issues.

5. The consultant will record the decision, citing rationale, and return all case documentation to the HCE office if the process is completed by mail. If the process is performed by telephone, the PA specialists or PA supervisor will document the rationale cited by the consultant.

6. The support specialist will be responsible for tracking individual requests forwarded to a consultant. The request timelines are monitored by a tickler system that will prompt the support specialist to contact the consultant for a decision status. Requests forwarded to a consultant must be returned with a decision that will allow notification to the provider and member within a ten day timeframe. For example, if a request is forwarded to a consultant on day three and has not been returned to the support specialist by day seven, the support specialist will contact that consultant. If it is determined that the consultant will be unable to render a decision by day 10 (ten), a second consultant will be contacted to review the request. The request will be retickled for compliance with the 10 (ten) day timeframe. A consultant decision may be received by telephone or fax if unable to mail the decision within the 10 (ten) day timeframe.

7. If the original denial decision has been changed by the consultant, the PA supervisor will enter the new decision into IndianaAIM which will generate a new decision letter which will be mailed by EDS. If the original denial decision is upheld by the consultant, the signed returned denial letter will be mailed individually by HCE to the provider and member within 24 (twenty-four) hours.
K. Review of Psychiatric Admissions with the 1261A-Certification of Need

Medicaid reimbursement is available for inpatient psychiatric services only when the member’s need for admission has been authorized. According to the Indiana Administrative Code, the Certification of Need must be completed as follows (405 IAC 5-20-5).

♦ By the attending physician or staff physician for an IHCP member between 22 and 65 years-of-age in a psychiatric hospital of 16 (sixteen) beds or less, and for an IHCP member 65 years-of-age and over.

♦ In accordance with 42 CFR 441.152(a) and 42 CFR 441.153 for an individual 21 years-of-age and under.

♦ By telephone, fax, 278 electronic transaction precertification, or Web interChange, prior to admission for an individual who is a member of IHCP when admitted to the facility as a non-emergency admission, to be followed by a written Certification of Need within 10 (ten) business days of admission.

♦ By telephone, fax, 278 electronic transaction precertification, or Web interChange, within 48 (forty-eight) hours of emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written Certification of Need within 14 (fourteen) business days of admission. If the provider fails to call within 48 (forty-eight) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, IHCP reimbursement will be denied for the period from admission to the actual date of notification.

♦ In writing, 278 electronic transaction, or Web interChange, within 10 (ten) business days after receiving notification of an eligibility determination for an individual applying for IHCP while in the facility and covering the entire period for which IHCP reimbursement is being sought.

♦ In writing, 278 electronic transaction or Web interChange, at least every 60 (sixty) days after admission, or as requested by the OMPP or its designee, to recertify that the patient continues to require inpatient psychiatric hospital services.
IHCP reimbursement will be denied for any days during which the inpatient psychiatric hospitalization is found not to have been medically necessary. Telephone prior authorizations of medical necessity will provide a basis for IHCP reimbursement only if adequately supported by the written Certification of Need submitted in accordance with 405 IAC 5-20-5. If the required written documentation is not submitted within the specified time frame, IHCP reimbursement will be denied (405 IAC 5-20-7).

The Certification of Need (1261A) is a four page form in triplicate that must be submitted by the provider within 10 (ten) days for non-emergency admissions, and within 14 (fourteen) days following emergency admissions for psychiatric or substance abuse treatment.

All 1261As are to be reviewed for timeliness and medical necessity, entered into IndianaAIM, and returned to the provider within 10 (ten) working days of receipt.

**Review Process**

- 1261As are received by the PA support specialist from the mail room staff.
- Because of the strict time limit mandated in the Indiana Administrative Code, it is imperative for each 1261A to be clearly stamped with the date the form is received by HCE.
- If the stamped date is beyond the acceptable time limit, all of the days of that hospitalization will be denied. Therefore, it is very important to be able to determine the exact date the forms were received.
- After the forms are date stamped, they are placed in a designated area in date received order.
- The PA reviewers will retrieve the 1261As and review each document for timely submission and for medical necessity utilizing the appropriate criteria.
- All 1261As received with retroactive requests for review must be kept with the retroactive request and attachments. By doing this, the reviewer can process not only the request, but also the 1261A simultaneously.
After the review process is completed, the top copy (white copy) of the 1261A must be detached from each of its pages, stapled together, and returned to the provider for attachment to the medical record. If the provider submitted a single page form, the 1261A must be copied and the signed original returned to the provider. The copy is maintained in HCE records. The provider must keep this document as a part of the medical record for post payment review. The PA support specialist will complete this function.

The following is a step-by-step procedure for processing the 1261A.

1. Pull up the previously assigned PA.

2. Determine if the 1261A was submitted timely.
   - Add 14 (fourteen) business days from the date of admission for emergency admissions.
   - Add 10 (ten) business days to the date of admission for non-emergency admissions.

   If the submission is untimely it must be denied.

3. If the PA number on the 1261A is incorrect, pull up PA history by using the Recipient Identification (RID) number. Locate the correct PA, by dates of service, and pull it up. If both the PA and the RID numbers are incorrect, return the 1261A to the provider for correction. If the request is returned from the provider after an additional 14 (fourteen) business days (from the date returned to the provider), the request will be determined “untimely” and the “pending” days will be “denied.” It is the responsibility of the provider to submit correctly completed documentation in a timely manner.

4. Review the information contained in the 1261A.
   - Does the documentation support the need for an emergency admission?
   - Does the plan of treatment seem appropriate for this type of case?
   - Is the discharge plan realistic for this member?
   - Has the physician signed the last page?
5. Is the date of the physician’s signature fewer than 14 (fourteen) days from the date of admission? If the signed date indicates the document was signed within the 14 (fourteen) business day time limit, review for medical necessity of the admission. If the document was signed after 14 (fourteen) business days, the request for approval of the days must be denied.

6. Based on the 1261A and the faxed or telephoned request for PA, the reviewer will make a decision to approve or modify (partially approve) or refer to a higher level of review.

7. Pull up the line item.
   - If approved or modified (partially approved), change the “pending” days to “approved”.
   - If referred, leave the decision as “pending” until a decision has been made to approve, modify, or deny. Refer the case to a PA supervisor or the PA Director.

8. After the decision has been made, change the “pending” days to the correct code.

9. Click on the “Psychiatric” box on the left of the PA screen.
   - Enter the date the 1261A was received.
   - Enter the date the 1261A was reviewed and entered into the system.

10. Use the pull-down box to find and select the most appropriate diagnosis.

11. If the information supports the denial of the request, use both the internal and external text options to document the rationale for the denial.

12. Proofread the external text. This text is sent to members and providers; it should be clear, concise, accurate, and free of any misspellings or typographical errors.

13. Click on “batch print” to generate copies for automated mailing to the provider and the member the following day.

Refer to Table III-13, for the step-by-step procedure for Modification of a Pending Prior Authorization, Figure III-16, (PA Psychiatric Diagnosis Selection Window), Figure III-17, (PA Psychiatric 1261A Window), and Exhibit VI-6, (OMPP Form 1261A) for detailed explanation of review of 1261As.
### TABLE III-12

**PROCEDURE/PROCESS: MODIFICATION OF A PENDING PRIOR AUTHORIZATION**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Provider submits for a phone request, which meets the criteria for a phone PA pending a decision based on paper documentation received via mail.</td>
<td>Provider, PA Reviewer</td>
</tr>
<tr>
<td>2.</td>
<td>The Certificate of Need (1261A) is received via mail and stamped with the date received at HCE.</td>
<td>PA Support Specialist</td>
</tr>
<tr>
<td>3.</td>
<td>The forms are placed on the shelves for review.</td>
<td>PA Support Specialist</td>
</tr>
<tr>
<td>4.</td>
<td>Retrieve the PA history in IndianaAIM by using either the RID number, member name, or the PA number. If member cannot be identified, the 1261A is returned to the provider and must be received back within 14 (fourteen) business days of the return date or the pended approval will be denied.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>5.</td>
<td>The previously assigned PA is pulled up in IndianaAIM and a determination will be made if the 1261A is submitted timely. If the submission is untimely, the request will be denied.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>6.</td>
<td>Verify the admission dates on the PA and the 1261A agree. If they do not, the PA may not have been requested until after the 48 (forty-eight) hour time limit during which authorization may be requested for an emergency admission.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>7.</td>
<td>Review the information contained in the 1261A for medical necessity.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>8.</td>
<td>Review the stamped received date and the date of admission. If the date span is greater than 14 (fourteen) business days, the request for approval of the days must be denied.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>9.</td>
<td>If the 1261A was received within the 14 (fourteen) business day time limit, review for medical necessity of the admission.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>10.</td>
<td>Based on the PA and the 1261A, make a decision to modify the case.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>11.</td>
<td>Retrieve the line item in IndianaAIM and change the pending days to approved.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>12.</td>
<td>Click on the “Psychiatric” box on the left of the PA screen and enter the date the 1261A was received, reviewed, and entered into the system.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>13.</td>
<td>Enter the most appropriate diagnosis in the diagnosis field.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>14.</td>
<td>Use both the internal and external text options to document the rationale for the modification to the original pending request.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>15.</td>
<td>Initiate “batch print” to automatically generate a decision letter to the provider and member.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>16.</td>
<td>After the review process is complete, the 1261A is broken down, or copied, and the original is returned to the provider for attachment to the medical record. <strong>The support specialist MUST use extreme caution in the return of the 1261A. Due to the highly confidential nature of the information documented on the 1261A, the support specialist will check the address on the 1261A and compare to the address on the envelope at least twice. Also, to ensure the 1261A is returned to the correct person at the facility it shall be addressed directly to the representative who submitted the 1261A or to the attention of the Director of Utilization Review.</strong></td>
<td>PA Support Specialist</td>
</tr>
</tbody>
</table>
FIGURE III-27

WINDOW: PA PSYCHIATRIC DIAGNOSIS SELECTION

The PA Table Maintenance Menu is used to store psychiatric diagnosis. These are used for reporting purposes for the Psychiatric reports. Valid values include the following.

00  Major Depression/Depression NOS
01  Dysthymia
02  Post Traumatic Stress Disorder
03  Alcohol/Poly Substance Abuse/Dependency
04  Attention Deficit Hyperactivity Disorder
05  Schizophrenia
06  Bipolar Disorder
07  Oppositional-Defiant Disorder/Conduct Disorder
08  Adjustment Disorder
09  Other
10  Conversion/No Date
Psych Diagnosis: The drop down list box that includes the valid values used for Psych reports. Select the appropriate value and then tab to the next field.

Emergency: The indicator with valid values of ‘E’ or ‘N’ used to indicate if this admission to a Psychiatric facility is an emergency or a non-emergency.

Received Date: The date in CCYYMMDD format that the PA staff received the 1261A form from the Provider.

Return Date: The date in CCYYMMDD format that the PA staff returned the 1261A form to the Provider.
L. Review of Hospice Services

Hospice is defined as a system of family-centered care designed to assist the terminally ill person to be comfortable and to maintain a satisfactory life-style through the phases of dying. Hospice care is multidisciplinary and includes the availability of professional health care on call, home visits, teaching and emotional support of the family, and physical care of the member. Hospice services include palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program member during the final stages of the member’s terminal illness. In addition, hospice services include care for the psychological, social, spiritual, and other needs of the hospice program patient’s family before and after the patient’s death.

The Indiana Administrative Code defines hospice as a person or health care provider who owns or operates a hospice program or facility, or both, that uses an interdisciplinary team directed by a licensed physician to provide a program of planned and continuous care for hospice program patients and their families. The hospice program is a specialized form of interdisciplinary health care that is designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease.

Hospice services became covered under the Indiana Health Coverage Programs on July 1, 1997. IHCP hospice rules can be found at 405 IAC 1-16, 405 IAC 5-2, and 405 IAC 5-34.

IHCP reimbursement is available for hospice services. Providers must meet certain conditions in order to receive reimbursement as hospice providers under the IHCP.

♦ A provider must submit a separate provider enrollment agreement (even if the provider currently participates in the IHCP as a provider of another service).

♦ A hospice provider must be certified as a hospice provider in the Medicare program.

♦ A hospice provider must be licensed by the Indiana State Department of Health.

♦ The provider must comply with all State and Federal requirements for IHCP providers.
The hospice provider must designate an interdisciplinary group composed of individuals who are employees of the hospice and who provide or supervise care and services offered by the hospice provider. At a minimum, this group must include all of the following persons:

- a medical director, who must be a doctor of medicine or osteopathy;
- a registered nurse;
- a social worker; and
- a pastoral or other counselor.

The interdisciplinary group is responsible for the following:

- participation in the establishment of the plan of care;
- provision or supervision of hospice care and services;
- review and updating of the plan of care; and
- establishment of policies governing the day-to-day provision of care and services.

IHCP reimbursement for hospice services is made at one of four all-inclusive per diem rates for each day in which an IHCP member is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories.

Routine home care is when the member is at home, a private home or a nursing facility (NF), under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The hospice provider receives the hospice per diem pay only if the member is in a private home. If the patient is in a nursing facility, the hospice provider receives the hospice per diem plus 95% of the lowest nursing facility room and board per diem (the hospice provider pays the nursing facility).

Effective October 1, 1998, reimbursement for the nursing facility room and board services shall be 95% of the single nursing facility case mix rate.
Continuous home care in a private home or nursing facility is provided only during a period of crisis (a period in which a member requires continuous care, that is primarily nursing care, to achieve palliation and management of acute medical symptoms). Either a registered nurse or a licensed practical nurse must provide this care, and a nurse must provide care for over half the total period of care. A minimum of eight hours of care must be provided during a 24 (twenty-four) hour day that begins and ends at midnight. This care need not be continuous and uninterrupted. In a private home, the hospice provider receives the hospice per diem only. Effective October 1, 1998, reimbursement for NF room and board services shall be 95% of the single NF case mix rate.

Inpatient respite care is paid for each day that the member is in an approved inpatient facility and is receiving respite care. Respite care is short-term inpatient care provided to the member only when necessary to relieve the family members or primary caregivers. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five consecutive days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

The general inpatient hospice rate is paid for each day the member is in an approved inpatient hospice facility and is receiving services related to the terminal illness. The member must require general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings. Documentation in the member’s record must clearly explain the reason for admission and the member’s condition during the stay in the facility at this level of care. Services provided in the inpatient setting must conform to the hospice patient’s plan of care. No other fixed payment rate (i.e., routine home care) will be made for a day on which the member receives general hospice inpatient care.

The hospice provider is the professional manager of the member’s care regardless of the physical setting or the level of care. If the inpatient facility is not also the hospice provider, then the hospice provider must have a contract with the inpatient facility delineating the roles of each provider in the plan of care.
The usual home of the hospice member determines the location of care for that member. The private home location of care applies if the member usually lives in his or her private home. Nursing facility location of care applies if the member usually lives in a nursing facility. Members in freestanding hospice facilities are considered to be living “at home,” unless the freestanding facility is authorized as a nursing facility.

1. Authorization of Hospice Services

Hospice services require hospice authorization. Hospice authorization is also required for any IHCP-covered service not related to the hospice member’s terminal condition if hospice authorization is otherwise required. Hospice Authorization is not required for the following services when provided to hospice members.

- Pharmacy services for conditions not related to the member’s terminal condition. Pharmacy services related to the member’s terminal condition also do not require hospice authorization because they are included in the hospice per diem.

- Dental services do not require hospice authorization.

- Vision care services do not require hospice authorization for hospice members.

In order to obtain authorization for hospice services, the provider must submit all of the following with an Indiana Prior Review Authorization Request.

a. There must be a member election statement.

In order to receive hospice services, a member or their representative must elect hospice services by filing an election statement with the hospice provider.

Election of the hospice benefit requires the member to waive IHCP coverage for the following services:

- other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness;
♦ services provided by another provider which are equivalent to the care provided by the elected hospice provider; and

♦ hospice services other than those provided by the elected hospice provider or its contractors.

The effective date for the election must begin with the first day of hospice care or any other subsequent day of hospice care. The hospice election form must be signed on the first day of care or signed on a date prior to the date in the future the member or his POA designate as the first day of hospice care.

The provider must request Revenue Code 651 as the requested service code, and will bill with the appropriate revenue code reflecting the actual hospice service rendered.

The election form must be submitted to HCE, Prior Authorization department, when hospice services are initiated. It is not necessary to submit the election form for the second and subsequent benefit periods unless the member has revoked the election and wishes to re-elect hospice care.

In the event that a member, or the member’s representative, wishes to revoke the election of hospice services, the following apply.

♦ The member must file a hospice revocation statement on a form approved by the State. The form includes a signed statement that the member revokes the election of IHCP hospice services for the remaining days in the benefit period.

♦ A member may elect to receive hospice care intermittently rather than consecutively over the benefit periods. The benefit approval period begins with an initial approval of 90 (ninety) days, a second approval period of 90 (ninety) days and then unlimited 60 (sixty) day periods will restart where they were stopped, should the member choose intermittent services.
If a member revokes hospice services during any benefit period, time remaining on that benefit period is forfeited. The IHCP hospice benefit mirrors the Medicare Hospice Program. If the member re-elects the IHCP benefit, then the member is re-enrolled into the subsequent hospice benefit period. For example, if a member revokes the first hospice benefit period, and then chooses to re-elect hospice care, the member would be enrolled into the second hospice benefit period. If a hospice provider discharges a hospice member and then re-enrolls the member, the re-enrollment begins with the next hospice benefit period.

A member, or the member’s representative, may change hospice providers once during any benefit period. This change does not constitute a revocation of services.

b. The provider must submit the physician certification form.

In order for a member to receive IHCP covered hospice services, a physician must certify that the member’s prognosis is for a life expectancy of six months or less if the terminal illness runs its course (the member is terminally ill and expected to die from that illness within six months).

The Medicaid Physician Certification form must be signed by the Medical Director of the hospice program and the attending physician for the first hospice benefit period. For subsequent benefit periods, if the Medical Director signs the Medicaid Physician Certification form, then the signature of the attending physician is not required. If the Medical Director cannot sign the Medicaid Physician Certification form, then the signature of the physician member of the interdisciplinary team and the signature of the member’s attending physician are required (except in cases where the member has no attending physician).
♦ The Medicaid Physician Certification form must be signed and dated.

♦ The Medicaid Physician Certification form must identify the diagnosis that prompted the member to elect hospice services and must include a statement that the prognosis is six months or less.

♦ The statement must support a terminal rather than chronic condition.

♦ The Medicaid Physician Certification form must be submitted within certain timeframes. For the first election period the Medicaid Physician Certification form must be submitted within 10 (ten) business days of the effective date of the member’s election. For the second and subsequent periods the Medicaid Physician Certification forms, including updated care plans, etc., must be submitted within 10 (ten) business days of the beginning of the benefit period.

c. The provider must submit a plan of care. The Medicaid Hospice Plan of Care form must be submitted with the Medicaid Physician Certification form and the Medicaid Hospice Election form for the first hospice benefit period. Subsequent benefit periods require the POC be submitted with the physician certification. In developing the plan of care, the provider must comply with the following procedures.

♦ One of the conferees must be a physician or a nurse, and all other team members must review the plan of care.

♦ All services stipulated within the plan of care must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

♦ Frequency and scope must be documented within the plan of care.

Hospice eligibility is available in the following benefit periods:
♦ one period of 90 (ninety) days;
♦ a second period of 90 (ninety) days; and
♦ an unlimited number of periods of 60 (sixty) days.
Approval must be granted separately for each benefit period. If benefit periods beyond the first 90 (ninety) days are necessary, then re-certification on the Medicaid Physician Certification form and an updated Medicaid Hospice Plan of Care form are required for hospice authorization of the second and subsequent benefit periods.

When approval for a benefit period has been granted, a hospice provider may manage a patient’s care at the four levels of care, according to the medical needs determined by the interdisciplinary team and the requirements of the patient and the patient’s family or primary caregivers. Changes in levels of care do not require hospice authorization as long as these levels are rendered within a prior approved hospice benefit period.

A member, or representative of the member, who is not satisfied with his or her hospice provider may change hospice providers during any benefit period. This change does not constitute a revocation of service. To change a designated hospice provider, the member, or the member’s representative, must file a Hospice Provider Change Request between Indiana Hospice Providers form. The hospice provider may fax this form to the HCE Prior Authorization unit so long as all hospice benefit period(s) preceding the date of the hospice revocations have been previously authorized.

If the hospice analyst discovers that there is a hospice authorization for the same dates of service in IndianaAIM which have been authorized for another hospice provider, the hospice analyst may not process the hospice authorization submitted by the new hospice provider until this discrepancy is resolved. The hospice analyst will resolve this issue as follows:

♦ For purposes of this explanation, the original hospice provider refers to the provider that first provided hospice services to the IHCP hospice member under the IHCP hospice benefit but who never formally notified the Prior Authorization Unit of any discharge/transfer to another provider. The new hospice member refers to the provider that recently assumed the management of the IHCP member’s hospice care.
The new hospice provider that submits the hospice authorization must coordinate with the original hospice provider that maintains the hospice authorization for dates of service that duplicates the new hospice provider’s dates of service.

Once the new hospice provider obtains the Hospice Provider Change Request between Indiana Hospice Providers form, the new hospice provider must resubmit the Hospice Provider Change Request between Indiana Hospice Providers form with the election packet. The hospice analyst will enter the day of the change in provider as the first day of that hospice benefit period.

FSSA DA Hospice Policy Analyst may direct PA contractor to update screens based on clarifications obtained while working with hospice providers and contracted nursing facilities in unique circumstances, such as when a discharge/transfer has a gap in service dates.

2. Procedure for processing of initial hospice requests.
   
a. The mailroom will forward the hospice requests to the Prior Authorization department.

b. The PA support specialist(s) will sort the hospice requests, date stamp and place the forms in a hospice assignment group folder.

c. The hospice requests will be forwarded to the hospice analyst.

d. The hospice analyst will evaluate the request to ensure that all forms are present, including the Medicaid Physician Certification form, member Medicaid Hospice Election form, and Medicaid Hospice Plan of Care form. If all forms have not been included, or are incomplete, the request will be suspended. The specialist will note the date the request was received by Health Care Excel and will modify as necessary for untimeliness. For each day the request is beyond the 10 (ten) business day filing limit, the start date will be modified one calendar day.
e. If the member is dually eligible, the hospice analyst will accept the Medicaid hospice authorization notice for dually-eligible Medicare/Medicaid nursing facility residents. The hospice analyst will validate member and provider information and follow Medicaid Hospice enrollment procedures. Dually eligible Medicare/IHCP members must elect, revoke, or change providers under both the Medicare and the IHCP programs at the same time. The hospice provider must notify both programs of any changes in the dually eligible Medicare/IHCP member’s hospice care status.

f. The hospice analyst will evaluate each form for completeness. The hospice analyst will suspend the request if it is not complete. The analyst will communicate with the provider via the Prior Authorization decision letter what paperwork is needed.

g. The hospice analyst will evaluate the member Medicaid Hospice Election form to see if the hospice provider exists in the system as a hospice provider (type/specialty = 06/060).

h. The hospice analyst will verify that the member exists in the system. If the RID is not valid, look for the member by SSN or name to find the valid RID. If unable to determine a valid RID, the packet is returned to the provider with instructions to supply the correct RID number.

i. The hospice analyst will verify that the member’s or member’s representative’s signature is present on the Medicaid Hospice Election form. If it is missing, the provider must resubmit the form with the signature included.

j. The hospice analyst will retroactively extend the member’s hospice eligibility 10 (ten) business days or to the effective date on the election form. The hospice eligibility date may only be extended past 10 (ten) business days if the member’s eligibility has been retro-authorized by the Division of Family and Children. (This retro-eligibility will be identified in the member database in IndianaAIM.)

k. If a nursing facility has been listed on the form, the hospice analyst will check to see if the correct nursing facility appears in the Level of Care (LOC) window. If the nursing home LOC segments are not present or are different from what was entered on the form, the hospice analyst will suspend the request and ask the provider to submit a system
update request when the nursing facility has an approved 450B form for the dates of service in question.

l. If any of the forms require corrections, the hospice analyst will suspend the request and require the hospice provider to make corrections. The provider will have 30 (thirty) days to send the correct information to HCE for processing.

m. For requests that do not require corrections, the hospice analyst will add the hospice LOC information for the member using the Member LOC window. If the member already has hospice LOC information loaded, and the stop reason for the last benefit period indicates the member revoked, or was discharged, then this is considered a “re-enrollment.” For these cases, the hospice analyst will check which benefit period was activated previously, compare it to the new Medicaid Physician Certification form, determine the new LOC segment information, and enter it in the LOC window.

n. Enter the hospice analyst ID (this item must be alpha numeric).

o. Enter the hospice provider ID that appears on the Medicaid Hospice Election form. Enter the period that the hospice member is entering in the LOC field (51H, 52H, and 53H).

p. Enter the reason for starting a hospice period in the start reason field.
   ♦ 51H First 90 (ninety) day benefit
   ♦ 52H Second 90 (ninety) day benefit
   ♦ 53H Third and subsequent benefit periods

q. Enter the approved start date for the period being set up in the start date field (CCYYMMDD). Never enter a date before 7/1/97.

r. Enter the reason for stopping a hospice period in the stop reason field.
   ♦ 51H Member revocation
   ♦ 52H Hospice discharge
   ♦ 53H Transfer to another hospice provider
♦ 54H Death
♦ 55H Enrollment period limitations
Dually-eligible Medicare and IHCP eligible members residing in a nursing facility will have matching Medicare/IHCP stop dates for the hospice benefit period.

s. Enter the appropriate stop date based on the segment being set up. The stop dates should be 90 (ninety), 90 (ninety), or 60 (sixty) calendar days from the start date depending on the period (CCYYMMDD).

t. If the member is enrolled in an IHCP managed care delivery system, the hospice analyst will forward a request to disenroll the member via secure, certified email to AmeriChoice, IHCP’s managed care enrollment broker contractor, to serve as documentation. In the event certified email is unavailable, the request will be faxed. AmeriChoice will disenroll on the same day and return, by certified email or fax, a disenrollment notification so that hospice enrollment may proceed on the following disenrollment day. Files for previous managed care members are filed in “Hospice” files.

u. If the member is already enrolled in the 590 Program, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB), Undocumented or Unqualified Aliens, Children’s Special Health Care Services (CSHCS), a PA denial is issued for the member. The denial must indicate that the member must be IHCP only eligible or disenrolled to be eligible for hospice services. The reason for denial is documented on the hospice return letter. A denial notice must also be sent to the member.

v. If the member is already enrolled in a Home and Community Based Services (HCBS) waiver program, notify the State waiver unit (317-232-5110) of the changes that were requested and enter the hospice segment. The Waiver unit and OMPP Policy analyst are notified of the name and RID number of IHCP Waiver hospice member in the event access to service or billing issues arise. Waiver members do not have to disenroll from the waiver program before electing the IHCP hospice program.
w. If the member is already enrolled as a restricted card member, the analyst should proceed with the enrollment, copy the request and submit to the SUR restricted card supervisor who will disenroll the member from restricted card. This should occur the same day to ensure correct claims processing. The packet should include a highlighted end-date for restricted card status, which should be at least one business day prior to the hospice effective date. In other words, no overlap should occur, or a claim denial could occur.

x. If a member Indiana AIM eligibility window reflects a date of death, the hospice election is processed to reflect the date of death as the hospice stop date. If a Medicaid Hospice Discharge form was not received with the benefit request, a date of death discharge letter is sent to the hospice provider indicating the stop date is modified to reflect the date of death. The hospice provider is instructed to submit a discharge form to complete the member hospice file.

y. Send decision letter to the provider and member as an acknowledgment that the hospice period has been approved and entered.

z. File the request and retain for three years.

3. The following is the process for member re-election to the next benefit period.

a. If the enrollment request does not have a Medicaid Hospice Election form, it may be a “re-certification” to the next benefit period, which means that the member is already enrolled. Check the Medicaid Physician Certification form for which benefit period is indicated.

b. Review the Medicaid Hospice Plan of Care and Medicaid Physician Certification forms.

c. If any of the forms require corrections, the request is suspended and the packet is returned to the hospice provider with a letter indicating the necessary corrections. The provider will have 30 (thirty) days to send correct information to HCE for processing.

d. Enter the re-election update information using the LOC window to activate the next benefit period.
e. Enter the hospice analyst ID (this item must be alpha numeric).

f. Enter the hospice provider ID that appears on the Medicaid Hospice Election form.

g. Enter the period that the hospice member is entering in the LOC field (52H, or 53H). Enter the reason for starting a hospice period in the start reason field.

h. Enter the approved start date for the period being set up in the start date field (CCYYMMDD). Never enter a date before 7/1/97.

i. Enter the reason for stopping a hospice period in the stop reason field (51H, 52H, 53H, 54H, and 55H).

j. Enter the appropriate stop date based on the segment being set up. The stop dates should be 90 (ninety) or 60 (sixty) calendar days from the start date, depending on the period (CCYYMMDD).

Send decision letter to the provider and the member indicating the hospice period was approved and entered.

k. File the request and retain for three years.

4. The following is the process for member re-enrollment in the hospice program.

a. Review the system update to ensure that all forms are present for re-enrollment. These are the Medicaid Physician Certification form, the Medicaid Hospice Election form, and the Medicaid Hospice Plan of Care Form. If all forms are not included, suspend the request.

b. Verify that the request is a re-enrollment by looking at the stop reason of the previous segment on the LOC window. The stop reasons that denote re-enrollment are 51H and 52H.

c. Refer to the new enrollment directions to complete the re-enrollment, beginning in Section L-1-a.
5. The following is the process for member revocation or discharge.
   a. The support specialist will date stamp the system update form and place the mailed or faxed Medicaid Hospice Revocation and Medicaid Hospice Discharge forms in a hospice assignment group folder.
   b. The system updates will be forwarded to the hospice analyst.
   c. The hospice analyst will retrieve the existing prior authorization and review the documentation to avoid duplication of revocation or discharge.
   d. Verify that the form received is complete and signed by the member, or their representative, and a witness.
   e. Proceed to the LOC window to revoke or discharge the hospice member.
   f. Close the LOC segment for the member using the appropriate start and stop reason codes (revocation 51H or discharge 52H-54H).
   g. Send a decision letter to the provider and the member.

6. The following is the process for member change of provider.
   a. The support specialist will date stamp and place the system update with the Hospice Provider Change Request between Indiana Hospice Providers form in the hospice assignment group folder.
   b. The system updates will be forwarded to the hospice analyst.
   c. Retrieve the prior authorization and review the documentation to avoid duplication.
   d. Verify that the hospice revocation form is complete and signed by the member and a witness.
   e. Verify that the hospice discharge form is complete and signed by the hospice medical director or the hospice patient care coordinator.
   f. Proceed to the LOC window to change the hospice member’s responsible provider. If the LOC segment does not match, alert the policy analyst at FSSA, Division of Aging, 317-233-1956. The FSSA policy analyst will coordinate with the administrative assistant with FSSA Division of Aging to research and resolve the discrepancy.
If a new enrollment request is received that does not include a Hospice Provider Change Request between Indiana Hospice Providers form and there is a current benefit period approved with another provider, the hospice analyst will suspend the request and ask the provider to complete the form and resubmit the request. The hospice analyst will end the existing benefit period one day prior to the change in status date. The new LOC segment will reflect the new provider number and begin on the date of the status change. The previous LOC segment and the new LOC segment days authorized will total one benefit period only.

e. Close the LOC segment for the member using the appropriate stop reason code (transfer to another provider 53H).

f. Open the LOC segment for the member using the appropriate start reason code (transfer to another provider 53H).

g. Send the provider a decision letter verifying receipt of system update and that the change has been made in the system.

7. The following is the process for member change in status.

a. The support specialist will date stamp and place the system update with the Change in Status form in the hospice assignment group folder.

b. The hospice folder will be forwarded to the hospice analyst.

c. Retrieve the existing prior authorization and review the documentation to avoid duplication.

d. File the documentation. No change to the member LOC window is necessary.

e. Verify that the nursing home LOC segment matches the request. If the LOC segment does not match, alert the policy analyst at FSSA, Division of Aging, 317-233-1956. The FSSA policy analyst will coordinate with the administrative assistant with FSSA Division of Aging to research and resolve the discrepancy.

f. Send the provider and member a decision letter informing of the change to request.

Refer to Figures III-29 through III-34 for a detailed illustration of entry of hospice review into the IndianaAIM system.
To access the Level of Care Window for entering hospice information:

1. Click on Applications on any IndianaAIM window.
2. Click on recipient window.
3. Enter the Recipient Identification Number (RID).
4. Click on Search.
For entering Hospice information:

1. On recipient search screen, click on Options
2. Then, click on LOC
FIGURE III-31

WINDOW: LEVEL OF CARE OPTIONS

1. By double clicking on the box beneath LOC, the box printed above will show.

2. Clicking on the scroll bars, either at the bottom or at the right of the window will reveal all the possible options.
1. By double clicking on the box beneath Start Rsn, the box printed above will show.

2. Clicking on the scroll bars, either at the bottom or at the right of the windows, all the possible options will be visible.
FIGURE III-33

WINDOW: LEVEL OF CARE STOP REASONS

1. By double clicking on the box beneath Stop Rsn, the box printed above will show.

2. Clicking on the scroll bars, either at the bottom or at the right of the windows, all the possible options will be visible.
1. By double clicking on the box beneath Prior Resid, the box printed above will show.

2. Clicking on the scroll bar at the right of the window will reveal all the possible options.
M. Waiver Services and Medicaid Prior Authorization

Six Medicaid Home and Community-Based Services (HCBS) waiver programs are part of the Indiana Health Coverage Programs and are administered by the Medicaid Waiver Unit of the Division of Disability, Aging, and Rehabilitative Services (DDARS). These waiver programs offer assistance to eligible members, allowing them to remain in non-institutional environments. To be eligible, members must be at imminent risk of institutionalization in the absence of the waiver services. Once an individual begins participating in the Medicaid HCBS waiver program, he or she is no longer eligible to participate in managed care programs or to receive services under any other waiver.

As a part of the Indiana Health Coverage Programs, Home and Community-Based Services (HCBS) includes six subprograms.

- Aged and Disabled Waiver
- Autism Waiver
- ICF/MR (Intermediate Care Facility/Mentally Retarded) Waiver
- Medically Fragile Children’s Waiver
- Traumatic Brain Injury Waiver
- Supportive Services Waiver.

The purpose of the waiver program is to provide the services necessary to allow the eligible member to avoid institutionalization. However, the cost of the waiver services is not to exceed the cost to IHCP of institutionalization. Services requested for members on waivers will continue to be evaluated for medical necessity and reasonableness, however service will not be denied based on cost.

Services and supplies that require prior authorization, and which are requested for waiver members, are reviewed for medical necessity and reasonableness, as are all requests for prior authorization. (Refer to the Prior Authorization Procedures). The decision whether to allow or deny the request should not be influenced or changed by the fact that waivers may be involved. If a denial should occur, the member need not appeal the denial.
After the denial has been received, the request can be taken to the appropriate waiver case manager for approval through the waiver program. The PA should include the name of the waiver case manager, so the correct person can be notified. A waiver case manager may be with one of the following:

♦ one of the 16 (sixteen) Area Agencies on Aging;
♦ one of the eight Bureau of Developmental Disabilities Services (BDDS) Field Offices;
♦ an independent case management agency; or
♦ an independent case manager.

Some waiver services are also covered under the IHCP program, and require an IHCP PA denial before the waiver program will pay for them. They are:

♦ speech/language therapy;
♦ occupational therapy;
♦ physical therapy;
♦ all adaptive aids/devices;
♦ all items considered assistive technology; and
♦ durable medical equipment.

Other specified services necessitate an approval by the waiver case manager and the Medicaid Waiver Unit before a client can receive the services. These services are requested by using the Request for Approval to Authorize Services form; a form utilized only by the waiver programs.

The services and items that require this approval are:

♦ institutional respite care;
♦ assistive technology (after receiving a IHCP PA denial);
♦ home modifications;
♦ environmental modifications;
♦ adaptive aids and devices (after receiving a IHCP PA denial); and
♦ personal emergency response systems.
The HCE PA department has no role in the authorization of these services.

It must be noted that computer system errors may necessitate that waiver services, approved by the waiver case manager, be entered into the system as “approved” (indicating the services as “approved by waiver” in the internal text screen) for reimbursement purposes only. For clarification, the PA Supervisor should be consulted.

N. Review of Out-of-State Services

Prior Authorization for out-of-state services should be performed following the normal review process, subject to the following. Refer to 405 IAC 5-5.

Medicaid reimbursement is available for the following services provided outside Indiana:

- acute general hospital care;
- physician services;
- dental services;
- pharmacy services;
- transportation services;
- therapy services;
- podiatry services;
- chiropractic services;
- durable medical equipment and supplies; and
- hospice services subject to conditions in 405 IAC 5-34-1. Routine home care and continuous home care hospice services cannot be provided to an Indiana resident in a nursing facility outside of Indiana, even if the nursing facility is located in an out-of-state designated city listed below unless approved after phone contact with the LOC department at the state.

1. All listed services are subject to the prior authorization requirements of Indiana. The above services require prior authorization except as follows.

- Emergency services provided out-of-state are exempt from prior authorization; however, continuation of inpatient treatment and hospitalization is subject to the prior authorization requirements of Indiana.
Members of the adoption assistance program placed outside of Indiana will receive approval for all routine medical and dental care provided out-of-state.

Members may obtain services listed above in the following designated out-of-state cities, subject to the prior authorization requirements for in-state services.

- Louisville, KY
- Sturgis, MI
- Cincinnati, OH
- Watseka, IL
- Harrison, OH
- Danville, IL
- Hamilton, OH
- Owensboro, KY
- Oxford, OH
- Chicago, IL*

*Members in Chicago, Illinois, may obtain services subject to the following:

- **only** if a member’s physician determines the service is medically necessary;
- if transportation to an Indiana facility would cause undue hardship to the member or the member’s family;
- if the service is not otherwise available in the immediate area; and
- the member’s physician complies with all criteria set forth in the state plan and 42 CFR 456.3.

2. Prior Authorization may be granted for any time period from one day to one year for out-of-state medical services listed above, if the service meets criteria for medical necessity and one of the following criteria is also met.

a. The requested service is not available in Indiana, e.g., long-term Traumatic Brain Injury placements. (Veterans Administration and Shrine hospitals are exceptions.)

b. The member has previously received services from the out-of-state provider.

c. Transportation to an Indiana facility would cause undue hardship on the member or the Indiana Health Coverage Programs.

d. The out-of-state provider is a regional treatment center or distributor.
e. The out-of-state provider is significantly less expensive than the Indiana providers of the same service(s). For example, large laboratories versus an individual pathologist.

Refer to the specific criteria for each service requested. See Section III-P, for specific instructions for Traumatic Brain Injury (TBI) patients being cared for in out-of-state facilities.

Note: Prior Authorization will not be approved for the following services outside of Indiana. These services are not covered outside of Indiana in the cities listed in Section III-O-1.

- Nursing facilities or ICFs/MR
- Any other type of long-term care facility, including facilities directly associated with, or part of, an acute general hospital

3. Commercial Air Transportation

Requests for scheduled commercial air transportation for approved medically necessary services should be received by mail and forwarded to a prior authorization supervisor who will consult with the Prior Authorization Manager and the OMPP if necessary. The prior authorization supervisor, in coordination with a consultant travel agent, will arrange approved air transportation.

a. The provider and member, if necessary, will be contacted to determine the scheduled dates of service, length of stay, flight origination, and destination.

b. Consideration should be given to any special needs or flight arrangements necessary to accommodate a member’s medical condition.

c. The most affordable flight will be arranged with the travel agent. The flight cannot be confirmed until payment is received by the travel agent. Any airfare pending must be paid in full by check by the close of the business week.

d. The SUR recoupment specialist will initiate a check request for the full airfare price from EDS to be received in the travel agent office by the end of the business week.

e. The provider and member are contacted to confirm that flight arrangements have been secured. Travel itinerary (and flight coupons if necessary) is mailed to the member.
P. Review of Traumatic Brain Injury Cases

Traumatic Brain Injury (TBI) patients often have special needs that make placement difficult. If in-state placement is not possible, out-of-state placement may be made, provided prior authorization requirements are met. (See the Policy and Procedure for prior authorization of out-of-state services.) This process is different from most other prior authorization functions; the cases are not entered into the IndianaAIM system, and no PA number is given.

1. Requests for out-of-state TBI prior authorization will be received in the Prior Authorization department.

2. The case will be entered into an Access Database. Initial data entered will include: member name; RID number; requesting provider name and number; planned facility; and planned admission date.

3. The reviewer will evaluate the request to ensure that all required documentation is present, including:
   - the physician’s Indiana IHCP provider number and specialty;
   - the length of time the physician has known and treated the member;
   - the member’s RID number;
   - the member’s age and other identifying characteristics;
   - the member’s present Rancho level (if applicable);
   - the member’s current residence;
   - a summary of the member’s complete medical history, including any past hospitalizations and rehabilitation services;
   - the initial date of any head injury and any history of previous head injury or cerebral harm;
   - a thorough description of any abnormal behavior, including aggressiveness, sexual inappropriateness, danger to self or others, and a description of how this has been dealt with (using concrete examples);
   - history of any attempts at in-state placements;
   - potential for rehabilitation (and the basis for that estimated potential);
   - any neuropsychiatric evaluation (if performed);
♦ history of the member’s pre-injury behavior and social condition (including history of drug use, abuse, or police arrests);
♦ any psychiatric history (depression, suicide);
♦ what out-of-state TBI facility has been contacted and any assessment from them; and
♦ plans for the member’s eventual return to Indiana.
♦ eligibility is checked through the Indiana.AIM system. Members in a Risk Based Managed Care Organization (RBMC) must be disenrolled prior to authorization for admission. HCE will contact the Managed Care Organization (MCO) requesting disenrollment. Once confirmation of disenrollment is received, the member can be admitted to the out-of-state TBI program. If the member is discharged from the out-of-state TBI program, HCE is required to contact the appropriate RBMC organization.

4. The rationale for any decisions will be stated clearly and concisely. Criteria currently in use include the following:

♦ The member is a Rancho Level V or greater.
♦ The member demonstrates a reasonable expectation for improvement with therapy.
♦ The member is free of acute mental illness or illicit drug use.
♦ The member is medically stable.
♦ The member cannot be placed, and adequately cared for, in any in-state facility.

5. The case will be returned to the PA Manager, and additional data will be entered into an Access Database. These data will include: decision; rate of reimbursement; date authorization expires; and comments. The table will also contain fields for date update completed, discharge date, and disposition.

6. If there is anything unusual about the case, an inquiry may be made by the PA manager to OMPP.

7. If criteria are not met, the admission is denied. A denial letter and appeal rights are mailed to the out-of-state provider and to the member.
8. If approved, a letter is sent to the provider giving a synopsis of the services, date the authorization expires, and amount of per diem approved.

9. The TBI Reviewer will produce a two-part monthly status report. The first part will contain a summary of current residents by facility, a listing of admissions within the month, and a listing of discharges within the prior 90 (ninety) days. The second part will include a detailed summary of each active or recently discharged patient, including:

♦ patient name, RID, date of birth, case manager
♦ admission date(s), Rancho score, initial injury summation
♦ list of all dates authorized and the negotiated per diem cost for each extension of days
♦ current status report/progress update.

10. The report will be distributed to the Prior Authorization Manager, OMPP, and EDS.

11. TBI out-of-state admissions are authorized using the HCPCS code H2013 with the modifier of U1.
Q. Prior Authorization and Third-Party Liability

If prior authorization is required for a particular service, and the patient has another insurance coverage that is primary, Medicaid prior authorization must still be obtained in order to receive payment for the balance of charges not paid by the primary insurance. However, prior authorization is not required for members with Medicare Part A and Part B coverage if the services are covered by Medicare, and Medicare allows for the services in whole or in part. Services not covered by Medicare are subject to normal prior authorization requirements. Prior Authorization should be performed utilizing the normal review process.

R. Referrals to Surveillance and Utilization Review

There may be occasions when HCE staff members become aware of possible cases of fraud or abuse. These cases may be identified in a number of ways, including, but not limited to the following.

- Recognition of “red flags” for fraud and abuse (e.g., PA request forms that appear to have been copied with the same set of requested services on each regardless of age or diagnosis; reports that paid services were not provided; repeated requests for excessive units or dollars; or reports that a member has received a lesser quality item than what was approved).

- Complaints or comments made by customers who have called for other reasons.

- Comments made at meetings of providers or members.

1. The following procedure should be followed.
   a. All staff will be appropriately trained on health care fraud and abuse during their orientation program.
   b. Should a staff member receive a telephoned complaint, the call should be transferred to the “Member Concerns Line,” if possible.
   c. Should a staff member identify any suspicious activity, or the caller refuses to be transferred, the staff member should complete the Referrals to Surveillance and Utilization Review form. (Refer to Figure III-35.)
d. The staff member should submit the completed form to his or her supervisor.

e. The supervisor will submit the form to his or her department director.

f. The department manager will submit the form to the Surveillance and Utilization Review Manager.

g. The SUR Manager will give feedback, at periodic intervals, of the results of these referrals to the reporting department director.

h. The department manager will give feedback to the reporting employee regarding the disposition of the case. This will provide positive reinforcement and recognition to reporting employees.
### FIGURE III-35

#### REFERRALS TO SURVEILLANCE AND UTILIZATION REVIEW

**INDIANA MEDICAID REFERRAL FORM**

<table>
<thead>
<tr>
<th>INDIANA MEDICAID REFERRALS</th>
<th>FOR HCE USE ONLY:</th>
<th>PROV. COS/CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PROV. TYPE/SPEC</td>
<td>REC. AGE/CLASS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DATE OF CALL ____/____/_____**

**COMPUTER RECORD #:_________________________________________________**

**OPERATOR________________________________________**

<table>
<thead>
<tr>
<th>TYPE CODE</th>
<th>SERVICE CLASS</th>
<th>COMPLAINT TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Recommendation</td>
<td>Reform health care system (OMPP)</td>
</tr>
<tr>
<td>15</td>
<td>Provider</td>
<td>Give people incentive to work (OMPP)</td>
</tr>
<tr>
<td>16</td>
<td>Member</td>
<td>Improve eligibility process (OMPP)</td>
</tr>
<tr>
<td>17</td>
<td>Other</td>
<td>Misreport income (County)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elderly hiding assets/income (County)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Able to work, but doesn’t (County)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employed-Insurance available (County)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Falsified eligibility information (County)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uses someone else’s card (County)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treats members poorly (IMFCU)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recruiting patients (IMFCU)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doesn’t report other health ins. (TPL)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Excessive/Unnecessary Services (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Charges too much (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Charges client for services (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mis/over-utilization of chiropractors (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mis/over-utilization of transportation (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mis/over-utilization of prescriptions (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mis/over-utilization of doctors (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mis/over-utilization of emergency (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Charges for services not provided (SUR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

**COMMENTS**

**COMPLAINT AGAINST**

| NAME_____________________________________________________________|
| ADDRESS__________________________________________________________|
| CITY________________________STATE_____________ZIP_______________|
| MEDICAID #:____________________PROVIDER#_______________________|

**CALLER INFORMATION**

| NAME_____________________________________________________________|
| ADDRESS__________________________________________________________|
| CITY_________________________STATE_____________ZIP_______________|
| PHONE ( )_________________________COUNTY_______________________|
S. Inpatient Burn Prior Authorization

Prior Authorization (PA) requests received for inpatient burn treatment (revenue code 207) will be entered into IndianaAIM and processed as approved.

T. Review of Cases Suspended to Location 22

Claims are automatically suspended to “Location 22” when they meet criteria listed in certain audits that signify the need for medical review. Location 22 is the electronic location designated in the IndianaAIM system for these suspended claims. The Prior Authorization department will review, research, and resolve these claims within 60 (sixty) days of receiving the source documentation (claims and attachments.) (Refer to Table III-13 and the Location 22 Procedure Flowchart.)
# TABLE III-13

## LOCATION 22 PROCEDURE

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Claims are suspended to Location 22 within the EDS claims system. On a regular basis, EDS staff will also copy paper claims with attachments and send them to HCE.</td>
<td>EDS</td>
</tr>
<tr>
<td>2.</td>
<td>The Prior Authorization (PA) Supervisor will review in Indiana AIM the electronic claims pending from the previous day in each PA reviewer’s workload. The total will be entered into the Location 22 report as “# Claims Remaining at end of Day” for the appropriate date.</td>
<td>PA Supervisor</td>
</tr>
<tr>
<td>3.</td>
<td>The PA Supervisor will review the new claims loaded to the designated workload location, and enter the number of claims received in the Location 22 report as “# Claims Received.”</td>
<td>PA Supervisor</td>
</tr>
<tr>
<td>4.</td>
<td>The PA Supervisor will reassign claims to the designated PA reviewers based on training, amount of claims remaining from previous day, and other workload requirements.</td>
<td>PA Supervisor</td>
</tr>
<tr>
<td>5.</td>
<td>PA Reviewers will review each claim, either electronic or electronic with paper attachments, and enter the claim resolution, if determined, into the system. The PA Reviewer will notify the PA Supervisor of any unresolved claims each day.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>6.</td>
<td>After the source documentation (paper claim with attachments) is reviewed in On Demand, if the PA Reviewer is unable to make resolution determination, the PA Reviewer will forward the documentation with a PA Consultant Review form, to the PA Supervisor.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>7.</td>
<td>The PA Supervisor will contact the Medical Director to arrange physician or consultant review of the documentation and claim form.</td>
<td>PA Supervisor</td>
</tr>
<tr>
<td>8.</td>
<td>The Medical Director will coordinate the review of the documentation, and return the completed Medical Necessity form to the PA Reviewer who will complete the claim resolution.</td>
<td>Medical Director</td>
</tr>
<tr>
<td>9.</td>
<td>The PA Reviewer will report any findings from resolving Location 22 claim suspensions that may require a systems change or policy change. The Medical Policy Director forwards the information to the PA Reviewer, OMPP or EDS as appropriate.</td>
<td>PA Reviewer</td>
</tr>
<tr>
<td>10.</td>
<td>Source documentation regarding abortion claims will be retained in files specific to Location 22.</td>
<td>Support Specialist</td>
</tr>
</tbody>
</table>
Claims are suspended to Location 22 and assigned to a Prior Authorization (PA) Reviewer.

PA Reviewer reviews suspended claims and enters resolution into system if determined.

Source documentation is necessary to resolve the claim.

Source documentation is viewed in On-Demand, and assigned to the appropriate PA Reviewer. PA Reviewer reviews documentation.

The PA Supervisor, Medical Director, or designated consultant will review the claim documentation and return the recommendation to the PA Reviewer. The PA Reviewer will enter the resolution into the system.

Is claim resolved by PA Reviewer?

No

Yes

PA Reviewer enters resolution into system.
U. **Review of Long Term Acute Care, Hospital Admissions**

Prior Authorization (PA) is required for Long Term Acute Care (LTAC) hospital admissions covered by the Indiana Health Coverage Programs (IHCP) and reimbursed under the level of care methodology described in the Indiana Administrative Code (IAC) 405 IAC 1-10.5. LTAC hospitals are designed to provide specialized acute care for patients that require a longer recovery period. These patients usually are in an acute care facility and their medical condition has stabilized, but they continue to require an acute level of care, such as skilled nursing facilities (SNF) or sub-acute care facilities. LTAC hospitals are licensed by state acute care licensing standards and are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Members must meet the admission and continued criteria outlined in IHCP Bulletin 200366, dated October 31, 2003. This service is requested using revenue code 101. All requested days and dates of service will be entered into Indiana AIM and processed in the usual manner (see Section III-A for the manual process of processing a request into Indiana AIM).

V. **Psychiatric Residential Treatment Facility Services**

The Office of Medicaid Policy and Planning (OMPP) implemented coverage of Psychiatric Residential Treatment Facility (PRTF) services when provided in accordance with the requirements listed in Bulletin 200404 with services retroactive starting January 1, 2004. The Bulletin outlines the provider enrollment requirements, coverage provisions and limitations, reimbursement methodology, billing requirements and prior authorization criteria for PRTF services. All providers must qualify for enrollment eligibility in the Indiana Health Coverage Programs (IHCP) as a PRTF facility and must be licensed under Indiana Administrative Code (IAC) 470 IAC 3-13 as a private, secure, child-caring institution, and must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or the Council on Accreditation (COA).

This service is covered for members 21 years old or younger. **Reimbursement is also available for children younger than 22-years-old who began receiving PRTF services before their 21st birthday.**

All services require prior authorization. Members must meet the admission and continued criteria outlined in Bulletin 200404 dated February 27, 2004. This service is requested using HCPCS T2048. All requested days and dates of service will be entered into Indiana AIM and processed in the usual manner (see Section III-A for the manual process of processing a request into Indiana AIM). If a member is in a managed care organization (MCO), a manual letter is sent to the appropriate MCO notifying them of the member’s admission.
EXHIBIT III-1

TELEPHONE SCRIPTS

A. Scripts for Telephone System Recordings

1. Daytime Recording

Thank you for calling the Indiana Medicaid Prior Authorization Department in Indianapolis, Indiana. Office hours are 7:30 am to 6 pm, Monday through Friday. Your call may be monitored for quality improvement purposes. Authorization of Indiana Medicaid services is based upon medical necessity and documentation must support this. Prior authorization does not guarantee payment. Please listen carefully as the call options have changed. For mental health service, please press 1. For home health or hospice, press 2. For DME or other medical/surgical services, press 3. For hearings and appeals, please press 8. For all other services, press 4. To access our company website, log on to www.hce.org. If you are calling from a rotary phone or need further assistance, please remain on the line. Thank you.

2. Queue Recording

All prior authorization reviewers are assisting other callers. Your call is important to us. Your call will be answered in the order that it was received. Health Care Excel authorizes services based upon medical necessity. Medical record documentation should support this medical necessity. Please hold for the first available reviewer.

3. After-hours Recording

You have reached the Indiana Medicaid Prior Authorization Department in Indianapolis, Indiana. Our office is now closed. Office hours are 7:30 am to 6 pm, Monday through Friday. Emergency services should not be delayed due to lack of prior authorization. Prior authorization is based upon medical necessity, which can be requested within 48 hours of the receipt of emergency service. Please call again during normal business hours. To access our company website, log on to www.hce.org. Thank you.
B. **Script for a Typical Prior Authorization Request Telephone Call**

Facility telephones the prior authorization toll-free number and makes a selection.

**HCE Reviewer:** Health Care Excel Prior Authorization, this is “HCE Reviewer.” How may I help you?

**Caller:** Yes, I am calling from a psychiatric facility, and I need to authorize a patient’s stay.

**HCE Reviewer:** I would be happy to help you with that. Can you tell me your facility’s provider number? *If the requesting provider is not enrolled, the license number and address must be obtained and entered into IndianaAIM.*

**Caller:** (gives provider number or license number and address, as appropriate)

**HCE Reviewer:** Is this a new admission or a continuing stay request?

**Caller:** This is a new admission.

**HCE Reviewer:** The Recipient Identification Number is…?.

**Caller:** (provides the necessary information)

**HCE Reviewer:** The patient’s name is ..? (caller must state name)

**Caller:** (caller must state name)

**HCE Reviewer:** Can you tell me the type of service you are requesting, and start date and/or admit date (if not already known)? Can you tell me the diagnosis code?

**Caller:** (If yes, continue with review. If no, the caller must determine the diagnosis code.)

**HCE Reviewer:** And what are the Service Code (HCPCS, ICD9 or NDC) and number of days/units you are requesting?

**Caller:** Gives code, and requests ten days.

**HCE Reviewer:** And your name is…? (If they have not stated their name at the beginning of the call. If they have, the reviewer should have written down the name. This information is entered into the internal text.)

**Caller:** My name is “caller”.

**HCE Reviewer:** And your telephone number is…? (This is also entered into the internal text.)

**Caller:** (Gives the information.)

**HCE Reviewer:** (If home health, DME, etc, would ask, “Does the member live at home or in another location, and if another location, where?”)

**Caller:** (Gives the information.)

**HCE Reviewer:** Thank you. Can you tell me the patient’s signs and symptoms, plan of care and initial discharge plan?
Script for a Typical Prior Authorization Request Telephone Call (continued)

Caller: Yes, gives information.
HCE Reviewer: Based upon the information you have given me, I can approve five (5) days in your unit (this is a modification). That would make your authorization valid through (give date) as the last covered day. You must call back no later than the following business day if the patient remains hospitalized at that time. This is pending verification and receipt of the Certification of Need within the 14-day required timeframe. Do you have any questions?

(If the case did not meet criteria, the caller would have been informed of this, and told when to expect a decision to be rendered.)

Caller: No, thank you.
HCE Reviewer: (Caller), the Prior Authorization number for this stay is 9999999999. You know that the stay will be pended until we receive the 1261A Certification of Need. Is there anything else I can assist you with?

Caller: No, thank you.
EXHIBIT III-2

MEDICAL RATIONALE

The consultant will read the reviewer’s case summary information and review all of the available
documentation to determine whether the service is medically justified and allowable under
Indiana statutes and policies.

A good medical rationale is necessary and central to the review process. As the consultant writes
his or her case determination, he or she must adhere to the following principles.

1. Compose your rationale as if you were addressing your comments or questions to the
responsible provider or practitioner(s). Please keep in mind that your answer may be
used in letters to the provider or practitioner(s) who provide services to the patient.

2. Be specific and coherent in your answers. Avoid “generic” answers – answers that are so
broad and nonspecific that they could apply to numerous patients in various cases. Avoid
such “generic” answers by writing rationale which includes relevant, specific items from
any of the following which are available for your review:

   a. history and physical exam;
   b. progress notes;
   c. nursing notes;
   d. graphic charts;
   e. laboratory reports;
   f. x-ray reports;
   g. other diagnostic tests and reports;
   h. consultations, operative notes, and miscellaneous reports;
   i. discharge summary; and
   j. additional information from letters, telephone and personal interviews from
      providers that may be available for review.

3. Cite accepted, commonly recognized standards of care, not personal preferences.
As you review the medical record and document the rationale for your decision, be careful to avoid common review errors. You can improve the reliability of review by adhering to the following principles.

1. **Write legibly.** This simple procedure avoids errors that can occur if staff members must try to decipher illegible writing.

2. **Review all of the documentation presented.** Perhaps the most egregious errors are those in which the reviewers simply fail to read documentation that is present in the record.

3. **Confirm all statements and information given to you by the non-physician reviewer with your own independent review of the documentation.** The reviewer may not have noted each pertinent item of the patient’s history, physical exam, progress notes, lab results, physician orders, consultation notes, etc. When the consultant assumes the reviewer’s statements are always correct, the consultant duplicates errors that may have been made in earlier levels of review.

4. **Avoid excessive reliance on the results of diagnostic studies rather than on clinical documentation.** When there is a question as to whether a service should have been ordered or performed, read the entire document carefully to ascertain whether the provider made an appropriate clinical evaluation and assessment without over-utilization of such services.

5. **Allow acceptable, alternative methods of patient evaluation and care.** As long as the provider under review displays adherence to standards of care and sound medical judgment, there are often multiple acceptable approaches to medical problems. Do not judge care unacceptable merely because it does not follow your own personal choice.

6. **When reviewing services retrospectively, avoid excessive use of the “retrospectroscope.”** Review the documentation to see if sound medical decisions were made with appropriate evaluation and care, based upon the information at hand at the time the services were rendered, not upon information which later became available.
IV. APPEALS

When a requesting provider disagrees with the modification or denial of a prior authorization request, an administrative review may be requested. An administrative review is an independent, objective review of the information submitted with the initial request, as well as any additional documentation submitted with the request for administrative review.

A. Letters of Intent

1. An administrative review request must be postmarked, faxed within seven working days of the receipt of modification or denial, or submitted via the Web interChange, by the provider who requested the prior authorization.

2. If the service in question is an inpatient hospitalization, and the patient remains hospitalized, the provider may submit a Letter of Intent to Request an Administrative Review. This letter signifies that the provider intends to request an administrative review upon the patient’s discharge from the facility. The letter must be postmarked within the same seven day limitation as is cited in the rules governing the request for administrative review (405 IAC 5-7-2) and must be forwarded, in writing, to Health Care Excel.

3. Upon receipt, the letter of intent will be forwarded to the HCE hearings and appeals staff. The hearings and appeals support specialist will stamp the date the document is received, attaching the envelope for proof of timely submission.

4. The prior authorization specialist will complete a letter of acknowledgment, and mail the letter to the provider. The letter will contain a listing of documentation needed to conduct the review as well as the time limit for the submission of the requested information. Refer to Exhibit IV-13. The PA specialist will enter the following information into the hearings and appeals log.

- Recipient Identification (RID) Number.
- Member name.
- Prior Authorization (PA) number.
- Provider number.
- Type of service.
- Procedure code(s) being appealed.
- Cost per unit.
- Number of units requested.
- Number of units denied.
- Dollars originally approved.
5. The letter of intent to file an administrative review will be filed alphabetically by the last name of the member and used as proof of timely filing, should that become an issue of the appeal.

B. Administrative Review

1. The request for an administrative review (AR) will be forwarded to the prior authorization specialist.

2. The request must be forwarded in writing, 278 electronic transaction, or Web interChange, to HCE (telephone requests will not be accepted). The support specialist will stamp the request with the date received, and attach the envelope to the request for verification of postmark or authorized mail date.

3. The support specialist will copy the paper or faxed request for prior authorization and all documentation originally received. This information will be attached to the request for administrative review, and placed in a folder labeled with the member’s name and Recipient Identification Number (RID).

4. The PA specialist will enter the following information into the tracking log (if it has not already been entered from a Letter of Intent to Request an Administrative Review).

   - Recipient Identification (RID) number.
   - Member name.
   - Prior Authorization (PA) number.
   - Provider number.
   - Type of service.
   - Procedure code(s) being appealed.
   - Cost per unit.
   - Number of units requested.
   - Number of units denied.
   - Dollars approved on the original request.
   - Dollars denied on the original request.
   - Date intent letter received (if appropriate for the administrative review).
   - Date intent letter acknowledged (if appropriate for the administrative review).
   - Date Administrative Review request received.
5. The prior authorization specialist will evaluate the AR request to ensure that it was submitted by the provider who submitted the original prior authorization request. The prior authorization specialist will assess the request to ensure that it was submitted within the required seven day limitation by counting 13 (thirteen) working days from the mailing date of the original decision letter to allow for mail delivery. If the AR request is untimely, a notification letter explaining the reason for the denial will be sent and IndianaAIM will be updated to reflect the decision and the reason for the decision. (Refer to Exhibit IV-11.)

6. The prior authorization specialist will evaluate the submitted documentation. If further information is needed, a letter requesting additional documentation will be sent (refer to Exhibit IV-10). The request will be held for 30 (thirty) calendar days following the request for additional documentation. If no documentation is received, the denial or modification will be upheld. If information is received, the review will be completed within seven business days of receipt of the additional information.

7. If new documentation brings the request into compliance with established criteria, the IAC requirements, IHCP bulletins or banners, or other directives by the Office of Medicaid Policy and Planning, the request will be approved by the prior authorization specialist. (The denial or modification is overturned.)

8. If criteria are still not met, the prior authorization specialist will select a consultant type to whom to refer the case. This consultant may be the Medical Director or another physician, but may not be the same person who made the original denial or modification of the request.

9. The prior authorization specialist will initiate the Administrative Review/Hearings and Appeals Review, Consultant Referral Form. The PA specialist will forward all of the case documentation to the designated support specialist, who will forward the case materials to the selected consultant via overnight mail or fax, if the consultant is not anticipated to be available in the HCE offices.

10. The consultant will review the entire case documentation, render a decision, complete the Administrative Review/Hearings and Appeals Review, Consultant Referral Form, and return it to the designated support specialist via overnight mail or fax. The designated support specialist will forward the decision to the prior authorization specialist.
11. Within seven business days of the receipt of the request (or the receipt of the additional documentation requested) the prior authorization specialist will review all the documentation and issue a determination notice to the requesting provider and the member. The notice will contain the determination, the rationale for the decision, and the provider and member appeal rights.

12. The IndianaAIM system should be updated in the following manner.

- Enter IndianaAIM.
- Click “Prior Authorization.”
- Enter prior authorization number in “Inquire PA Number” block.
- Click “inquire.”
- Click “Admin Review” box.
- Enter requested information, including dates received and mailed.
- Save and exit.
- Click on “Line Item.”
- Change units, dates or decision to match administrative review decision.
- Save and exit.
- Click on “New IAC/Text.”
- Enter any laws utilized in making the administrative review decision as well as any narrative to be read by the provider or the member.
- Save and exit.
- Click on “Internal Text.”
- Enter name of appellant, if a consultant reviewed the case, the AR decision, and the initials of the staff writing and sending the letter.
- Save and exit.
- Click on “Batch” for automatic batch mailing to the provider and member, or click on “online text” for online printing and mailing with the letter by prior authorization specialist.
- Exit all.
13. The prior authorization specialist will update the tracking log (in Access) with the new information regarding the administrative review decision, action, dollars, etc.

14. The designated support specialist will file the case according to the decision and date. For example, all approved decisions are filed by date, and are forwarded to long-term storage for eventual destruction in compliance with the Approved Records Retention and Disposition schedule. All modified and denied decisions are filed by date and kept in close proximity to the hearings and appeals area until such time as a hearing is requested, or until the time frame for the filing of the appeal for a hearing has expired.

After the time for further appeal has expired, the case will be moved to long-term storage for destruction in compliance with the approved Records Retention and Disposition Schedule.

Note:

♦ A prior authorization request will be “suspended” when insufficient information is submitted to render a decision. A suspension is not a final decision on the merits of the request and is not subject to appeal. A “suspended” request may be resubmitted with additional information (405 IAC 5-7-1).

♦ Any administrative review request that is not reviewed and a decision made, within seven business days will be automatically approved, unless approval is in direct conflict with a published law or rule.

Refer to Table IV-1, (Administrative Review of a Modified or Denied Prior Authorization Decision), Figure IV-1, (IndianaAIM Windows), and Figure IV-2 (Administrative Review Procedure flow chart) for detailed instructions on completion of an administrative review.
TABLE IV-1

PROCEDURE/PROCESS: ADMINISTRATIVE REVIEW OF A MODIFIED OR DENIED PRIOR AUTHORIZATION DECISION

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A requesting provider wishing to appeal a PA decision must initiate a request for administrative review to HCE within seven days from the date the decision was received.</td>
<td>Requesting Provider</td>
</tr>
<tr>
<td>2.</td>
<td>The HCE prior authorization specialists will re-evaluate all of the information submitted (as well as any additional information requested by HCE) within seven business days of the receipt of all the information necessary to conduct the review.</td>
<td>Prior Authorization Specialist</td>
</tr>
<tr>
<td>3.</td>
<td>If it is not possible to approve the request, a consultation is sought with the Medical Director or a consultant, by phone or in person.</td>
<td>Prior Authorization Specialist &amp; Medical staff</td>
</tr>
<tr>
<td>4.</td>
<td>A decision is made based on medical necessity and the submitted documentation.</td>
<td>Prior Authorization Specialist &amp; Medical staff</td>
</tr>
<tr>
<td>5.</td>
<td>The decision is entered into Indiana AIM by the prior authorization specialist, who also completes the appropriate administrative review response letter and mails the letter to the requesting provider and member.</td>
<td>Prior Authorization Specialist</td>
</tr>
<tr>
<td>6.</td>
<td>If the provider is appealing the denial of continued hospitalization, and the member is still hospitalized, the provider must submit a letter of “Intent to file an Administrative Review” within the same time limits as noted in #1.</td>
<td>Requesting Provider</td>
</tr>
<tr>
<td>7.</td>
<td>After filing a Letter of Intent, the requesting provider has 45 (forty-five) days following the member’s discharge from the facility in which to submit the entire medical record and the request for administrative review.</td>
<td>Requesting Provider</td>
</tr>
<tr>
<td>8.</td>
<td>If the provider disagrees with the administrative review decision, he/she may submit a request for an administrative appeal. (See ALJ hearing.)</td>
<td>Requesting Provider</td>
</tr>
<tr>
<td>9.</td>
<td>Once the decision has been made, each case is filed by the type of decision and the date of the decision in the administrative review files.</td>
<td>Support Specialist</td>
</tr>
</tbody>
</table>
FIGURE IV-1

WINDOW: PA ADMINISTRATIVE REVIEW

Received Date: The date in CCYYMMDD format that an Administrative Review is received by the hearings and appeals support specialist.

Mailed Date: The date in CCYYMMDD format that the appeal is printed.

See page IV-4, item 12, for information to be entered in internal text.
FIGURE IV-2

ADMINISTRATIVE REVIEW PROCEDURE

Requesting provider initiates a request for an Administrative Review per 405 IAC 5-7-2.

1. PA specialist receives request via mail, 278 electronic transaction, or Web interChange.
2. Stamps with date of receipt and attaches envelope with postmark date.
3. Attaches original PA request and additional information.
4. Enters all information into Access log.

- Documentation does not support a change of the original decision.
- Decision sustained due to procedural error(s).

- PA specialist evaluates all information and researches as needed.
- Medical necessity of requested service(s) is met.

- PA specialist refers to Medical Director for decision of medical necessity.

- Decision modified or approved by Medical Director.
- Decision entered into Indiana AIM and AIM letter sent to member. Administration review and AIM letter completed and mailed to provider by PA specialist (405 IAC 5-7-3).

- Provider agrees with decision. No further appeal in order.

- Provider disagrees with modifications or denial. Files administrative appeal (405 IAC 1.1-1.3).

1. PA specialist provides support specialist with decision and any written comments relative to the case.
2. The PA specialist enters the information into the Access log.
3. The support specialist then files the records by the date of the administrative review decision and retains all records in compliance with the approved Record Retention and Disposition Schedule.
C. Administrative Appeal

An Administrative Law Judge (ALJ) hearing is a mechanism for providers and members to appeal any modified or denied prior authorization decision. All procedures surrounding administrative appeals are governed by the Indiana Administrative Code, 405 IAC 1.1-1.3 (Appeal Procedures for Applicants and Members of IHCP). Instructions for appealing are included with each prior authorization decision mailed to the requesting provider and to the member.

It is the responsibility of the PA reviewers, consultants, hearings and appeals staff, and Medical Director to provide an impartial review of all submitted documentation and information, as well as all documents and testimony provided during the hearing. This will ensure the appealed decisions meet the rules set forth in the Indiana Administrative Code and any internal criteria or directives from OMPP.

A Medicaid provider is entitled to an administrative appeal if an administrative review was requested first (405 IAC 1.1-1.3). If the provider is dissatisfied with the administrative review decision, a request for an Administrative Law Judge hearing may be filed. The request must be forwarded in writing to the Indiana Family and Social Services Administration (FSSA) within 30 (thirty) days, plus three days mail time, of receipt of the administrative review decision as outlined in 405 IAC 5-7.

A member need not request an administrative review prior to requesting an administrative hearing. In compliance with 405 IAC 1.1-1.3, the member’s request for administrative hearing must be forwarded in writing to FSSA within 30 (thirty) days, plus three days mail time, of receipt of the initial prior authorization decision form. The member’s caseworker may utilize the form provided by the State to assist the member in filing the appeal, or the member may send the appeal directly to the FSSA.

Either the provider or the member must submit requests for an administrative hearing before an Administrative Law Judge to the following address.

MS04
Indiana Family and Social Service Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals
After the FSSA hearings and appeals staff receives the hearing request, HCE will be contacted to supply the issues surrounding the request, e.g., the service requested, the decision, and the rationale for that decision. If the appeal is for a prior authorization request that was approved, the State is notified and the appeal is dismissed.

If the appeal is appropriate, FSSA schedules the administrative hearing. All hearings for provider appeals are held at the Indiana Government Center South, and all hearings for member appeals are held at the County Division of Family and Children in the member’s county of residence. Only in special situations will the hearing be held at the member’s place of residence, or be conducted via telephone.

Prior to the hearing, all cases are reviewed by the HCE hearings and appeals staff and the Medical Director, if needed.

1. The PA specialist locates any previously submitted documentation relating to the appeal.

2. The PA specialist assesses the documentation and compares this to the IAC rules, relevant IHCP Provider Bulletins, Banner pages, internal criteria, and verbal directives from the OMPP, where applicable.

Appeals filed for a service that is a continuing service, e.g., home health care, therapies or outpatient psychiatric care, must be given special and immediate consideration. Due to a previous court decision, these types of services must be “restored” to the level of the previous authorization period when the member files an appeal within 10 (ten) days of receipt by the member of the decision to modify or deny the requested service(s).

For example, the member has been receiving 40 (forty) hours of home health weekly.

- The provider submits a request for continuation of the services at 40 (forty) hours weekly to begin 6/1/02.

- The decision is made on 5/15/2002 to approve 40 (forty) hours per week from 6/1/2002 to 7/1/2002, and then reduce the hours to 20 (twenty) hours per week beginning on 7/1/2002.
The member receives the prior authorization decision letter on 5/20/2002, informing him or her of the reduction or termination of services.

If the member files an appeal prior to the effective date (7/1/2002), even if it is after the beginning of the PA period (6/1/2002), services **must** be restored to the level at which they were approved during the authorization period previous to the period which is being appealed, if the member files the appeal within 10 days of the mailing of the notice of action and the action is not a result of the application of state or Federal Law 942 CFR 431.231 (1, 2, 3).

Once HCE is made aware of this appeal, services must be restored to the previously authorized level (40 hours weekly) so there is no reduction in the provided services until the case can be reviewed, a hearing held, and a decision rendered.

If the ALJ's decision is in favor of the State, the reinstated services are reduced to the level designated by the ALJ.

If the appeal is withdrawn, or the member fails to appear for the scheduled hearing, the reinstated services are reduced to the level originally approved on that PA request.

If additional information has been provided which justifies the request for services or supplies, the prior authorization decision may be changed to approved, or modified, if supported by the additional information.

The appellant is notified, verbally or in writing, of the option to withdraw the appeal, since the issue of the appeal has been resolved to the satisfaction of all parties involved.

If the appeal is resolved prior to the scheduled hearing, the PA Specialist notifies the FSSA, both verbally and in writing, that the issue has been resolved.

After updating the IndianaAIM system, duplicate letters and decision forms are prepared and mailed to both the provider and member. Since the case has been resolved, there will be no further action, and the file can be forwarded for long-term storage.

If no agreement can be reached, the hearing will be held as scheduled.
8. The role of the HCE PA specialist is to prepare and present the case at the hearing as a representative of the State. The hearing packet must accurately reflect all pertinent information relating to the medical necessity of the issue(s) being appealed.

Applicable citations of the Indiana Administrative Code, or any other laws, and all other documentation used in the decision-making process will be included in the appeal packet. The Medical Director may also attend selected hearings to present medical testimony and respond to medical questioning.

Contents of the hearings and appeals packet should include the following items, if appropriate to the service being appealed.

- A letter of rationale detailing the reasons for the initial decision in a clear and concise manner. (refer to Exhibit IV-25.)
- A copy of the notification of the scheduled hearing.
- A copy of the appellant’s letter requesting the hearing.
- A copy of the history and physical.
- A copy of the physicians’ progress notes.
- A copy of any psychological evaluation (if a mental health service).
- A copy of the Certification of Need (if applicable).
- A copy of the original request for prior authorization, and all attachments.
- A copy of the Prior Authorization Decision Form.
- A copy of the request for Administrative Review (if applicable).
- A copy of the HCE Administrative Review response (if applicable).
- A copy of the prior authorization history.
- A copy of the discharge summary, nurses’ notes, and therapy notes, etc.
- Copies of any criteria or documentation utilized at any point in the review process.
- Any other documentation deemed necessary to facilitate an accurate decision.
9. Attendance at ALJ hearings held in the counties is at the discretion of the Prior Authorization Specialist, Prior Authorization Manager, and the Medical Director. Factors taken into consideration are, the degree of medical involvement; the location of the hearing; multiple hearings on the same date and time; the cost-effectiveness of pursuing the issue; and the significance of the case in terms of setting precedence for future determinations of similar cases. Whenever feasible, HCE staff should attend the hearings.

10. The ALJ renders a decision based upon the information presented at the hearing. The decision must be rendered within 60 (sixty) days of the appeal. If a continuance is granted for submission of additional evidence, the decision date is continued equally.

11. Following the hearing, the files, including all original documentation, are filed by member’s last name under the title, “Awaiting Decision.”

12. When the decision is received, the system is updated and a copy of the updated decision is mailed to both the member and the requesting provider. If either the member or requesting provider wishes to appeal the administrative hearing decision, instructions for requesting an agency review are included at the end of the administrative hearing decision notice.

13. Agency review requests must be submitted promptly to allow for the review to be conducted and the decision rendered before the 90 (ninety) day limitation expires (per Gomolisky vs Davis, no decision may be rendered after 90 (ninety) days from the date the original appeal was received by FSSA).

14. Hearing decisions approving all of the requested services are filed under “Hearings Approved”. Hearing decisions approving only a portion of the requested service(s) or supply(s) are filed under the title, “Hearings Modified and Denied,” since these may be appealed.

15. If no agency review is received within the stated time limit, the files are withdrawn and forwarded for long-term storage.

Refer to **Table IV-2**, (Administrative Law Judge Hearing process), and **Figure IV-4**, (Administrative Law Judge Hearing Procedure flow chart) for detailed instructions on review of ALJ hearings.
FIGURE IV-3

WINDOW: PA APPEAL

Received Date: The date in CCYYMMDD format that an Appeal is received from the FSSA Office of Hearing and Appeals by the PA department.

Mailed Date: The date in CCYYMMDD format that the appeal is printed.

Appeal Date: The date in CCYYMMDD format that FSSA scheduled the appeal hearing.

EDS Attended: An ‘X’ indicator to be flagged if an HCE representative attended the hearing.

Dismiss Date: The date in CCYYMMDD format if the appeal is dismissed.
### TABLE IV-2

**PROCEDURE/PROCESS: ADMINISTRATIVE LAW JUDGE HEARING**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Activity</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>When the requesting provider disagrees with the Administrative Review decision, or the member disagrees with the original PA decision, either or both may request an administrative appeal.</td>
<td>Requesting provider or member</td>
</tr>
<tr>
<td>2.</td>
<td>Either party must submit an appeal request to FSSA-Hearings and Appeals within 30 (thirty) days, plus three days mail time, of receipt of the decision.</td>
<td>Requesting provider or member</td>
</tr>
<tr>
<td>3.</td>
<td>FSSA notifies HCE of the appeal and requests information regarding the issue to appeal from HCE.</td>
<td>FSSA Hearings and Appeals</td>
</tr>
<tr>
<td>4.</td>
<td>FSSA schedules the ALJ hearing and notifies in writing all parties involved. (Provider appeals are heard at the Indiana Govt. Center while member appeals are heard at the county Office of Family Resources in the member’s county of residence.)</td>
<td>FSSA Hearings and Appeals</td>
</tr>
<tr>
<td>5.</td>
<td>HCE PA specialist attempts to resolve the appeal through teleconference(s) with the provider and/or member.</td>
<td>HCE Prior Authorization Specialist and/or medical staff.</td>
</tr>
<tr>
<td>6.</td>
<td>If issue(s) are resolved, the agreement is entered into IndianaAIM, and letters indicating the resolution are mailed to all involved parties, including FSSA.</td>
<td>HCE Prior Authorization Specialist</td>
</tr>
<tr>
<td>7.</td>
<td>If issue is resolved, the appellant must withdraw the appeal by notifying FSSA in writing.</td>
<td>Requesting provider or member</td>
</tr>
<tr>
<td>8.</td>
<td>Cases that cannot be resolved are prepared for hearing.</td>
<td>HCE Prior Authorization Specialist</td>
</tr>
<tr>
<td>9.</td>
<td>The facts are presented and the issues are argued at hearing.</td>
<td>HCE Prior Authorization Specialist</td>
</tr>
<tr>
<td>10.</td>
<td>A decision is issued within 60 (sixty) days from the date the appeal was filed.</td>
<td>Administrative Law Judge</td>
</tr>
<tr>
<td>11.</td>
<td>ALJ decision issued.</td>
<td>Administrative Law Judge</td>
</tr>
<tr>
<td>12.</td>
<td>IndianaAIM is updated to comply with ALJ decisions and updates are mailed to all involved parties.</td>
<td>HCE Prior Authorization Specialist</td>
</tr>
<tr>
<td>13.</td>
<td>Cases are filed according to decision and date of decision.</td>
<td>HCE Hearings and Appeals Support Specialist</td>
</tr>
<tr>
<td>14.</td>
<td>If any party disagrees with the ALJ decision, an agency review may be requested.</td>
<td>Any involved party</td>
</tr>
</tbody>
</table>
FIGURE IV-4

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURE

The requesting provider disagrees with the administrative review decision. An appeal must be filed within 30 days, plus three days mail time, from receipt of that decision. (405 IAC 1.1)

Written appeal received by Indiana Family and Social Service Administration, H&A Dept.

A member, who disagrees with the original prior authorization decision, may file an appeal, requesting an ALJ Hearing, within 30 days, plus three days mail time, from the date of receipt of the decision.

FSSA schedules the ALJ hearing and notifies HCE, the provider, the member and any other involved party(s).

HCE receives notification of the appeal from FSSA.

HCE PA Specialist and Medical Director, or appropriate consultant, attempts to negotiate a settlement with the appellant by teleconference.

Unsuccessful Teleconference

All parties notified of ALJ decision within 60 days of the filing of the appeal.

HCE PA specialist prepares appeal packet, represents the state at the ALJ hearing.

1. Teleconference is successful.
2. IndianaAIM is updated and a copy of the update is mailed and/or faxed to all involved parties by the HCE PA specialist.

All original documentation pertaining to the issue of the appeal is filed by the date of the ALJ decision and retained per the approved Record Retention and Disposition Schedule by the support specialist.

The support specialist updates the information in the Access Log.

Within five days, HCE H&A forwards any info relating to the appeal to FSSA.

Appellant voluntarily withdraws the appeal in writing to FSSA.

FSSA mails confirmation of the withdrawal to all involved parties.

Any involved party who disagrees with the ALJ hearing decision, may request an Agency Review.

FSSA mails confirmation of the withdrawal to all involved parties.

Unsuccessful

All parties are notified of ALJ decisions when completed, by the office of the IFSSA.

Approved (no further issue).

Any involved party who disagrees with the ALJ hearing decision, may request an Agency Review.

The PA specialist updates IndianaAIM and mails and/or faxes updated letters to all involved parties.
D. Agency Review

The member, the provider, or HCE may appeal the administrative hearing decision by requesting an Agency Review. This is the last step before judicial review.

The HCE staff may not submit new documentation. If HCE chooses to provide any input, a “memorandum of law” may be submitted to the hearings and appeals department at the State, to be presented at the agency review. Copies are provided to all involved parties.

1. Following receipt of the agency review decision, the IndianaAIM system is updated, as is the Access log.

2. A copy of the IndianaAIM decision letter is mailed to both the member and the provider.

3. The decision is placed in the case file under the title, “Agency Review Decisions” by the member’s last name. These files can be kept in the long-term storage facility, but apart from all other records. In the event that either the member or the provider should appeal this decision by requesting a Judicial Review, it may be necessary to access these records up to four years after the date of the agency review. Therefore, it is imperative that all files for which an agency review was requested are readily accessible.

HCE retains all original documents. Only copies of documents are included in any appeal packet or documentation otherwise forwarded to any entity. All records for appealed services are filed by the hearings and appeals support specialist, and destroyed only after the time limit has expired for any future appeal.

Refer to Exhibits IV-1 through IV-25, for examples of review letters applicable to appeals.
EXHIBIT IV-1

Administrative Review Letter #1
Decision Modified

Date
Address
Re:
RID:
PA #:
Dates of Service:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-3-11 (4), stipulates that the Office’s decision will be based upon medical necessity as determined by current professional standards commonly held to be applicable to the case; review of criteria set out in the IAC; medical and social information provided on the request form or documentation accompanying the request form; and an individual case-by-case review of the request.

Administrative review by ________ finds ________. Therefore, our original decision has changed to approve a portion of the service(s) requested. Enclosed is the updated Prior Authorization decision letter that will also be sent to the member.

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any Indiana Health Coverage Programs (IHCP) covered service. The member may request an Administrative Hearing without first requesting an Administrative Review.

After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing. Attached to the provider’s request for hearing should be the following documentation:

1. A letter summarizing the requested services, the member’s name, the RID (Recipient Identification Number) and Prior Authorization number.
2. Documentation, including any pertinent medical records, consultations, or other records to support the appellant’s case, not previously submitted
3. A copy of the Prior Authorization form (if applicable).
Either request must be in writing, and mailed to the following address within thirty (30) days, plus three (3) days mailing time, of the receipt of the notice of the Administrative Review decision.

MS04  
Indiana Family and Social Services Administration  
Office of Family Resources  
402 W. Washington Street, Room W392  
Indianapolis, IN 46204  
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Medical Director  
Indiana Medical Policy and Review Services

Enclosure
EXHIBIT IV-2

Administrative Review Letter #2
Decision Approved

Date: 

Address: 

Re: 
RID: 
PA #: 
Dates of Service: 

Dear: 

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-3-11 (4), stipulates that the Office’s decision will be based upon:

- medical necessity as determined by current professional standards commonly held to be applicable to the case
- review of criteria set out in the IAC
- medical and social information provided on the request form or documentation accompanying the request form
- and an individual case-by-case review of the request.

The submitted documentation has been reviewed by Health Care Excel staff. After review of the documentation submitted, the requested (services) have been approved. Enclosed is a copy of the Prior Authorization decision letter that will be mailed to the member.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services

Enclosure
EXHIBIT IV-3

Administrative Review Letter #3
Decision Upheld

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-3-11 (4), stipulates that the Office’s decision will be based upon medical necessity as determined by current professional standards commonly held to be applicable to the case; review of criteria set out in the IAC; medical and social information provided on the request form or documentation accompanying the request form; and an individual case-by-case review of the request.

Administrative Review by a (insert specialty) consultant finds (insert decision text). Therefore, the original decision has been reaffirmed. Enclosed is a copy of the Prior Authorization decision letter that will be mailed to the member.

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any Medicaid covered service. The member may request an Administrative Hearing without first requesting an Administrative Review.

After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing. Attached to the provider’s request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member’s name, Recipient Identification Number (RID), and Prior Authorization (PA) number.

2. Documentation, including any pertinent medical records, consultations, or other records to support the appellant’s case, not previously submitted.

3. A copy of the PA form (if applicable).

Either request must be in writing, and mailed to the following address within thirty (30) days of the receipt of the notice of the Administrative Review decision.
EXHIBIT IV-3 – continued

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Medical Director
Indiana Medical Policy and Review Services

Enclosure
EXHIBIT IV-4

Administrative Review Letter #4
Psychiatric Admission – Late Submission of Certification of Need

Date

Address

Re: RID: PA #: Admission Date:

Dear:

This letter is in response to your request for an Administrative Review of the (insert description) of services for the above-named member. Our medical staff has reviewed your request and has reaffirmed the original decision.

The Indiana Administrative Code (IAC), 405 IAC 5-20-5, stipulates that Indiana Health Coverage Programs (IHCP) reimbursement is available for mental health services provided in an inpatient psychiatric facility only when the member’s need for admission has been authorized. The authorization must be completed as follows.

1. By the attending physician or staff physician.

2. By telephone prior authorization review prior to admission for an individual who is a member of IHCP when admitted to the facility as a non-emergency admission, to be followed by a written Certification of Need (1261A) within ten (10) business days of admission.

3. By telephone prior authorization review within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written Certification of Need within fourteen (14) business days of admission. If the provider fails to call within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, IHCP reimbursement shall be denied for the period from admission to the actual date of notification.

4. In writing, within ten (10) business days after receiving notification of an eligibility determination for individuals applying for IHCP while in the hospital, and covering the entire period for which IHCP reimbursement is being sought.
EXHIBIT IV-4 – continued

5. In writing, at least every 60 days after admission, or as requested by the state IHCP agency or its designee, to re-certify that the patient continued to require inpatient psychiatric hospital services.

The Indiana Administrative Code, 405 IAC 5-20-7, stipulates that IHCP reimbursement will be denied for any days during which the inpatient psychiatric hospitalization is found not to have been medically necessary, and if the required documentation is not submitted in compliance with the specified timeframes in accordance with the provisions in 405 IAC 5-20-5.

The member was admitted (insert date). The Certification of Need (1261A) was signed by the physician on (insert date), and received by HCE on (insert date). This exceeds the allotted time limit. Therefore, the entire hospital stay has been denied.

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any Medicaid covered service. The member may request an Administrative Hearing without first requesting an Administrative Review.

The Indiana Administrative Code, 405 IAC 5-7-2, stipulates that a provider must request an administrative review of denial or modification of a prior authorization decision before filing an appeal under 405 IAC 1-1. The provider who submitted the initial prior authorization request must initiate an administrative review request within seven (7) working days of the receipt of modification or denial. The request must be forwarded, in writing, to the contractor; telephone requests will not be accepted.

After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing. Attached to the provider’s request for hearing should be the following documentation.

1. A letter summarizing the requested services, the member’s name, Recipient Identification (RID) number and Prior Authorization number.

2. Documentation, including any pertinent medical records, consultations, or other records to support the appellant’s case, not previously submitted.

3. A copy of the Prior Authorization form (if applicable).

Either request must be in writing, and mailed to the following address within 30 days of the receipt of the notice of the administrative review decision.
EXHIBIT IV-4 – continued

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
EXHIBIT IV-5

Administrative Review Letter #5
The Member was Eligible on Dates of Service
Request for Retroactive Authorization Denied

Date

Address

Re:
RID:
PA #:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-3-7 states, “The provider assumes responsibility for verifying the member’s eligibility on the service date.”

The Indiana Administrative Code 405 IAC 5-3-9 provides the circumstances under which prior authorization will be given after services have begun or supplies have been delivered. These are: (1) pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member’s Indiana Health Coverage Programs (IHCP) card. (2) Mechanical or administrative delays or errors by the contractor or county Office of Family Resources. (3) Services rendered outside Indiana by a provider who has not yet received a provider manual. (4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service. (5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:

(A) The provider’s records document that the member refused or was physically unable to provide the member identification (RID or IHCP) number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered.

(C) The provider submitted the request for prior authorization within sixty (60) days of the date IHCP eligibility was discovered.

The submitted records indicate the services were provided starting (insert date). This member was eligible on this date. Prior authorization was not requested until (insert date). There is no indication any of the exceptions listed in the Indiana Administrative Code have been met. Therefore, the previous denial is reaffirmed.
EXHIBIT IV-5 – continued

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any IHCP covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider’s request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member’s name, Member Identification Number (RID) and Prior Authorization (PA) number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant’s case (not previously submitted).

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1-3, either request must be in writing and mailed to the following address within thirty-three (33) days of the receipt of the Administrative Review decision.

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services

Enclosure
EXHIBIT IV-6

Administrative Review Letter #6
Appeal Resolved Prior to Scheduled Hearing

Date

MS04
Hearing Supervisor
State of Indiana Family and Social Services Administration
Office of Family Resources
402 West Washington Street, Room W392
Indianapolis, IN 46204

Recipient:
RID:
PA #:

Dear:

The issue(s) surrounding the appeal filed on behalf of the above-named member has been resolved. Please dismiss the appeal.

Date of scheduled hearing:
Place of scheduled hearing:
HCE Approved:

Enclosed is the updated decision form reflecting the approval and updates made to Indiana AIM. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(Name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

Enclosure(s)
EXHIBIT IV-7

Administrative Review Letter #7
Delinquent Submission Following 30 Day Suspension

Date

Address

Re:
RID:
PA #:

Dear:

This is in response to your request for an Administrative Review for the above-named member. Our records show that the request for prior authorization was submitted within the designated time limitations. A decision could not be rendered based on the information provided. Additional information was requested. You were notified that 30 days would be allowed for the submission of the requested information. If the requested information was not received within the 30 day limitation, the request would be denied.

Our records show this decision was made on (insert date). The decision letter was mailed to you and to the member on the following business day. The submitted information was received in our offices on (insert date). This exceeds the stated time limitation. Therefore, your request remains denied.

The Indiana Administrative Code (IAC), 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any Indiana Health Coverage Programs (IHCP) covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider’s request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member’s name, Member’s Identification Number (RID) and Prior Authorization number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant’s case (not previously submitted).

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1.3, either request must be in writing and mailed to the following address within thirty (30) days, plus three (3) days mailing time, of the receipt of the Administrative Review decision.

10/31/2003
Exhibit IV-7 – continued

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services

Enclosure
EXHIBIT IV-8
Administrative Review Letter #8
More than One Year Elapsed from Enrollment in Medicaid

Date

Name
Address
City, State, Zip

Recipient:
RID:
PA#:
Date(s) of service:

Dear:

This letter is in response to your request for an Administrative Review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. Our medical staff has reviewed the request and the (modification/denial) of services has been reaffirmed.

Indiana Administrative Code (IAC), 405 IAC 5-3-9, stipulates authorization for payment will be given after services have begun or supplies have been delivered under certain circumstances. One of those circumstances is pending or retroactive member eligibility. The prior authorization request must be submitted within one year from the date eligibility is established or within 60 days of the date IHCP eligibility was discovered. The same standards will be applied as would have been applied if the authorization had been requested before the provision of services or supplies. The prior authorization request may request services or supplies retroactively for up to one year from the date the member was enrolled.

Our records indicate this member was enrolled on (insert date). The request for prior authorization was received on (insert date). Since more than one year from the enrollment has elapsed, your request is considered untimely and cannot be honored.

If you disagree with this denial, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be in writing and filed within thirty (30) days, plus three (3) days mailing time, of the receipt of this letter. Such an appeal must be mailed to the following address.

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals
Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
EXHIBIT IV-9
Administrative Review Letter #9
Late Administrative Review Request Following Denied Certification of Need

Date

Recipient:
RID:
PA#:
Admission Date:

Dear:

This letter is in response to your request for an Administrative Review of the decision made by Indiana Health Coverage Programs (IHCP) for the above named member. The Indiana Administrative Code (IAC), 405 IAC 5-7-2 (b), states, “An administrative review request must be initiated within seven working days of the receipt of modification or denial by the provider who submitted the prior authorization request. The request must be forwarded in writing to the contractor; telephone requests will not be accepted.”

The Certification of Need (1261A) was denied by IHCP on (insert date) and mailed on or about (insert date). With three days added for delivery of first class U.S. mail, you had a total of 10 days to initiate a request for Administrative Review by filing your request on or before (insert date). Your request was postmarked on (insert date) and delivered on (insert date). This exceeds the allotted time period for initiation of an Administrative Review. Therefore, we are unable to consider your request.

If you disagree with this determination regarding your request for Administrative Review, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be in writing and filed within thirty (30) days, plus three (3) days mailing time, of the receipt of this letter. Such an appeal must be mailed to the following address.

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals
Exhibit IV-9 – continued

Should you request reconsideration of this denial of review; the issue at a hearing will be whether you qualify under 405 IAC 5-7-2 (b) to obtain review of the original prior authorization decision.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
EXHIBIT IV-10

Administrative Review Letter #10
Request for Additional Information

Date:
Address:
Re:
RID:
PA#:
Dates of Service:

Dear:

This is in response to your request for an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. We have received the documentation mailed to us. However, in order to conduct the review, the following additional information is requested:

- **(List each document needed)**

The Indiana Administrative Code (IAC), 405 IAC 5-7-3 (b) and (c), stipulates that the administrative review will assess medical information pertinent to the case in question and the review decision of the IHCP contractor will be rendered within seven (7) working days of request. The time limit for issuance of a decision does not commence until the provider submits a complete request, including all necessary documentation required by the contractor to render a decision.

This appeal will be held for 30 calendar days, awaiting the requested information. Failure to comply by submitting the requested information will result in a denial of your request for administrative review.

Thank you in advance for your prompt attention to this request. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of Specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services
EXHIBIT IV-11

Administrative Review Letter #11
Untimely Administrative Review Request

Date

Address

RE:
RID:
PA#:
Dates of Service:

Dear:

Pursuant to Indiana Administrative Code (IAC) 405 IAC 5-7-2, you have requested an administrative review of the prior authorization decision for the above-named member. This law states the request must be initiated within seven (7) days (plus three (3) days for mail) from the date the modification or denial is received by the provider or member.

Our records show this denial was made on (insert date). Your request for administrative review was received in our office (insert date). This exceeds the time limit as specified in the Indiana Administrative Code.

Pursuant to 405 IAC 5-7-2(a), you may file an appeal of this decision under 405 IAC 1.1-1.3. Your appeal request must be filed in writing within thirty (30) days, plus three (3) days mailing time, from the date on this letter. Please mail your appeal request to:

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 West Washington Street, Room W392
Indianapolis, Indiana 46204
Attention: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
EXHIBIT IV-12

Administrative Review Letter #12
Response to Letter of Intent to File an Administrative Review

Date

Address

Re:
RID #:
PA #:
Dates of Service:

Dear:

This is in response to your Letter of Intent to File an Administrative Review, received in our office on (insert date). The issue is that of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-7-3 (b) and (c), stipulates the review will assess medical information pertinent to the case in question and the review decision of the IHCP contractor will be rendered within seven (7) business days of the request. The time limit for issuance of a decision does not commence until the provider submits a complete request, including all necessary documentation required to render a decision.

The entire medical record is needed for all inpatient hospitalizations, including acute care, psychiatric and rehabilitation hospitalizations. The submitted documentation must include the typed physician’s discharge summary, therapy notes, mental health commitment documentation, and documentation of referral to Child Protective Services, including notification from the County Office of Family Resources indicating an investigation was conducted and completed.

All pertinent documentation must be submitted to Health Care Excel within forty-five (45) calendar days of discharge. Failure to comply will result in a denial of your request for administrative review. Please submit the required documentation so that we may review the request.

Thank you for your cooperation. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services
EXHIBIT IV-13

Administrative Review Letter #13
Denied Untimely Request – No Letter of Intent

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:
This is in response to your request for an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. Your request has been denied because of the late submission of the request. The Indiana Administrative Code (IAC), 405 IAC 5-7-2 (b), stipulates that an administrative review request must be initiated within seven (7) business days of the receipt of modification or denial by the provider who submitted the prior authorization request.

Our records indicate the Prior Authorization Decision form was mailed or faxed to you on (insert date). Allowing three (3) additional days for delivery of first class United States mail, you had a total of ten (10) days to initiate your request for administrative review. If you did not make the request because the member had not yet been discharged from your facility, a Letter of Intent to Request an Administrative Review must have been filed within the allowed ten (10) days. Once the letter of intent has been submitted, you are allowed an additional forty-five (45) calendar days from the date of discharge in which to submit the entire medical record along with your request for administrative review.

If the letter of intent had been received, your request would not be viewed as untimely. However, we have no letter of intent on file for this prior authorization decision. Your request for administrative review is postmarked (insert date) and was received on (insert date). This exceeds the time limit for the initiation of an administrative review.

If you disagree with this determination, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be filed, in writing, within thirty (30) days from the receipt of this letter and mailed to the following address.
Exhibit IV-13 – continued

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Should you request reconsideration of this denial of administrative review; the only issue at a hearing will be whether you qualify under 405 IAC 5-7-2 (b) to obtain an administrative review of the original prior authorization decision.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of Specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services
EXHIBIT IV-14
Administrative Review Letter #14
Administrative Review Request Submitted Untimely Following Inpatient Admission
Letter of Intent Filed

Dear:

This is in response to your letter of intent to file an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member’s above admission. Your letter of intent was received on (insert date). The medical records department at your hospital indicates the member was discharged from your facility on (insert date). As of today’s date, no medical records have been received. This exceeds the allowed time period (45 calendar days after discharge) for submission of the complete chart for review. Therefore, we are unable to consider your request.

If you disagree with this determination, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be filed in writing, within thirty (30) days from the receipt of this letter and mailed to the following address.

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Should you request reconsideration of this denial of administrative review; the only issue at a hearing will be whether you qualify under 405 IAC 5-7-2 (b) to obtain an administrative review of the original prior authorization decision.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services
EXHIBIT IV-15

Administrative Review Letter #15
Denied Incorrect Requestor

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:

This is in response to your request for an Administrative Review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. Your request cannot be processed for the following reasons: The Indiana Administrative Code (IAC), 405 IAC 5-3-10, stipulates that “prior authorization requests may be submitted by any of the following: doctor of medicine, doctor of osteopathy, dentist, optometrist, podiatrist, chiropractor, psychologist endorsed as a health service provider in psychology (HSPP), home health agency or hospital.”

405 IAC 5-7-2 stipulates that an “administrative review request must be initiated by the provider who submitted the prior authorization request.” Since your organization is not the provider that may request a prior authorization without a physician’s signature, your organization does not meet the requirements to request an administrative review of the prior authorization decision.

Also, please note that 405 IAC 5-31-4 (3) states, “The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients, is included in the nursing facility per diem.” (may be deleted if patient not in LTC facility)

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services
EXHIBIT IV-16

Administrative Review Letter #16
ALJ Hearing – Issue Resolved

Date:

Appellant’s name
Appellant’s address
Appellant’s city/state/zip

Re:
RID:
PA#:
Date(s) of Service:

Dear:

This is to notify you that a teleconference was held on __/__/__ with ___________ in an attempt to resolve the issue(s) of the appeal filed for the above-named member.

During this communication, it was agreed that the request for prior authorization of _____________ be modified/approved. Therefore, we are approving ___ additional units for dates of service __/__/__ to __/__/__.

If you agree with this decision, you may wish to withdraw your appeal. Your written request to withdraw must be mailed to the following address early enough that it will be received prior to the __/__/__ scheduled hearing date.

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

If you disagree with this determination, the hearing will proceed as scheduled.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Medical Director
Indiana Medical Policy and Review Services
EXHIBIT IV-17

Administrative Review Letter #17
ALJ – Unable to Resolve Issue Prior to Hearing

Date:

Appellant’s name:
Appellant’s address:
Appellant’s city/state/zip

Re:
RID:
PA#:
Date(s) of Service:

Dear:

This is to notify you that a teleconference was held on __/__/__ with ______________ in an attempt to resolve the issue(s) of the appeal filed for the above-named member. During this communication we were unable to reach an agreement. Therefore, no additional units are being authorized, and the Administrative Law Judge hearing scheduled for __/__/__ will be conducted.

If you should wish to withdraw the appeal, your written request to withdraw must be mailed to the following address early enough that it will be received prior to the scheduled hearing date.

MS04
Indiana Family and Social Service Administration
Office of Family Resources
402 W. Washington Street, W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

If you wish to proceed with the hearing, you must be either be present at the time of the hearing or request that the hearing be rescheduled. Please be advised that failure to appear at the scheduled hearing will result in dismissal of the appeal.
Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Medical Director
Indiana Medical Policy and Review Services
EXHIBIT IV-18

Administrative Review Letter #18
Required Information Not Received – Request Denied

Date:

Provider name
Provider address
Provider city/state/zip

Re:
RID:
PA#:
Dates of service:

Dear:

This is in response to your request for an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. Although your request for administrative review was received within the time limit required, the review could not be conducted because additional information was necessary in order to assess the medical information pertinent to the case.

A letter was mailed to you on date listing the requested information and also stating that your appeal would “be held for thirty (30) calendar days, awaiting the requested information. Failure to comply by submitting the requested information will result in a denial of your request for administrative review.” As of this date, no information has been received in our office. Therefore, your request for administrative review has been dismissed and the decision remains unchanged.

If you do not agree with this decision, or if you mailed the requested information prior to the date of this letter, you may call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511 for further discussion or clarification. Thank you for your support of the Indiana Health Coverage Programs.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services
EXHIBIT IV-19

Administrative Review Letter #19
Recipient Not Eligible

Date:

Provider name:
Provider address:
Provider city/state/zip

Re:
RID:
PA#:
Dates of service:

Dear Sir or Madam:

This is in response to your request for an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-2-23, defines “Recipient” (Medicaid Recipient) as “an individual who has been determined by the office or the county office to be eligible for payment of medical or remedial services pursuant to IC 12-15.” 405 IAC 5-3-7 states, “The provider assumes responsibility for verifying the recipient’s eligibility on the service date.”

The above-named member was not eligible for Indiana Medicaid on the requested date(s) of service. Therefore, your request for administrative review is being dismissed.

If you disagree with this determination, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be filed in writing, within thirty (30) days, plus three (3) days mailing time, from the receipt of this letter, and mailed to the following address.

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Should you request reconsideration of this denial of administrative review, documentation must be presented showing that you or your office were given eligibility information that was incorrect.
Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

*(name and credentials of Specialist)*
Prior Authorization Specialist
Indiana Medical Policy and Review Services
EXHIBIT IV-20

Administrative Review Letter #20
Untimely Prior Authorization Request

Date

Address

Re:
RID:
PA #:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC) 405 IAC 5-3-8 states, “Except as provided in section 2 of this rule, prior to providing any Indiana Health Coverage Programs (IHCP) service that requires prior authorization, the provider must submit a properly completed IHCP prior review and authorization request and receive written notice indicating the approval for provision of such service.” The rules also state, “It is the responsibility of the provider to submit new requests for prior authorization for ongoing services in a timely manner before the current authorization period expires in order to ensure that services are not interrupted.”

The Indiana Administrative Code 405 IAC 5-3-9 provides the circumstances under which prior authorization will be given after services have begun or supplies have been delivered. These are: (1) pending or retroactive recipient eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member’s IHCP card. (2) Mechanical or administrative delays or errors by the contractor or county office of family and children. (3) Services rendered outside Indiana by a provider who has not yet received a provider manual. (4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service. (5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:

(A) The provider’s records document that the member refused or was physically unable to provide the member identification (RID or IHCP) number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered.

(C) The provider submitted the request for prior authorization within sixty (60) days of the date IHCP eligibility was discovered.
The submitted records indicate the services were provided starting *(insert date)*. Prior authorization was not requested until *(insert date)*. There is no indication any of the exceptions listed in the Indiana Administrative Code have been met. Therefore, the previous denial is reaffirmed.

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any IHCP covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider’s request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member’s name, Member Identification Number (RID), and Prior Authorization number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant’s case (not previously submitted).

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1-3, either request must be in writing and mailed to the following address within thirty (30) days, plus three (3) days mailing time, of the receipt of the Administrative Review decision.

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
EXHIBIT IV-21

Administrative Review Letter #21

Untimely Request for Administrative Review

Date

Address

Re:

RID:

PA #:

Dates of Service:

Dear:

Pursuant to 405 IAC 5-7-2, you have requested an administrative review of the prior authorization decision for the above-named recipient. This law states the request must be initiated within seven days (plus 3 days for mail) from the date the modification or denial is received by the provider or recipient.

Our records show this denial was made on (insert date). Your request for administrative review was not received in our office until (insert date). This exceeds the time limit as specified in the Indiana Administrative Code. Please note, the documentation received did not indicate this request met any of the criteria for retroactive authorization listed in 405 IAC 5-3-9.

Pursuant to 405 IAC 5-7-2(a), you may file an appeal of this decision under 405 IAC 1.1-1-3. Your appeal request must be filed in writing within thirty-three (33) days from the date on this letter. Please mail your appeal request to:

MSO4
Indiana Family and Social Services Administration
Office of Family Resources
402 West Washington Street, Room 392
Indianapolis, Indiana 46204
Attention: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
EXHIBIT IV-22

Administrative Review Letter # 22
Additional Information Required, Not Received, Original Decision Reaffirmed

Date
Address
Re:
RID:
PA #:
Date of Service:

Dear:

This is in response to your request for an Administrative Review for the above-named recipient. Our records show that the request for prior authorization was submitted within the designated time limitations. A decision could not be rendered based on the information provided. Additional information was requested. You were notified that thirty (30) days would be allowed for the submission of the requested information and that if the requested information was not received within the thirty (30) day limitation, the request would be denied.

Our records show this decision was made on (insert date). The decision letter was mailed to you and to the member on the following business day. The submitted information was received in our office (insert date). This surpasses the stated time limitation. Therefore, your request remains denied/modified.

The Indiana Administrative Code (IAC), 405 IAC 5-7-1, stipulates that a recipient or provider may appeal the modification or denial of any Medicaid covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider’s request for hearing should be the following information:

1. A letter summarizing the requested service(s), the recipients name, Recipient Identification Number (RID) and Prior Authorization number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant’s case (not previously submitted)

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1-3, either request must be in writing, and mailed to the following address within 33 days of the receipt of the Administrative Review decision.
EXHIBIT IV-22 – continued

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
EXHIBIT IV-23

Administrative Review Letter #23
Hospice Request Submitted Untimely

Date:

Address:

Re:
RID:
PA #:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC) 405 IAC 5-34-4 (g) states, “In order to obtain authorization and reimbursement for hospice services, the provider must submit the documentation listed in this section to the office or its contractor within ten (10) business days of the effective date of the recipient’s election, and within ten (10) business days of the beginning of the second and subsequent benefit periods if required under this section.”

The Indiana Administrative Code 405 IAC 5-34-4 provides the circumstances under which prior authorization will be given after services have been furnished. These are:

1. Pending or retroactive recipient eligibility. The hospice authorization request must be submitted within twelve (12) months of the date of the issuance of the recipient’s Medicaid card.

2. The provider was unaware that the recipient was eligible for services at the time services were rendered. Hospice authorization will be 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 the member identification number,
   - the provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered,
   - and the provider submitted the request for prior authorization within sixty (60) days of the date IHCP eligibility was discovered.

The submitted records indicate the services were provided starting _______. Prior authorization was not requested until _______. There is no indication any of the exceptions listed in the Indiana Administrative Code have been met. Therefore, the previous denial is reaffirmed.

R1 – 4/28/2006 IV-53
EXHIBIT IV-23 (Continued)

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any IHCP covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider’s request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member’s name, Member Identification Number (RID), and Prior Authorization number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant’s case (not previously submitted).

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1-3, either request must be in writing and mailed to the following address within 33 days of the receipt of the Administrative Review decision.

MS04
Indiana Family and Social Services Administration
Office of Family Resources
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
EXHIBIT IV-24

Administrative Review Letter #24
Hospice Administrative Review Request Received Untimely

Date

Address

Re:
RID:
PA #:
Date(s) of Service:

Dear:

Pursuant to Indiana Administrative Codes 405 IAC 5-7-2 and 405 IAC 5-34-4.1, you have requested an administrative review of the prior authorization decision for the above-named member. These laws state the request must be initiated within seven days (plus three days for mail) from the date the modification or denial is received by the provider or member.

Administrative review finds this denial was made on ____. Your request for administrative review was not received in our office until ____. This exceeds the time limit as specified in the Indiana Administrative Code.

Pursuant to 405 IAC 5-7-2(a), you may file an appeal of this decision under 405 IAC 1.1-1-3. Your appeal request must be filed in writing within thirty-three (33) days from the date on this letter. Please mail your appeal request to:

MSO4
Indiana Family and Social Services Administration
Office of Family Resources
402 West Washington Street, Room 392
Indianapolis, Indiana 46204
Attention: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Manager, Prior Authorization
Indiana Medical Policy and Review Services
LETTER OF RATIONALE

DATE:
RE:
RID:
PA#:

Dear Administrative Law Judge:

1. **ACTION(S) REQUESTED BY APPELLANT**

   *(insert appropriate description)*

2. **ACTION(S) / DECISION(S) TAKEN BY MEDICAID**

   *(insert appropriate description)*

3. **RATIONALE FOR ACTION(S) / DECISION(S) TAKEN BY MEDICAID**

   a.  *Background description including eligibility information* (Exhibit #) [includes Face sheet, print of eligibility screen, print of prior authorization history screen]

   b.  The submitted documentation indicates *further description as necessary* (Exhibit #)

   c.  *further description as necessary* (Exhibit #)

   d.  *further description as necessary* (Exhibit #)

   e.  *further description as necessary* (Exhibit #)

   f.  *further description as necessary* (Exhibit #)
4. SPECIFIC REGULATION(S) CITED FOR ACTION(S)/DECISION(S) TAKEN

Indiana Medicaid Regulation 405 IAC 5-3-11 states: “The office’s decision to authorize, modify, or deny a given request for prior authorization shall include consideration of the following:

♦ Individual case-by-case review of the completed Medicaid prior review and authorization request form;
♦ The medical and social information provided on the request form or documentation accompanying the request form;
♦ Review of criteria set out in this section for the service requested; and
♦ The medical necessity of the requested service based upon current professional standards commonly held to be applicable to the case.”

42 CFR 440.230(d) states, “The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.”

Additional citations as appropriate to specific case

5. SUMMARY

We request the decision be upheld. The submitted documentation indicates case specific rationale based on documentation cited in Section 3.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services
V. REPORTING

The following is a list of reports that HCE will create for internal purposes and for submission to the State. Reports will be developed to meet the needs of the Indiana Medical Policy and Review Services contract, and will be utilized to measure, monitor, evaluate, and improve the program. Reports may be defined, and redefined, and are therefore subject to change.

♦ Monthly Responses to Inquiries Report.
  ➢ Criteria sent to providers, date requested, criteria requested, date mailed or faxed, responsible person.
  ➢ Inquiries received from the State or providers, or government officials (date of inquiry, date of response).
  ➢ Report of PA forms sent to providers (date of request, date mailed).

♦ PA Staffing Report.

♦ PA Bariatric Report

♦ PA Transplant Report

♦ PA Consultant Report.

♦ TBI Monthly Status Report.

♦ Quarterly Trend Analysis. Sent to the State to evaluate authorized services, the number of services suspended, the number of appeal requests by PA category, and the number of appeals that are successful. Upon completion of the qualitative and quantitative analysis, HCE shall provide recommendations to the State for suggested policy changes. The report shall be delivered within 30 (thirty) days of the end of the quarter.

♦ Weekly Status Report (complementary to the On-Demand report) – gives a synopsis of the activity of the department, including hearings attended. ACD phone reports will include abandonment rates, average time to answer, average talk time, and average hold time.

♦ Annual Business Plan (which includes cases referred to SUR).

♦ Report of Cases Referred to SUR.
♦ PA Monitoring Report (for monitoring reviewer, consultant, and medical director decisions).

♦ Monthly report to the State of materials related to PA submitted to the core contractor for inclusion in IHCP bulletins, etc.


Other reports will be obtained from the IndianaAIM system. They will include the following reports.

**Prior Authorization Daily 7-10 Days Old Report (PAU-0002-D)**

This report includes all prior authorization requests that are seven to 10 (ten) business days old that have not had a final decision made on them. These will have a decision status of “E.” The PA number, RID number, provider number, assignment code, Julian Date received, and Days Aged are included. The oldest day prints first. This report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.


This report includes all prior authorization requests that have been automatically approved. The assignment code, PA number, RID number, provider number, and date received, with the oldest day printing first, are included. The total number of prior authorizations for each assignment code for the previous month and previous year are also displayed. A total calculation of prior authorizations that have been automatically approved for all assignment codes for the previous month and previous year are summarized at the end of the report. This report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

**Prior Authorization Monthly Activity Report (PAU-0005-M)**

The Prior Authorization Monthly Activity Report is printed monthly and includes all activity on prior authorization requests with Julian dates received for that month. This includes all prior authorization requests that have been requested, rejected, approved, modified, and denied. The assignment codes and the service codes along with the total for each category are included, as well as the total of all categories and total year-to-date of all categories. The report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

The Prior Authorization Monthly Administrative Review report is printed monthly and includes all activity on prior authorization requests that have gone through the Administrative Review process. These are prior authorizations with a decision status of “X,” modified through administrative review, and “Y,” approved through administrative review, and prior authorizations that have not been changed because the administrative review request was denied. The report gathers data from the drop down window box, PA Administrative Review. All activity with an Administrative Review decision date for the month will print on the report. The report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

Prior Authorization Monthly Hearings and Appeals Report (PAU-0007-M)

The Prior Authorization Monthly Hearings and Appeals Report is printed monthly and include all activity on prior authorization requests that have gone through the hearings and appeals process. These are prior authorizations with a decision status of “C,” decision overturned by Administrative Law Judge (ALJ), “L,” restored waiting appeal, “S,” dismiss no hearing, approve, “T,” dismiss no hearing, modified, “U,” dismiss no hearing denied, “V,” modified through court, and “W,” decision upheld by ALJ. This report will gather data from the drop down window box, PA Appeal. All activity with an appeal decision for the month will print on the report. This report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

Prior Authorization Monthly Utilization Report (PAU-0008-M)

This report prints monthly and includes the number of times a particular service was requested, approved, modified, denied, and rejected for a particular provider. This report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

Psychiatric Admissions Analysis Report (PAU-0009-M)

This report includes all admissions to Freestanding Psychiatric Facilities and Psychiatric Wings of Acute Care Hospitals. These are included together under provider specialty 011. The report lists psychiatric admissions by age group, and covers three options: 21 years and under; 22-64 years; and 65 years and older. Indiana Health Coverage Programs do not authorize psychiatric admissions to Freestanding Psychiatric Facilities between the ages of 22 and 65. The report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.
**Psychiatric Admissions by Diagnosis Analysis Report (PAU-0010-M)**

This report lists all admissions by psychiatric diagnosis to Freestanding Psychiatric Facilities and Psychiatric Wings of Acute Care Hospitals. These are included together under provider specialty 011. The report lists psychiatric admissions by age group, and covers three options: less than 22 years; 22-64 years; and 65 years and older. Indiana Health Coverage Programs do not authorize psychiatric admissions to Freestanding Psychiatric Facilities between the ages of 22 and 65. It is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

**Psychiatric Admissions by Facility Analysis Report (PAU-0011-M)**

This report is a quarterly report and lists all psychiatric admissions, by provider number and name, to Freestanding Psychiatric Facilities and Psychiatric Wings of Acute Care Hospitals. These are included together under provider specialty 011. This report lists psychiatric admissions by age group, and covers three options: 21 years and under; 22 to 64 years; and 65 years and older. Indiana Health Coverage Programs do not authorize psychiatric admissions to Freestanding Psychiatric Facilities between the ages of 22 and 65. The report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

**Prior Authorization for Transportation Services Report (PAU-0012-M)**

This report is a monthly report that lists the total number of transportation services (i.e., trips) that have been requested, approved, modified, and denied. The report is divided into two sections. The first section lists all trips in excess of 20 (twenty) per 12 (twelve) months, and the second section lists all trips in excess of 49 (forty-nine) miles.

**Prior Authorization Transportation Exemptions Analysis Report (PAU-0013-M)**

This report is printed monthly and captures data from the paid claims file. The report provides a summary, by provider, of the number of transportation services (i.e., trips) paid by IHCP which are not counted towards the 20 (twenty) trip limit.

**Prior Authorization Transportation Limits Analysis Report (PAU-0014-M)**

This report is a quarterly report that provides a summary of members receiving transportation services for both the previous quarter and previous 12 (twelve) months. It includes the number of trips paid for members exceeding the 20 (twenty) trips per 12 (twelve) month limit, and the number of providers used by members who exceeded the 20 (twenty) trip limit.

This report is a monthly report that includes the number of times a particular service was approved, by provider type, provider number, assignment category, and service code, for PCCM members. This report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

PCCM Prior Authorization Monthly Activity Report (PAU-0017-M)

This report is printed monthly and includes all activity on PCCM prior authorizations that have been requested, rejected, approved, modified, or denied based on the initial prior authorization data entry date. The assignment category and the service codes along with the total for each category and total year-to-date for each category are included, as well as the total of all categories and total year-to-date of all categories. In order to include complete data, the report will be printed on the 15th of the following month. The report is distributed to the Prior Authorization department and the Program Director. It is available in On-Demand.

Package C (Chip) Prior Authorization Monthly Activity Report (PAU-0105-M)

This report is printed monthly and includes all activity on Package C (Chip) prior authorizations that have been requested, rejected, approved, modified, or denied based on initial prior authorization data entry date. The assignment category and service codes along with the total for each category and total year-to-date for each category are included, as well as the total of all categories and total year-to-date for all categories. The report is distributed to the Prior Authorization department and the program director. It is available in On-Demand.
VI. SAMPLE FORMS

HCE has established policies and procedures for the production and distribution of forms for use by members and providers. Existing forms will be distributed to providers upon request. When a need for a new or revised form is identified, the form will be developed in accordance with the policy and procedure for the development of forms. They will be coordinated with EDS and forwarded to the OMPP for approval. Providers will be notified of the new or revised form through Bulletins, Banner Pages, or other means, and forms will be distributed to providers upon request.

A. Production and Distribution of Prior Authorization Forms

The Office of Medicaid Policy and Planning (OMPP) must approve any forms distributed for use in pre-certifying services or supplies. Certain forms have been developed by the Centers for Medicare and Medicaid Services (CMS), and Health Care Excel and the OMPP have developed others.

Providers will be notified of new or revised forms through the use of Bulletins, Banner Pages, or other forms of communications as approved by the OMPP.

1. Forms may be proposed by any review or other person who identifies the need for a new or revised form.

2. The person who identifies the need will notify the Manager of Prior Authorization, in writing, of the type of form, the reason for the need, and any suggestions or revisions.

3. The Manager of PA will conduct an evaluation to determine whether a new form is required. This will be accomplished within five business days of receipt of the request.

4. If the Manager determines that the form is not needed, the requesting party will be notified of the rationale for not developing a new form.

5. If it is determined that a new form is needed, the Manager of Prior Authorization (or designee) will draft a form.
   - For revised forms, the draft of the old form should have revisions clearly indicated.
   - Instructions for completing any blanks in the form should be included with the draft copy.
6. Factors to consider in the development of the form include the following:
   ♦ citations of rules and regulations;
   ♦ readability;
   ♦ Prior Authorization requirements;
   ♦ the audience for whom it is intended; and
   ♦ ease of use.

7. The draft form will be labeled with its indications for usage, and will be routed for comment to the members of the Operations Assessment Committee.

8. Recommendations for changes can be made on the form and/or on the approval form.

9. The completed form should be returned to the Manager of Prior Authorization within 10 business days of routing.

10. The Manager of Prior Authorization will seek to resolve all areas of concern raised by staff prior to finalizing the form. If substantive or conflicting changes are suggested, the changes will be incorporated and a second draft will be routed.

11. A copy will be sent to the Fiscal Agent for feedback. Coordination activities will be undertaken, as appropriate and relevant.

12. If the changes suggested are not substantive, or subsequent to the routing of the second draft, the changes will be incorporated into the form, and the form will be forwarded to the Health Care Excel Central Point of Contact.

13. The Central Point of Contact will forward the form to the Office of Medicaid Policy and Planning for approval.
14. If the OMPP suggests changes, the Manager of Prior Authorization will incorporate these into the form.

15. Upon receipt of approval from the State, the Contract Director will authorize that the form be adopted for use.

16. Notification of providers will be accomplished through Banner Pages, Bulletins, or other media, and will be coordinated with the Fiscal Agent and the OMPP.

17. Prior Authorization staff and other appropriate staff will be notified of the existence and appropriate use of the new form, and of the implementation date. This training will occur through staff meetings, routing of the form with an explanation, or a more formal session, depending upon the complexity of the use of the form.

18. The form will be placed in the PA Operations Manual, and will be available electronically.

19. In the event that a staff member identifies a need to delete an obsolete form, the staff person will prepare a written memorandum to the Manager of Prior Authorization. The form should be specifically identified, and the rationale for the proposed deletion should be included in the memorandum.

20. All forms will contain a privacy notice at the bottom of the form.

21. Copies of forms will be sent to providers free of charge upon request.
# EXHIBIT VI-1-

## PRIOR AUTHORIZATION REQUEST FORM

### INDIANA PRIOR REVIEW AND AUTHORIZATION REQUEST

<table>
<thead>
<tr>
<th>(# REQUIRED IF MEDICAID PROVIDER) PMP (  )</th>
<th>INTERNAL USE ONLY</th>
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<tbody>
<tr>
<td>Requesting Provider # ______________</td>
<td>(1) HOME HEALTH</td>
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<tr>
<td>Name</td>
<td>(2-3) HOSP., OUT PT</td>
</tr>
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<td>(4) PHYSICIAN</td>
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<td>(5) REHAB.</td>
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<td>(7) TRANSPORTATION</td>
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<td>(9) SPEECH</td>
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<td>(10) MENTAL HEALTH</td>
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<tr>
<td>Rendering Provider # ______________</td>
<td>(11) DURABLE EQUIPMENT</td>
</tr>
<tr>
<td>Name</td>
<td>(12) OCCUPATIONAL THERAPY (OT)</td>
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<tr>
<td>Phone</td>
<td>(13) PHYSICAL THERAPY (PT)</td>
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<tr>
<td>Rendering Provider # ______________</td>
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<td>590 (  ) DOB</td>
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<td>City/State/ZIP</td>
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**MEDICAL DIAGNOSIS:** (USE OF ICD-9-CM DIAGNOSTIC CODE REQUIRED)

Primary ____________________________

Secondary __________________________

Is this a request for continuing service?  Yes ☐ No ☐ (No gap in certification) ☐

Will DME be: Purchased: ☐ Rented: ☐ Repaired: ☐

Has service or medical supply been previously provided? Yes ☐ Date ________ No ☐

__WARNING: ANY AUTHORIZATION IS VALID ONLY IF THE MEMBER IS ELIGIBLE ON THE DATE SERVICE WAS PROVIDED.__

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<tr>
<th>DATES OF SERVICE</th>
<th>SERVICE CODE (REQUIRED)</th>
<th>MODIFIER (S)</th>
<th>REQUESTED SERVICE</th>
<th>TAXONOMY</th>
<th>POS</th>
<th>UNITS</th>
<th>DOLLARS</th>
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Clinical Summary: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes as to the necessity, effectiveness, and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Home Health, and Transportation) must be attached.

_________  
Signature of Requesting Provider  
(Date) (original signature required) The above sections must be completed or the request will be rejected.

FORWARD TO:  
HCE Prior Authorization department  
P.O. Box 531520  
Indianapolis, IN 46253-1520  
Date of Submission ____________________

EDS-September 2003 / PAU-8001
**INDIANA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST**

<table>
<thead>
<tr>
<th>Provider #</th>
<th>Phone</th>
<th>RID NO</th>
<th>DOB</th>
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<td></td>
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<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>City/State/Zip</th>
</tr>
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<table>
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<tr>
<th>Dates of Service</th>
<th>Service Code</th>
<th>Requested Service</th>
<th>Place of Service</th>
<th>Units</th>
<th>Dollars</th>
</tr>
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<table>
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<tr>
<th>Caseworker</th>
<th>Phone</th>
<th>590 Program ( )</th>
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<tr>
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<table>
<thead>
<tr>
<th>Is Member Employed?</th>
<th>YES</th>
<th>NO</th>
<th>Circumstances (Place/Type):</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Is Member in Job Training?</th>
<th>YES</th>
<th>NO</th>
<th>Type of Job Training:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Dental Treatment Plan**

1. Endodontics – Indicate on diagram below the tooth/teeth to be treated by root canal therapy.

   ![Diagram of teeth]

   Does the Member have missing teeth? YES ___ NO ___
   If YES please indicate missing teeth with an X.

2. Periodontics – Evaluate the periodontal condition.

3. Partial dentures (use chart to right to indicate teeth involved)
   
   A. Date or dates of extractions of missing teeth: ______
   
   B. Which teeth (use tooth number) are to be extracted? ______
   
   C. Which teeth (use tooth number) are to be replaced? ______
   
   D. Brief description of materials and design of partial: ______

   E. Is member wearing partials now? YES ___ 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 ___ NO ___ Age of present dentures ______

5. Describe treatment if different from above:

   ____________________________________________

6. Is the member on parenteral/enteral nutritional supplements? YES ___ 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:**

   ____________________________________________

**Signature of Requesting Dentist:** ____________________________  **Date of Submission:** ____________________________

**Health Care Excel**

**Prior Authorization Department**

**P.O. Box 531520**

**Indianapolis, IN 46253-1520**

**EDS-9-06-94 / PA-U-8002**
## INPATIENT PSYCHIATRIC FAX FORM

### PRIOR AUTHORIZATION

<table>
<thead>
<tr>
<th>Prior Authorization Number:</th>
<th>Date of Submission:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Name:</td>
<td>Provider #:</td>
</tr>
<tr>
<td>Physician’s Name:</td>
<td></td>
</tr>
<tr>
<td>Facility Contact Person:</td>
<td></td>
</tr>
<tr>
<td>Telephone #:</td>
<td>Fax #:</td>
</tr>
</tbody>
</table>

### MEMBER DATA

1. Name: ___________________________  DOB: _______  Sex: _______
2. Medicaid #: _______________________  

Where does he/she live? ___________________________

Date of Admission: ___________________________

Primary Diagnosis: ___________________________  ICD-9 Code (DSM Code): _______
   (Is this diagnosis different than the one given at time of initial request?)

Reason for Admission/Recertification:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Previous Treatment History:  CD: _______  INPT Psych: _______  OUTPT Psych: _______
Where: ___________________________  When: ___________________________
Diagnosis: ___________________________

Was he/she compliant with previous treatment? (explain if no)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Page 1 of 2
<table>
<thead>
<tr>
<th>Name of Patient:</th>
<th>Date of Submission:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization Number:</td>
<td></td>
</tr>
</tbody>
</table>

**Services Requested:**

<table>
<thead>
<tr>
<th>Previous Certification: Requested from</th>
<th>to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days Authorized (pending Approval of the 1261A)</td>
<td>to</td>
</tr>
<tr>
<td>Additional Days Requested</td>
<td>to</td>
</tr>
<tr>
<td>Precautions (including start-stop dates)</td>
<td>Suicide</td>
</tr>
<tr>
<td>Assault</td>
<td>Sexual</td>
</tr>
<tr>
<td>Locked</td>
<td>Seclusion</td>
</tr>
<tr>
<td>Family Therapies (including dates and family involvement)</td>
<td></td>
</tr>
<tr>
<td>Furloughs (including date, length, and success)</td>
<td></td>
</tr>
<tr>
<td>Psychological Testing results:</td>
<td></td>
</tr>
<tr>
<td>LAB Tests and Procedures:</td>
<td></td>
</tr>
<tr>
<td>Medication(s) and Dates of Changes and Dates of New Orders:</td>
<td></td>
</tr>
<tr>
<td>Discharge Plans: Date of proposed DC</td>
<td></td>
</tr>
<tr>
<td>Discharge Destination:</td>
<td></td>
</tr>
<tr>
<td>Discharge Issues:</td>
<td></td>
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</tbody>
</table>

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MEDICAID REHABILITATION PRE-ADMISSION FORM

DIRECTIONS: Fax the completed forms along with the appropriate FIMS (Functional Independent Measures) your facility presently uses, as well as a letter of medical necessity to Rehab Reviewer. This agency has TWO working days to adjudicate faxes. If you do not receive a response within TWO working days, you may call (800) 457-4518 to check on status.

INFORMATION MARKED WITH ★ IS MANDATORY AND FORM WILL BE RETURNED IF THIS INFORMATION IS NOT PROVIDED. PLEASE COMPLETE ENTIRE FORM.

DATE OF SUBMISSION ________________

PROVIDER DATA

★Name of Rehabilitation Facility: ______________________________________________________
★Medicaid Provider Number: __ __ __ __ __ __ __ __ __ __ __
Street Address of Facility: __________________________________________________________
City: __________________________ State: _____ Zip: ____________
★Facility Contact Person: __________________________
★Phone Number: (____)__________ Fax Number: (____)__________
Referring Physician: ______________________________________________________________
Admitting Physiatrist/Neurologist: _____________________________________________

MEMBER DATA

★Member Name: __________________________ ★ DOB: ______________
★Member ID Number (RID): __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Other Insurance: ____________________________________________________________
Sex: _____ Weight: _____ lbs. _____ oz. Height: __________
Marital Status: __________
★Member’s Place of Residence Prior to this Illness or Inquiry (circle one)

HOME SNF ICF OTHER (please specify) _____________
Exhibit VI-4 (Continued)

CLINICAL DATA
★Rehabilitation Diagnosis: ________________________________
★Secondary Diagnosis: ________________________________
Entiology: ___________ ★ ICD–9 Codes: ________________________________
★Date of Onset: ________________________________
★Requested Admit Date: ___________ ★ Projected Discharge Date: ___________
★Primary Discharge Plan: ________________________________
Has recipient had previous inpatient rehabilitation? YES NO
If Yes, when and where: __________________________________________

VITAL SIGNS
Temp: ________ Resp: __________
Pulse: ________ B/P: __________
DECUBITI: YES NO Location: __________________________________________
Degree: ______________ Treatment: ______________________________

★PREVIOUS FUNCTIONAL STATUS:
 SELF CARE: INDEPENDENT REQUIRES ASSISTANCE
 AMBULATION: INDEPENDENT REQUIRES ASSISTANCE
 DEVICE: NONE CRUTCHES CANE WALKER W/C
 DISTANCE: ________________________________

★PRESENT FUNCTIONAL STATUS
RANGE OF MOTION:
RIGHT UE WNL WFL LIMITED RIGHT UE WNL WFL LIMITED
RIGHT LE WNL WFL LIMITED RIGHT LE WNL WFL LIMITED
LEFT UE WNL WFL LIMITED LEFT UE WNL WFL LIMITED
LEFT LE WNL WFL LIMITED LEFT LE WNL WFL LIMITED
Exhibit VI-4 (Continued)

★PRESENT FUNCTIONAL STATUS (Continued)★

<table>
<thead>
<tr>
<th>STRENGTH:</th>
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<td></td>
<td>1 2 3 4 5 NT SHOULDER</td>
<td>1 2 3 4 5 NT</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5 NT ELBOW</td>
<td>1 2 3 4 5 NT</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5 NT HIP</td>
<td>1 2 3 4 5 NT</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5 NT KNEE</td>
<td>1 2 3 4 5 NT</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5 NT ANKLE</td>
<td>1 2 3 4 5 NT</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MOBILITY:</th>
<th>ROLLING</th>
<th>I SBA CGA MIN MOD MAX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SCOOTING</td>
<td>I SBA CGA MIN MOD MAX</td>
</tr>
<tr>
<td></td>
<td>SUPINE TO SIT</td>
<td>I SBA CGA MIN MOD MAX</td>
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<td></td>
<td>SIT TO STAND</td>
<td>I SBA CGA MIN MOD MAX</td>
</tr>
<tr>
<td></td>
<td>STAND PIVOT</td>
<td>I SBA CGA MIN MOD MAX</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMBULATION:</th>
<th>WBAT PWB ____% TWB R L NWB R L</th>
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<tbody>
<tr>
<td>DEVICE:</td>
<td>NONE HHA WALKER CANE CRUTCHES</td>
</tr>
<tr>
<td>DISTANCE:</td>
<td>_______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHEELCHAIR:</th>
<th>TYPE: __________________</th>
<th>POSITIONING: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROPULSION:</td>
<td>__________________</td>
<td>DISTANCE: __________________</td>
</tr>
<tr>
<td>MANAGEMENT OF PARTS:</td>
<td>FOOTRESTS_____ ARMREST_____ BRAKES_____</td>
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</table>

<table>
<thead>
<tr>
<th>BALANCE:</th>
<th>STATIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>SITTING</td>
<td>NT POOR FAIR GOOD NT POOR FAIR GOOD</td>
</tr>
<tr>
<td>STANDING</td>
<td>NT POOR FAIR GOOD NT POOR FAIR GOOD</td>
</tr>
</tbody>
</table>

| ENDURANCE: | POOR FAIR GOOD |

★MEDICAL STATUS:★ STABLE GUARDED CRITICAL UNDETERMINED

★PROGNOSIS FOR REHABILITATION:★ EXCELLENT GOOD FAIR UNDETERMINED
Exhibit VI-4 (Continued)

**NUTRITIONAL STATUS:**

Diet: ____________________________________________

Enteral Feedings? YES NO

Type: __________________________ Rate/Frequency: __________

**NEURO STATUS:**

Is patient alert and orientated times three?

Time? YES NO If No, please specify __________________________

Person? YES NO If No, please specify __________________________

Place? YES NO If No, please specify __________________________

Rancho Los Amigos Level: _________

Seizures? YES NO If Yes, please specify frequency __________

Does patient have any central lines? YES NO

If Yes, please specify: _______________________________________

________________________________________________________________

What are they receiving through the line? _________________

________________________________________________________________

Does patient require special equipment? YES NO

If Yes, please specify: _______________________________________

________________________________________________________________

Post Surgical Wound Care? YES NO

Location: ____________________________________________

Treatment: ____________________________________________

Recent Fractures: YES NO
Exhibit VI-4 (Continued)

THERAPY: (please circle)

<table>
<thead>
<tr>
<th>Recommended Therapy</th>
<th>Hours per Day</th>
<th>Days per Week</th>
</tr>
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<tbody>
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<td>PT</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>OT</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>ST</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>RT</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>PSYCH</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>

Please Specify: ____________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Short Term Goals Prior to Discharge (please include target date or date completed)
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Long Term Goals Prior to Discharge (please include target date or date completed)
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Routine Medications

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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EXHIBIT VI-5
REHABILITATION CONCURRENT REVIEW FORM
INDIANA HEALTH COVERAGE PROGRAMS (IHCP) REHABILITATION
CONCURRENT REVIEW FORM

DIRECTIONS: Fax the completed forms along with the appropriate FIMS (Functional Independent Measures) your facility presently uses to Rehab Reviewer. This agency has TWO working days to adjudicate faxes. If you do not receive a response within TWO working days, you may call (800) 457-4518 to check on status. INFORMATION MARKED WITH ★ IS MANDATORY AND FORM WILL BE RETURNED IF THIS INFORMATION IS NOT PROVIDED. PLEASE COMPLETE ENTIRE FORM.

DATE OF SUBMISSION ________________

PROVIDER DATA

★Name of Rehabilitation Facility: ________________________________
★Medicaid Provider Number: __ __ __ __ __ __ __ __
Street Address of Facility: ________________________________
City: ____________________ State: _____ Zip: ________
★Facility Contact Person: ________________________________
★Phone Number: (___)__________ Fax Number: (___)__________
Attending Physiatrist: ________________________________

MEMBER DATA

★Member Name: ________________________________ ★DOB: ________________
★Recipient ID Number (RID): __ __ __ __ __ __ __ __ __ __ __ __ __
Prior Authorization Number: __ __ __ __ __ __ __ __ __ __
★How has patient changed from last review? ________________________________
Exhibit VI-5 (Continued)

**Other Insurance:**

Weight: ______ lbs. ______ oz.

Rehabilitation Diagnosis: ____________________________________________

Secondary Diagnosis: ______________________________________________

Admission Date: _______________       Projected Discharge Date: _________

Primary Discharge Plan: _____________________________________________

Alternative/Secondary Discharge Plan: ________________________________

**CLINICAL DATA**

Has patient had any medical complications since last review?     YES     NO

If Yes, please be specific and include dates and treatment that was given: __________________________________________

________________________________________________________________

**VITAL SIGNS**

Temp: ______  Resp: ______  Special Bed?    YES     NO

Pulse: ______  B/P: ______

DECUBITI:     YES     NO  Location: ________________________________

Degree: ___________________________  Treatment: ___________________________

FRACTURES: ________________________  Location: ___________________________

Cast?     YES     NO  Splint:     YES     NO  Date Cast or Splint Removed: ____________
**PRESENT ADL FUNCTIONAL STATUS**

<table>
<thead>
<tr>
<th>SELF CARE:</th>
<th>INDEPENDENT</th>
<th>REQUIRES ASSISTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF ASSISTANCE REQUIRED:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STRENGTH:**

<table>
<thead>
<tr>
<th></th>
<th>RIGHT</th>
<th></th>
<th>LEFT</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>2 3 4 5</td>
<td>NT</td>
<td>1 2 3 4 5 NT</td>
</tr>
<tr>
<td>1</td>
<td>2 3 4 5</td>
<td>NT</td>
<td>1 2 3 4 5 NT</td>
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<tr>
<td>1</td>
<td>2 3 4 5</td>
<td>NT</td>
<td>1 2 3 4 5 NT</td>
</tr>
</tbody>
</table>

**RANGE OF MOTION:**

<table>
<thead>
<tr>
<th>RIGHT UE</th>
<th>WNL</th>
<th>WFL</th>
<th>LIMITED</th>
<th>RIGHT UE</th>
<th>WNL</th>
<th>WFL</th>
<th>LIMITED</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEFT UE</td>
<td>WNL</td>
<td>WFL</td>
<td>LIMITED</td>
<td>LEFT UE</td>
<td>WNL</td>
<td>WFL</td>
<td>LIMITED</td>
</tr>
<tr>
<td>LEFT LE</td>
<td>WNL</td>
<td>WFL</td>
<td>LIMITED</td>
<td>LEFT LE</td>
<td>WNL</td>
<td>WFL</td>
<td>LIMITED</td>
</tr>
</tbody>
</table>

**ENDURANCE:**

POOR FAIR GOOD

**MOBILITY:**

<table>
<thead>
<tr>
<th>ROLLING</th>
<th>I</th>
<th>SBA</th>
<th>CGA</th>
<th>MIN</th>
<th>MOD</th>
<th>MAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCOOTING</td>
<td>I</td>
<td>SBA</td>
<td>CGA</td>
<td>MIN</td>
<td>MOD</td>
<td>MAX</td>
</tr>
<tr>
<td>SUPINE TO SIT</td>
<td>I</td>
<td>SBA</td>
<td>CGA</td>
<td>MIN</td>
<td>MOD</td>
<td>MAX</td>
</tr>
<tr>
<td>SIT TO STAND</td>
<td>I</td>
<td>SBA</td>
<td>CGA</td>
<td>MIN</td>
<td>MOD</td>
<td>MAX</td>
</tr>
<tr>
<td>STAND PIVOT</td>
<td>I</td>
<td>SBA</td>
<td>CGA</td>
<td>MIN</td>
<td>MOD</td>
<td>MAX</td>
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</table>
## Present ADL Functional Status (Continued)

### Ambulation:

<table>
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<tr>
<th>WBAT</th>
<th>PWB</th>
<th>TWB</th>
<th>R</th>
<th>L</th>
<th>NWB</th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- I: Self-Propelled
- SBA: Semilunar
- CGA: Cane
- MIN: Minimum
- MOD: Moderate
- MAX: Maximum

**Device:**
- NONE
- HHA
- Walker
- Cane
- Crutches

**Distance:**

### Wheelchair:

- **Type:**
- **Positioning:**
- **Propulsion:**
- **Distance:**

**Management of Parts:**
- Footrests
- Armrest
- Brakes

### Balance:

- **Static**
  - Sitting: NT, Poor, Fair, Good
  - Standing: NT, Poor, Fair, Good

- **Dynamic**
  - Sitting: NT, Poor, Fair, Good
  - Standing: NT, Poor, Fair, Good

### Medical Status:

- Stable
- Guarded
- Critical
- Undetermined

### Prognosis:

- Excellent
- Good
- Fair
- Undetermined

### Nutritional Status:

- Diet: ______________
- Enteral Feedings?: YES, NO
- Type: ______________
- Frequency: ______________
Respiratory Status:

Does patient have any of the following? (please circle all that apply)

- ET Tube
- Trach
- O2 Liters: _______

★ Neuro Status:

Orientation:

- Time? YES NO
- Person? YES NO
- Place? YES NO

Rancho Los Amigos Level: _______

- Seizures? YES NO

- Does patient have any Special Needs? ________________________________

Post Surgical Wound Care? YES NO

Location: __________________________________________

Treatment: __________________________________________

Does patient have any central lines? YES NO

If Yes, please specify: __________________________________________

What are they receiving through the line? ____________________________
Exhibit VI-5 (Continued)

Does patient require special equipment?  YES  NO

If yes, please specify: ____________________________________________

THERAPY:  (please circle)

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Hours per Day</th>
<th>Days per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>OT</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>ST</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>PSYCH</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>RT</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>

Please specify: ____________________________________________

Inhibitory Casting and/or Splinting:

Has casting been performed?  YES  NO  If yes, date first cast applied ______________

What body part? __________________________

Date first cast removed: ______________________

Date second cast applied: ______________________

What body part? __________________________

Date cast removed: ______________________

R2 – 10/29/2004  VI-18
Exhibit VI-5 (Continued)

Short Term Goals Prior to Discharge (please include target date or date completed)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Long Term Goals Prior to Discharge (please include target date or date completed)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Routine Medications

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

Other Pertinent Information

__________________________________________________________________________

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## EXHIBIT VI-6

### OMPP FORM 1261A

**CERTIFICATION - PLAN OF CARE FOR INPATIENT PSYCHIATRIC HOSPITAL SERVICES / DETERMINATION OF MEDICAID ELIGIBILITY**

| State Form 44697 (R3 / 11-00) OMPP 1261A |

<table>
<thead>
<tr>
<th>COMPLETED BY PROVIDER</th>
<th>COMPLETED BY HOSPITAL PERSONNEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid number</td>
<td>Provider hospital (name, address, city, state and ZIP code)</td>
</tr>
</tbody>
</table>

### PATIENT IDENTIFICATION

<table>
<thead>
<tr>
<th>Name (first, middle, last)</th>
<th>Sex</th>
<th>Race</th>
<th>Age</th>
<th>Date of birth (month, day, year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital status</td>
<td>Number of children</td>
<td>Date of admission (month, day, year)</td>
<td>Time of admission</td>
<td></td>
</tr>
<tr>
<td>Admitted from</td>
<td>Other (designate)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own home</td>
<td>Parents' home</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize release of information when necessary for determination of my eligibility for Medicaid.

Signature of patient, responsible relative or guardian: ____________________________

Date signed (month, day, year): __________

### I. PSYCHIATRIC AND MEDICAL EVALUATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Systolic:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diastolic:</td>
</tr>
</tbody>
</table>

Significant laboratory data:

- Blood work
- Radiological
- Psychological testing

Particular psychiatric history as related to this illness (include medical history)

Estimated length of inpatient treatment (be as specific as possible)

Distribution: White - requester; Canary - MD contractor
Exhibit VI-6 (Continued)

<table>
<thead>
<tr>
<th>PSYCHIATRIC AND MEDICAL EVALUATION (continued from previous page)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant findings upon current mental examination</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Significant findings upon current physical examination</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Primary psychiatric diagnoses</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Secondary psychiatric diagnoses</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Functional Capacity</strong></td>
</tr>
<tr>
<td>Can patient take own medication? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Is patient capable of handling own affairs? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Mental capacity</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Physical capacity</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

II. PLAN OF PSYCHIATRIC TREATMENT

State treatment objectives, long and short range (include estimated timetable)
EXHIBIT VI-6 (continued)

<table>
<thead>
<tr>
<th>PLAN OF PSYCHIATRIC TREATMENT (continued from previous page)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment modalities for attainment of objectives or relating to specific problems (check appropriate items)</td>
</tr>
<tr>
<td>□ Behavior modification</td>
</tr>
<tr>
<td>□ E.C.T.</td>
</tr>
<tr>
<td>□ Family therapy</td>
</tr>
<tr>
<td>□ Group psychotherapy</td>
</tr>
<tr>
<td>□ Individual psychotherapy</td>
</tr>
<tr>
<td>□ Other</td>
</tr>
<tr>
<td>Describe modalities</td>
</tr>
</tbody>
</table>

| Discharge plans - coordination of services                   |                                                             |                                                             |

State names of relatives with whom the Treatment Plan was discussed and their relationship to the patient

<table>
<thead>
<tr>
<th>Designate the persons responsible for formulating the Treatment Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### III. CERTIFICATION

<table>
<thead>
<tr>
<th>A. UNDER AGE 21: Interdisciplinary Team Certification: Based upon physical, mental and social evaluations, I certify the above named individual requires inpatient psychiatric treatment. These treatment services will improve the patient's condition so that inpatient services will no longer be required. Available alternate community resources do not meet the patient's needs. The Plan of Treatment identified above is verified as existing or implemented on this date.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Physician Team Member</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. AGE 22 TO 65: Interdisciplinary Team Certification: Based upon physical, mental and social evaluations, I certify the above named individual requires inpatient psychiatric treatment. These treatment services will improve the patient's condition so that inpatient services will no longer be required. Available alternate community resources do not meet the patient's needs. The Plan of Treatment identified above is verified as existing or implemented on this date.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Physician Team Member</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. AGE 65 OR OVER: Physician's Certification: Based upon physical, mental and social evaluations, I certify the above named individual requires inpatient psychiatric treatment which is necessary to maintain the patient or restore him/her to the greatest possible degree of health or individual functioning. The Plan of Treatment identified above is verified as existing or implemented on this date.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Attending or Staff Physician</td>
</tr>
</tbody>
</table>

### IV. MEDICAID AGENCY DECISION

The Office of Medicaid Policy and Planning Review Physician has reviewed the content of this patient referral and has taken the following action.

- [ ] APPROVAL
- [ ] DISAPPROVAL

Comments

| Signature of Review Physician | Date signed (month, day, year) |
EXHIBIT VI-7
HOSPICE ELECTION FORM

MEDICAID HOSPICE ELECTION
State Form 40775 (R/11-04) CMFP 0035

The information contained on this completed form is CONFIDENTIAL according to 409: PAC 1.16, 5.2.10.1, 5.2.10.2, 5.5.1, and 5.34.

Effective date of Hospice Care

Medicaid Hospice effective date (State use only)  
Signature of Hospice Analyzer

<table>
<thead>
<tr>
<th>A. RECIPIENT INFORMATION</th>
<th>Primary hospice diagnosis (ICD-9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of recipient (last, first, middle initial)</td>
<td>Recipient’s Medicaid number</td>
</tr>
<tr>
<td>Address of other location, if not private home (number and street, apt. number, city, state, ZIP code)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recipient’s Social Security number</th>
<th>Telephone number</th>
<th>Date of birth (month, day, year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>{ }</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

Sex of recipient

[ ] Male  [ ] Female

<table>
<thead>
<tr>
<th>B. PROVIDER’S INFORMATION</th>
<th>Date of physician’s verbal approval of hospice care (month, day, year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Hospice Provider</td>
<td>Medicaid Hospice Provider number</td>
</tr>
<tr>
<td>Name of Attending Physician</td>
<td>Hospital telephone number</td>
</tr>
<tr>
<td>Attending Physician Medicaid Provider number</td>
<td>If applicable) Name of Nursing Facility Nursing Facility Medicaid Provider number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. HOSPICE BENEFIT INFORMATION</th>
<th>2nd Period (90 days)</th>
<th>Indefinite number of 60 day periods (circle as appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Period (180 days)</td>
<td>2nd Period (90 days)</td>
<td>Indefinite number of 60 day periods (circle as appropriate)</td>
</tr>
<tr>
<td>2nd Period (90 days)</td>
<td>2nd Period (90 days)</td>
<td>Indefinite number of 60 day periods (circle as appropriate)</td>
</tr>
<tr>
<td>3rd Period (90 days)</td>
<td>3rd Period (90 days)</td>
<td>Indefinite number of 60 day periods (circle as appropriate)</td>
</tr>
<tr>
<td>4th Period (90 days)</td>
<td>4th Period (90 days)</td>
<td>Indefinite number of 60 day periods (circle as appropriate)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. ELECTION STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) The Indiana Medicaid hospice benefit has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of this program and the terms of this election statement;</td>
</tr>
<tr>
<td>(b) I understand that by signing this election statement I waive all rights to regular Medicaid services except for payment to my attending physician and prior authorized treatment for services unrelated to my terminal illness, medical transportation unrelated to the terminal illness, dental services and Medicaid pharmacy services for prescriptions not covered under hospice;</td>
</tr>
<tr>
<td>(c) I understand that I will be entitled to Medicaid hospice services as long as I am Medicaid eligible. The benefit will be provided in three benefit periods of an initial 90 days, a subsequent 90 days, and an unlimited period consisting of successive 90 day periods. I may qualify for each of these periods after review by the Indiana Office of Medicaid Policy and Planning and its contractor;</td>
</tr>
<tr>
<td>(d) I understand that I may revoke the hospice benefit at any time by completing a Hospice Revocation Form, specifying the date when the revocation is to be effective and submitting the form to the hospice provider at the time of revocation. I also understand that if I choose to revoke services for a benefit period, I am not entitled to coverage of the remaining days of that benefit period. At the time I revoke hospice services, I understand my rights to other Medicaid services will resume, provided that I continue to be Medicaid eligible;</td>
</tr>
<tr>
<td>(e) I understand that I may change the designated hospice provider one time per election period without affecting the provision of my hospice benefit and that to do so my hospice provider is required to fill out a Change of Hospice Provider Form;</td>
</tr>
<tr>
<td>(f) I understand that if I am a Medicare recipient, I must elect to use the Medicare hospice benefit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. SIGNATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of recipient (or recipient representative)</td>
</tr>
</tbody>
</table>

(See reverse side for the Election Statement in large print)
E. LARGE PRINT OF ELECTION STATEMENT

ELECTION STATEMENT

(a) The Indiana Medicaid hospice benefit has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitation of this program and the terms of the election statement;
(b) I understand that by signing this election statement I waive all rights to regular Medicaid services except for payment to my attending physician and prior authorized treatment for services unrelated to my terminal illness, medical transportation unrelated to the terminal illness, dental services and Medicaid pharmacy services for prescriptions not covered under hospice;
(c) I understand that I will be entitled to Medicaid hospice services as long as I am Medicaid eligible. The benefit will be provided in three benefit periods of an initial 90 days, a subsequent 90 days, and an unlimited period consisting of successive 60 day periods. I may qualify for each of these periods after review by the Indiana Office of Medicaid Policy and Planning and its contractor;
(d) I understand that I may revoke the hospice benefit at any time by completing a Hospice Revocation Form, specifying the date when the revocation is to be effective and submitting the form to the hospice provider at the time of revocation. I also understand that if I choose to revoke services for a benefit period, I am not entitled to coverage of the remaining days of that benefit period. At the time I revoke hospice services, I understand my rights to other Medicaid services will resume, provided that I continue to be Medicaid eligible;
(e) I understand that I may change the designated hospice provider one time per election period without affecting the provision of my hospice benefit and that to do so my hospice provider is required to fill out a Change of Hospice Provider Form;
(f) I understand that if I am a Medicare recipient, I must elect to use the Medicare hospice benefit.
This completed form is CONFIDENTIAL according to 465 IAC 1-16, 5-2-10, 1, 5-1-10, 2, 5-5-1, and 5-34.

The purpose of this form is to enroll nursing facility residents who elect the Medicare hospice benefit in the Medicaid hospice benefit to ensure payment of room and board services as required under 465 IAC 1-16-4. The hospice provider understands that the only time this enrollment form must be completed again is if the individual receives hospice care following a hospice discharge or hospice resuscitation.

Through the primary hospice nurse's signature on the bottom of this form, the hospice provider certifies that all medical documentation has been completed according to the Medicare Conditions of Participation for Hospice Care and Medicaid program guidelines and that all required Medicaid forms have been included in the patient's medical chart in the hospice agency and contracted nursing facility.

The hospice provider must still complete the Medicaid hospice election form, Medicaid physician certification form and Medicaid hospice plan of care for the Medicaid-only nursing facility resident as required for each hospice benefit period.

<table>
<thead>
<tr>
<th>Date of the original Medicare hospice election:</th>
<th>Previous hospice enrolled?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Attach signed copy of Medicare election statement)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Medicare hospice re-election</th>
<th>Current hospice benefit period</th>
</tr>
</thead>
<tbody>
<tr>
<td>(This is for the date that the member re-elects hospice following a preceding hospice resuscitation or hospice discharge)</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
</tbody>
</table>

### A. RECIPIENT INFORMATION

- **Primary hospice diagnosis (ICD-9-CM)**
- **Name of recipient (last, first, middle initial)**
- **Recipient's Medicaid number**
- **Address or other location (if not private home) (number and street, apt. number, city, state, ZIP code)**
- **Recipient's Social Security number**
- **Telephone number**
- **Date of birth (month, day, year)**
- **Name of parent, guardian or representative**
- **Sex of recipient**
  - Male
  - Female

### B. PROVIDER'S INFORMATION

- **Date of physician's written approval of hospice care (month, day, year)**
- **Name of hospice provider**
- **Medicare hospice provider number**
- **Name of attending physician**
- **Hospice telephone number**
- **Attending physician Medicaid provider number**
- **Name of nursing facility (if applicable)**
- **Nursing facility Medicaid provider number**
- **Signature of Primary Hospice Nurse (PN) and title**
- **Date (month, day, year)**

This form must be completed in its entirety to be processed by the Medicaid prior authorization contractor to ensure hospice authorization. Hospice authorization is required for the dates of service that the hospice bills for room and board services.
# EXHIBIT VI-9

## HOSPICE PHYSICIAN CERTIFICATION FORM

**MEDICAID HOSPICE PHYSICIAN CERTIFICATION**

State Form 10/30/96 (6/15/96) COMPLIANCE

The information contained on this completed form is **CONFIDENTIAL**
according to 405 IAC 1-19. 5-2-19.1, 5-2-19.2, 5-6-1, and 5-34.

### A. RECIPIENT INFORMATION

<table>
<thead>
<tr>
<th>Name of recipient (last, first, middle initial)</th>
<th>Recipient's Medicaid number</th>
</tr>
</thead>
</table>

### B. PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Name of hospice provider</th>
<th>Hospice Medicaid provider number</th>
</tr>
</thead>
</table>

- Please check the appropriate benefit period below:
  - 1st hospice benefit period
  - 2nd hospice benefit period
  - 3rd hospice benefit period

Should **additional** hospice care be required after the first 60 days of the Third Benefit Period, please complete this page again and check the appropriate box below.

### THIRD BENEFIT PERIOD (SUBSEQUENT 90 DAY PERIODS)

<table>
<thead>
<tr>
<th>90th 60 days</th>
<th>3rd 90 days</th>
<th>4th 90 days</th>
<th>5th 90 days</th>
<th>6th 90 days</th>
</tr>
</thead>
</table>

Please specify the number of any subsequent benefit period

C. Having reviewed this patient's care and the course of his/her illness, I certify that this patient's medically predictable life expectancy is (6) months or less, given that the illness runs its normal course, as evidenced by the following clinical indications:

<table>
<thead>
<tr>
<th>Signature of Attending Physician (if required 1st hospice benefit period)</th>
<th>Certification date (month, day, year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Medical Director or Hospice Physician</td>
<td>Certification date (month, day, year)</td>
</tr>
</tbody>
</table>

R2 – 10/29/2004
EXHIBIT VI-10

HOSPICE PLAN OF CARE

The information contained on this completed form is CONFIDENTIAL according to 405 IAC 1-18, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

A. RECIPIENT INFORMATION

<table>
<thead>
<tr>
<th>Name of recipient (last, first, middle initial)</th>
<th>Recipient's Medicaid number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. HOSPICE PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Name of hospice provider</th>
<th>Hospice provider number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. ASSESSMENT: Complete the following using the problem severity code listed at the bottom of the chart.

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>PROBLEM SEVERITY CODE</th>
<th>ASSESSMENT</th>
<th>PROBLEM SEVERITY CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altered Physical Comfort</td>
<td>Altered Urinary Elimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altered Respiratory Status</td>
<td>Altered Bowel Elimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altered Cardiovascular Status</td>
<td>Altered Sleep Pattern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altered Nutritional Status</td>
<td>Altered Grief/Spiritual (patient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altered Skin Integrity</td>
<td>Altered Grief/Spiritual (family)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altered Mobility Status</td>
<td>Altered Oral Mucosa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVITIES OF DAILY LIVING</th>
<th>PROBLEM SEVERITY CODE</th>
<th>ACTIVITIES OF DAILY LIVING</th>
<th>PROBLEM SEVERITY CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating / Feeding</td>
<td>Toileting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grooming / Hygiene</td>
<td>Continence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>Transferring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>Mobility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROBLEM SEVERITY CODE

0 = None: no problem present
1 = Problem: controlled at time of assessment
2 = Mild: function could be improved.
3 = Moderate: able to function with support
4 = Marked: able to function only with daily intervention
5 = Severe: incapacitated by the problem

D. SERVICES: Document the proposed services for this benefit period (include frequency and expected outcome).

<table>
<thead>
<tr>
<th>Services Required</th>
<th>Frequency</th>
<th>Expected Outlook</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued on the reverse side)
Exhibit VI-10 (Continued)

<table>
<thead>
<tr>
<th>E. SERVICES (continued)</th>
<th>Frequency</th>
<th>Expected Outlook</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other unencoded services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F. SIGNATURES: Date and sign the following. Signatures must represent the Medical Director as well as one signature from any of the other disciplines listed above.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title</th>
<th>Date (month, day, year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Title</td>
<td>Date (month, day, year)</td>
</tr>
<tr>
<td>Signature</td>
<td>Title</td>
<td>Date (month, day, year)</td>
</tr>
</tbody>
</table>
### EXHIBIT VI-11

**HOSPICE DISCHARGE FORM**

**MEDICAID HOSPICE DISCHARGE**

State Form 497-14 (R 12-02) / GMPF 0008

---

The information contained on this completed form is CONFIDENTIAL according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

---

**A. RECIPIENT INFORMATION**

<table>
<thead>
<tr>
<th>Name of recipient (last, first, middle initial)</th>
<th>Recipient’s Medicaid number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Recipient’s Social Security number</th>
</tr>
</thead>
</table>

**B. HOSPICE PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Name of Hospice Provider</th>
<th>Hospice Provider number</th>
</tr>
</thead>
</table>

---

**C. DISCHARGE STATEMENT**

Hospice benefits for the above named recipient, enrolled with the above named provider since ______ / ______ / ______ have terminated on ______ / ______ / ______ for the following reasons:

- [ ] Recipient is deceased. Date of death was ______ / ______ / ______.
- [ ] Prognosis is now greater than six months.
- [ ] Safety of recipient or hospice staff is compromised (explain below and attach relevant documentation).
- [ ] Recipient moved out of service area.
- [ ] Other (explain below)

---

**Signature of Medical Director or Patient Care Coordinator**

**Date**
# EXHIBIT VI-12

## HOSPICE REVOCATION FORM

### MEDICAID HOSPICE REVOCATION

State Form 48735 (4-98) / OMPP 0007

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2.

### A. RECIPIENT INFORMATION

<table>
<thead>
<tr>
<th>Name of recipient (last, first, middle initial)</th>
<th>Recipient’s Medicaid number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient’s Social Security number</td>
<td></td>
</tr>
</tbody>
</table>

| Primary hospice diagnosis (ICD-10): |

### B. PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Name of Hospice Provider</th>
<th>Hospice Medicaid Provider number</th>
</tr>
</thead>
</table>

### C. REVOCATION STATEMENT

(a) The Medicaid Hospice Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of this program and the terms of the revocation of these services;

(b) I **understand** that by signing this revocation statement I will, if eligible, resume Medicaid coverage of benefits waived when the hospice care was elected;

(c) I **will forfeit** ALL hospice coverage days remaining in this benefit period;

(d) I **may at any time** elect to receive hospice coverage for any other hospice benefit period for which I am eligible.

### D. SIGNATURES

<table>
<thead>
<tr>
<th>Signature of recipient (or recipient representative)</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of witness</th>
<th>Date</th>
</tr>
</thead>
</table>
EXHIBIT VI-13
HOSPICE CHANGE IN STATUS FORM

<table>
<thead>
<tr>
<th>A. RECIPIENT INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of recipient (last, first, middle initial)</td>
<td>Recipient's Medicaid number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. PROVIDER INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Hospice Provider</td>
<td>Hospice Medicaid Provider number</td>
</tr>
<tr>
<td>Signature of Hospice Provider</td>
<td>Hospice telephone number</td>
</tr>
</tbody>
</table>

| C. THE STATUS |  |
|----------------|
| of the above patient in the care of the above provider has changed as of ______ / ______ / ______ (date) for the following reason(s): |
| ☐ Patient has become eligible for Medicare; |
| ☐ Patient has changed his / her normal daily residence (NOTE: Fill out A, B or C as relevant): |

<table>
<thead>
<tr>
<th>A. FROM: Private Home</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private address (number and street, apt. number, city, state, ZIP code)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TO: Institutional Care Setting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of institution</td>
<td></td>
</tr>
<tr>
<td>Address (number and street, city, state ZIP code)</td>
<td></td>
</tr>
<tr>
<td>Medicaid Provider number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. FROM: Institutional Care Setting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of institution</td>
<td></td>
</tr>
<tr>
<td>Address (number and street, city, state ZIP code)</td>
<td></td>
</tr>
<tr>
<td>Medicaid Provider number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TO: Private Home</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private address (number and street, apt. number, city, state, ZIP code)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C. FROM: OLD Institutional Care Setting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of institution</td>
<td></td>
</tr>
<tr>
<td>Address (number and street, city, state ZIP code)</td>
<td></td>
</tr>
<tr>
<td>Medicaid Provider number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TO: NEW Institutional Care Setting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of institution</td>
<td></td>
</tr>
<tr>
<td>Address (number and street, city, state ZIP code)</td>
<td></td>
</tr>
<tr>
<td>Medicaid Provider number</td>
<td></td>
</tr>
</tbody>
</table>
# EXHIBIT VI-14

## HOSPICE PROVIDER CHANGE REQUEST BETWEEN INDIANA HOSPICE PROVIDERS FORM

The information contained on this completed form is CONFIDENTIAL according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

### A. PROVIDER CHANGE REQUEST EFFECTIVE DATE OF CHANGE:

- [ ] FIRST BENEFIT PERIOD
- [ ] SECOND BENEFIT PERIOD
- [ ] THIRD BENEFIT PERIOD

### B. RECIPIENT INFORMATION

<table>
<thead>
<tr>
<th>Name of recipient (last, first, middle initial)</th>
<th>Recipient’s Medicaid number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recipient’s Social Security number:

The above named recipient requests that the designation of his / her hospice be changed from (completed by sending hospice):

### C. PROVIDER LEAVING

<table>
<thead>
<tr>
<th>Name of Hospice Provider</th>
<th>Hospice Medicaid Provider number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Provider RH: Hospice telephone number

Name of Attending Physician: Physician Medicaid Provider number

TO THE FOLLOWING HOSPICE PROVIDER (completed by receiving hospice):

### C. PROVIDER ENTERING

<table>
<thead>
<tr>
<th>Name of Hospice Provider</th>
<th>Hospice Medicaid Provider number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Provider RH: Hospice telephone number

Name of Attending Physician: Physician Medicaid Provider number

As a hospice recipient, I understand that this change in hospice providers is not a revocation of the remainder of my current election benefit period.

### E. Signature of recipient or representative

<table>
<thead>
<tr>
<th>Signature of witness</th>
<th>Date</th>
</tr>
</thead>
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<td></td>
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</table>

### NOTES:

1. Patient must be accepted for transfer by the new provider prior to leaving current provider.
2. Each hospice must maintain a copy of the Provider Change Request. It is the responsibility of the receiving hospice to forward a completed copy to the Medicaid Prior Authorization Unit within 5 days of the effective date stipulated in Part A above.
3. A change of ownership is not considered a change in the patient’s designation of a hospice and requires no recipient action.
EXHIBIT VI-15
SYSTEM UPDATE REQUEST FORM

Prior Authorization
System Update Request Form

Date: ____________________  Provider Number: ____________________
Provider Name: ____________________
Contact Person: ____________________
Phone: ____________________

Member Name: ____________________
Member ID (RID): ____________________
Prior Authorization #: ____________________

Service Code (CPT/Modifier/Taxonomy, HCPCS, ICD-9-CM, and so forth):
___________________________________________________________

Summary of requested action(s):
___________________________________________________________
___________________________________________________________
___________________________________________________________

Change(s) prompting the system update request:
___________________________________________________________
___________________________________________________________
___________________________________________________________

Prior Authorization department Use Only

Reviewer: ____________________  Date System: ____________________
Update: ____________________

Decision and comments:
___________________________________________________________
___________________________________________________________

Mail to: HCE Prior Authorization department
P.O. Box 531520
Indianapolis, IN  46253-1520

A copy of the decision will be provided to the requesting provider and to the member.
EXHIBIT VI-16

FAX COMMUNICATION FORM

MEDICAID – HEALTH CARE EXCEL
PRIOR AUTHORIZATION FAX COMMUNICATION SHEET
FAX NUMBER (317) 347-4537

FACILITY NAME __________________________________________
DATE RECEIVED _____/_____/________ DATE RETURNED _____/_____/________
REVIEWED BY __________________________________________

<table>
<thead>
<tr>
<th>Recipient Name</th>
<th>Date Start</th>
<th>Date stop</th>
<th>Decision</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RID Number</td>
<td>Prior Authorization Number</td>
<td></td>
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</tr>
</tbody>
</table>

Reciprocal Name Date Start Date stop Decision Comments

RID Number Prior Authorization Number

CONFIDENTIALITY NOTICE: This message (and attachments) may contain protected health information from Health Care Excel (HCE), and is covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521. This information is intended only for the use of the individual or entity named in this facsimile. Any unintended recipient is hereby notified that the information is privileged and confidential. Any use, disclosure, or reproduction of this information is prohibited.
EXHIBIT VI-17

MEDICAID MEDICAL CLEARANCE AND AUDIOMETRIC TEST

<table>
<thead>
<tr>
<th>MEDICAID MEDICAL CLEARANCE AND AUDIOMETRIC TEST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Instructions:</strong> The Medical Clearance and Audiometric Test Form must be used for all hearing aid fittings under the Indiana Medicaid Program. This form must be completed and carry the proper signature where indicated, before requests will be considered for prior authorization.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PART I Recipient History</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient's Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>If Institution, Admission Date</td>
</tr>
</tbody>
</table>

If unable to independently maintain your hearing aid, are there resources available to assist in maintenance? Yes No Explain:

Medical Diagnosis

Hearing Diagnosis

Has this recipient worn a hearing aid previously? Yes No If so, purchase dates Medicaid Purchased?

If recipient previously owns/wears amplification give the model and status of the instrument and settings.

**PART II Medical Clearance (to be completed by physician)**

A hearing aid will not be approved for a patient prior to that patient’s having had a medical examination. Preferably, this examination should be conducted by an otolaryngologist, if available and accessible, but a basic medical survey as indicated below can be performed by a licensed physician.

All children under fifteen (15) years of age must be seen by an otolaryngologist before the hearing aid is fitted.

The following minimal assessment is required before the fitting of any hearing aid:

1. Is there any evidence of infection or drainage from either ear? Yes No
2. Is there any significant headache, vertigo, or dizziness, nausea, or vomiting? Yes No
3. Has the hearing loss been sudden in onset? Yes No
4. Is the patient able to hear and understand speech at conversational level? Yes No
5. Presence of pus in the ear drum? Yes No
6. Perforation of the ear drum? Yes No
7. Impacted cerumen? Yes No
8. Presence of external ear canal infection? Yes No
9. The possibility of the complete closure of the ear canal? Yes No

Remarks:

I certify that I have examined the patient mentioned above and to my knowledge there is no medical or surgical contraindication to wearing a hearing aid.

Otolologic Diagnosis

I recommend the patient to be fitted for a hearing aid I recommend the patient be referred for future medical evaluation Signature of ENT or MD Date

R2 – 10/29/2004

VI-36
Exhibit VI-17 (Continued)

### PART III Audiological Assessment (to be completed by audiologist/otolaryngologist)

<table>
<thead>
<tr>
<th>Recipient’s Name</th>
<th>Age</th>
<th>Medicaid Number</th>
</tr>
</thead>
</table>

**RE ANSI 1969**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>250</th>
<th>500</th>
<th>1000</th>
<th>2000</th>
<th>4000</th>
<th>8000</th>
<th>Speech</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left-Air</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Left-Bone</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Right-Air</td>
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<tr>
<td>Right-Bone</td>
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<td></td>
</tr>
</tbody>
</table>

Validity of Test Results: Special Tests or Conditions:

- Hearing aid recommended for (left - right) ear
- Hearing aid NOT recommended

Recommendation information:

- Signature (Testing conducted by audiologist or otolaryngologist)

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

If pure tone testing indicates a bone-air gap of 15 decibels (dB) or more for two (2) adjacent frequencies on the same ear, or if speech discrimination tests indicate a score of less than 60 percent in either ear, or if hearing loss in one (1) ear is greater than the other ear by 20 decibels (dB) in the pure tone average or 20 percent in the discrimination score, the patient must be referred for further assessment by an otolaryngologist, providing the physician has not already considered these conditions.

### Test IV Hearing Aid Evaluation (to be completed by hearing aid dealer)

<table>
<thead>
<tr>
<th>Ear</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Make/Model</td>
<td>UNAIDED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tone Setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volume Setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PB Quiet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PB Noise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PB Level</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature (Evaluation conducted by Audiologist, Otolaryngologist or Hearing Aid Dealer) Date

### PART V Hearing Aid Contract (to be completed by hearing aid dealer)

Should there be complaints from a recipient and/or other responsible persons directly interested in the recipient, as to the user’s failure to receive satisfactory benefits from the hear aid, the Indiana State Registered Hearing Aid Dealer must attempt to make satisfactory adjustment or follow the recommendation as deemed advisable by the Medicaid Program. Failure to do so may cause payment to be withheld. If payment has been received by the Indiana State Registered hearing Aid Dealer, the full refund will be made to the contractor.

There is to be no solicitation of Medicaid patients, for the purpose of fitting hearing aids. As a general policy, there are to be no replacement hearing aid fittings for Medicaid patients where the hearing aid in use is less than five (5) years old.

“I have read the regulations and standards adopted and approved by the Indiana Department of Public Welfare, for the fitting and dispensing of hearing aids for Medicaid cases, and I have followed the procedures provided therein."

<table>
<thead>
<tr>
<th>Hearing Aid Dealer’s Signature</th>
<th>Indiana Registration No.</th>
<th>Date</th>
</tr>
</thead>
</table>
# MEDICAL CLEARANCE FOR NON-MOTORIZED WHEELCHAIR PURCHASE

**Indiana Health Coverage Programs**

**Medical Clearance for Non-Motorized Wheelchair Purchase**

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>RID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary and Secondary Diagnoses:</td>
<td>Length of illness:</td>
</tr>
<tr>
<td>Height:</td>
<td>Weight:</td>
</tr>
</tbody>
</table>

405 IAC 5-19-9 (a) – Medicaid reimbursement is available for wheelchairs or similar motorized vehicles, subject to the restrictions in this section, and requires prior authorization. (c) Requests for wheelchairs or similar motorized wheelchairs require a completed medical clearance form submitted with the prior authorization request before the request shall be reviewed.

1. Does the member currently have a wheelchair? What brand and model?
2. What is the condition of the current chair?
3. Why is this chair no longer effective for this member? Explain

4. Can it be repaired? Estimated cost? Will this chair be a second chair for this person?

## Functional Status

Please provide the functional status of the member that warrants the use of the wheelchair and accessories.

1. Upper extremities (be specific)
2. Lower extremities (be specific)
3. Hand function (be specific)
4. Contractures (be specific)
5. Neck/spine (be specific)
6. Static/dynamic sitting balance (be specific)
7. Ambulation (be specific)
8. Transfer/bed mobility (be specific)
9. ADLS (be specific)
10. Medical problems that require special positioning equipment (be specific)
11. Other

The provider may submit an Occupational Therapy or Physical Therapy evaluation if the above information is not sufficient for review.

## Residence

<table>
<thead>
<tr>
<th>Where does the member reside?</th>
<th>Home</th>
<th>Group Home</th>
<th>Nursing Facility</th>
<th>ICF/MR</th>
</tr>
</thead>
</table>

**405 IAC 5-19-3 (b) DME and associated repair costs for the usual care and treatment of members in long-term care facilities are reimbursed in the facility’s per diem rate and may not be billed to Medicaid by the facility, pharmacy, or other provider. Nonstandard or custom special equipment and associated repair costs require prior authorization by the office, and may be billed separately to Medicaid, when authorized.**

1. If the member resides in a nursing facility or ICF/MR, what modifications are currently on the per diem wheelchair or previously used on the per diem wheelchair to improve the member’s function?
Exhibit VI-18 (Continued)

**Indiana Health Coverage Programs**

**Medical Clearance for Non-Motorized Wheelchair Purchase**

2. If these modifications to the per diem wheelchair failed, please explain why. 

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

3. If no modifications were added to the per diem wheelchair, please explain why. 

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

**Wheelchair Specifications**

1. Specify the Brand and Model of the requested wheelchair.

2. What are the special features of the above-mentioned wheelchair that are needed by the member?

<table>
<thead>
<tr>
<th>Special Feature</th>
<th>Body Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Hemi height</td>
<td>Knee to heel</td>
</tr>
<tr>
<td>b. Seat depth</td>
<td>Femur length</td>
</tr>
<tr>
<td>c. Seat width</td>
<td>Hip width</td>
</tr>
<tr>
<td>d. Other</td>
<td></td>
</tr>
</tbody>
</table>

**Wheelchair Accessories**

List the accessories needed to make this wheelchair functional for the member and the corresponding problem that will be corrected or will be prevented from worsening. Use an additional page if more items need to be listed.

<table>
<thead>
<tr>
<th>Accessory</th>
<th>Member Specific Problem Corrected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

**Comments:**

________________________________________________________________________

________________________________________________________________________

Signature and Title ___________________________ Date ____________
# EXHIBIT VI-19

## MEDICAL CLEARANCE FOR MOTORIZED WHEELCHAIR PURCHASE

### Indiana Health Coverage Programs

**Medical Clearance for Motorized Wheelchair Purchase**

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>RID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary and Secondary Diagnoses:</td>
<td>Length of illness:</td>
</tr>
<tr>
<td>Height:</td>
<td>Weight:</td>
</tr>
</tbody>
</table>

405 IAC 3-19-9 (a) – Medicaid reimbursement is available for wheelchairs or similar motorized vehicles, subject to the restrictions in this section, and requires prior authorization. Motorized vehicles are covered only when the member is enrolled in a school, sheltered workshop, or work setting, or if the member is left alone for significant periods of time. It must be documented that the member can safely operate the vehicle and that the member does not have the upper extremity function necessary to operate a manual wheelchair.

(e) Requests for wheelchairs or similar motorized wheelchairs require a completed medical clearance form submitted with the prior authorization request before the request shall be reviewed.

1. Does the member currently have a wheelchair? What brand and model? 
2. What is the condition of the current chair? 
3. Why is this chair no longer effective for this member? Explain 
4. Can it be repaired? Estimated cost? Will this chair be a second chair for this person? 

### Functional Status

Please provide the functional status of the member that warrants the use of the wheelchair and accessories.

1. Upper extremities (be specific) 
2. Lower extremities (be specific) 
3. Hand function (be specific) 
4. Contractures (be specific) 
5. Neck/spine (be specific) 
6. Static/dynamic sitting balance (be specific) 
7. Ambulation (be specific) 
8. Transfer/bed mobility (be specific) 
9. ADLS (be specific) 
10. Medical problems that require special positioning equipment (be specific) 
11. Other 

The provider may submit an Occupational Therapy or Physical Therapy evaluation if the above information is not sufficient for review.

### Residence

Where does the member reside?  
- [ ] Home  
- [ ] Group Home  
- [ ] Nursing Facility  
- [ ] ICF/MR

### Motorized Wheelchair Criteria

1. Does the member live alone or have caregivers? If the member has a caregiver/family, how long is the member left alone? Explain 

---

R2 – 10/29/2004
### Indiana Health Coverage Programs

#### Medical Clearance for Motorized Wheelchair Purchase

2. Does the member have a caregiver in the home who is physically capable of assisting the member? Explain.

3. Is the member employed or attending a vocational or sheltered workshop? If so, where?

4. Does the member attend school? If so, where?

5. How does the member get to and from work, workshop, or school?

6. Can the member operate a manual wheelchair? If so, how far?

7. Does the member have the upper extremity function necessary to operate a motorized wheelchair? Explain.

8. Can the member safely operate the motorized wheelchair? Explain?

#### Wheelchair Specifications

1. Specify the Brand and Model of the requested wheelchair.

2. What are the special features of the above-mentioned wheelchair that are needed by the member?

#### Wheelchair Accessories

List the accessories needed to make this wheelchair functional for the member and the corresponding problem that will be corrected or will be prevented from worsening. Use an additional page if more items need to be listed.

<table>
<thead>
<tr>
<th>Accessory</th>
<th>Member Specific Problem Corrected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

#### Comments:

________________________________________________________________________
________________________________________________________________________

Signature and Title __________________________ Date ____________

R2 – 10/29/2004
MEDICAL CLEARANCE FOR TENS UNIT (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR)

A TENS unit may be authorized for rental or purchase by the Indiana Medicaid Program. The following questions must be answered completely before a determination can be made. Telephone authorizations will not be given for this item.

1. What is clinical history in relation to pain source? __________________________

2. What medications are currently being prescribed for this condition? How frequently are they taken? ____________________________________________________________

3. Has a trial period of TENS rental been utilized? How long? What objective signs of improvement were seen? ____________________________________________________________

4. What is the patient’s current activity level? (ambulatory; with or without assistance; is a walker, cane, crutches or wheelchair necessary?) ____________________________________________________________

5. What are the anticipated goals after TENS use? ____________________________

6. In your judgment, what period of time will this patient require the use of the TENS unit? Check one: days _____ weeks _____ months _____

7. Your comments ________________________________________________________
   ________________________________________________________
   ________________________________________________________
## MEDICAL CLEARANCE FOR AUGMENTATIVE COMMUNICATION DEVICE

### AUGMENTATIVE COMMUNICATION SYSTEM SELECTION

<table>
<thead>
<tr>
<th>Recipient Name</th>
<th>Medicaid Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

**Section A** – To be completed by physician. Use additional sheets as needed.

Medical diagnosis and history:

---

Physician Signature

Name

Phone

Provider Number

Address

---

**Section B** - To be completed by speech or language pathologist. Use additional sheets as needed. Please describe current functional abilities in terms of:

Communication Skills:

Motor Status:
Exhibit VI-21 (Continued)

Sensory Status:

Cognitive Status:

Social/Emotional Status:

Language Status:

Information is also needed on the following:
Educational ability and needs:

Vocational potential:

Anticipated duration of need:

Prognosis regarding oral communication skills:

Prognosis with a particular device: (Has there been a trial period with this or a similar device?)

Recommendation: (Why this particular device? What other kinds of equipment have been used?)

________________________________________  Name _______________________________________

________________________________________  Phone _______________________________________ 

________________________________________  Address ________________________________
## MEDICAL CLEARANCE FOR PARENTERAL OR ENTERAL NUTRITION

### Effective 10/93 DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER DMERC 10.01

#### Certificate of Medical Necessity: Parenteral or Enteral Nutrition

<table>
<thead>
<tr>
<th>Section A</th>
<th>Initial</th>
<th>Revised</th>
<th>Recertification</th>
<th>Supplier Name, Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name, Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place of Service</td>
<td>Replacement Item</td>
<td>HCPCS Code(s)</td>
<td>Warranty Length</td>
<td>Type</td>
</tr>
<tr>
<td>Name and Address of Facility if applicable:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Section B

<table>
<thead>
<tr>
<th>Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis (ICD9):</td>
</tr>
<tr>
<td>I last examined this patient for this condition on:</td>
</tr>
<tr>
<td>/ /</td>
</tr>
<tr>
<td>/ /</td>
</tr>
<tr>
<td>Ed, Length of Need: # of Months:</td>
</tr>
</tbody>
</table>

Answer Questions 1-6 for Parenteral, answer 2, 6-15 for Enteral Use Y – Yes, N – No or D – Does Not Apply, unless otherwise noted.

1. Does the patient have severe permanent disease of the gastrointestinal tract which prevents absorption of sufficient nutrients to maintain weight and strength commensurate with the patient’s overall health status?

2. Do the number of calories prescribed average 20-35 cal/kg/day?

3. Days per week infused? Enter 1-7

4. **Formula components:**
   - Amino acid (ml/day) concen% gms protein/day
   - Dextrose (ml/day) concen %
   - Lipids (ml/day) days/week concen %

5. **What is the route of administration?**
   - Central Line
   - Peripheral line
   - Hemodialysis access line
   - Peripherally inserted central catheter (PICC)

6. Has there been a break in therapy of two or more consecutive months, necessitating a new certification, during which time the patient did not receive enteral or parenteral feeding?

7. Does the patient have permanent nonfunction or disease of the structures that normally permit food to reach the small bowel?

8. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient’s overall health status?

9. **What is the prescribed route of administration?**
   - Nasogastric tube
   - Gastrostomy tube
   - Jejunostomy tube

10. **Product name:**

11. Calories per day?

12. Days per week administered? Enter 1-7

13. **Method of administration?**
   - Syringe
   - Gravity
   - Pump

14. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?

15. Additional information when required by policy:

I certify the medical necessity of these items for this patient. Section B of this form and any statement on my letterhead attached hereon has been completed by me or reviewed by me. The foregoing information is true, accurate and complete. I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

<table>
<thead>
<tr>
<th>Physician Name, Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Signature:</td>
</tr>
<tr>
<td>(Stamped Signature is NOT Acceptable)</td>
</tr>
<tr>
<td>□ Attending □ Consulting □ Other ordering</td>
</tr>
<tr>
<td>UPIN:</td>
</tr>
<tr>
<td>Telephone #:</td>
</tr>
</tbody>
</table>

R2 – 10/29/2004 VI-45
# EXHIBIT VI-23

## MEDICAL CLEARANCE FOR OXYGEN THERAPY

**Certificate of Medical Necessity**

**Oxygen**

<table>
<thead>
<tr>
<th>Section A</th>
<th>Certification Type/Date:</th>
<th>Initial <strong>/</strong>/__</th>
<th>Revised <strong>/</strong>/__</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name, Address</td>
<td>Supplier Name, Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone #(<em><strong>)</strong>_____-</em>______</td>
<td>HICN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone #(<em><strong>)</strong>_____-</em>______</td>
<td>NSC#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place of Service</td>
<td>HCPCS Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name, Address of Facility if applicable</td>
<td>Physician Name, Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone #(<em><strong><strong><strong>)</strong></strong></strong></em>-_______</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UPIN#</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION B INFORMATION IN THIS SECTION MAY NOT BE COMPLETED BY THE SUPPLIER OF THE ITEMS/SUPPLIES**

<table>
<thead>
<tr>
<th>Est. Length of Need (0 of Months):</th>
<th>(00 - lifetime)</th>
<th>Diagnosis Codes (ICD-9):</th>
</tr>
</thead>
</table>

### Answers

1. Enter the results of most recent test taken *on or before* the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test. Enter date of test (c).

2. Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home?

3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep

4. Physician/provider performing test Question 1 (and if applicable, Question 7). Print/type name, address below:
   - Name:
   - Address:

5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen circle D.

6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter X.

7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).

### IF PO2 = 56-59 OR OXYGEN SATURATION = 89% OR ABOVE, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.

8. Does the patient have dependent edema due to congestive heart failure?

9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?

10. Does the patient have a hematocrit greater than 56%?

**Name of Person Answering Section B Questions, If Other Than Physician (Please Print):**

- Name: ______________________
- Title: ______________________
- Employer: ___________________

**SECTION C**

**Narrative Description of Equipment and Cost**

- (1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See Instructions on back)

**SECTION D**

**Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

- Physician's Signature: ______________________
- Date: ______________________

(Signature and Date Stamps are not acceptable)
## EXHIBIT VI-24

**PHYSICAL ASSESSMENT FOR STANDING EQUIPMENT**

**MEDICAL CLEARANCE FORM**

### Section A: Patient Information

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Recipient identification number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td>Onset date of disability</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Current weight</td>
<td>Current height</td>
</tr>
</tbody>
</table>

### Section B: Physician Information

<table>
<thead>
<tr>
<th>Provider’s name</th>
<th>Provider number</th>
</tr>
</thead>
</table>

### Section C: General Physical Status

*Please circle most appropriate answer. If abnormal or progress is circled, please explain in the space provided.*

<table>
<thead>
<tr>
<th>Cardiopulmonary status</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensation/body awareness</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Progress</td>
</tr>
<tr>
<td>Skin status</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Progress</td>
</tr>
<tr>
<td>Sensation status</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Progress</td>
</tr>
<tr>
<td>Muscle strength status (Specify upper and lower strength)</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Progress</td>
</tr>
<tr>
<td>Muscle tone status</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Progress</td>
</tr>
<tr>
<td>ROM status (Specify upper and lower ROM)</td>
<td>WFL (within functional limits)</td>
<td>Abnormal</td>
<td>Progress</td>
</tr>
<tr>
<td>Standing static and dynamic balance</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Progress</td>
</tr>
<tr>
<td>Sitting static and dynamic balance</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Progress</td>
</tr>
</tbody>
</table>
Exhibit VI-24 (Continued)

Section D: Requires Assistance With The Following
* Please circle most appropriate answer

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propelling wheelchair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section E: Rational For Use
* Please circle yes or no

- To maintain bone integrity and increase bone density: Yes No
- To improve circulation in the lower extremities: Yes No
- To improve range of motion: Yes No
- To decrease muscle spasms: Yes No
- To strengthen cardiovascular system and build endurance: Yes No
- To improve strength to the trunk and lower extremities: Yes No
- To prevent or decrease joint muscle contractures: Yes No
- To lessen or prevent progressive scoliosis: Yes No
- To aid normal skeletal development: Yes No

Section F: Special Considerations
* Please circle the correct answer or fill in the blanks

- What is the height range and weight capacity of the stander requested?
  - Height range from _______ to _______
  - Weight capacity from _______ to _______
  - Additional Comments:

- What are the position needs?
  - Supine Vertical Prone Multi-positional
  - Additional Comments:

- What is the cost of the stander?
  - Please individually list each requested accessory and its cost.
  - How long will the stander be required?
    - Months _______ Years _______ Lifetime _______
    - Additional Comments:
  - Is the nonpaid primary caregiver willing and able to be trained to use the equipment safely? Yes No
  - Additional Comments:

Assessment Completed By: ___________________________ Date: _______________________

Section G: Physician’s Signature and Date

I certify the medical necessity of these items for this patient. I have examined the above-mentioned patient and to my knowledge there are no medical or surgical contraindications for the use of a stander.

Physician’s signature: ___________________________ Date: _______________________

EDS
P. O. Box 7263
Indianapolis, IN 46207-7263
For more information visit www.indianamedical.com
## EXHIBIT VI-25

### HOSPITAL AND SPECIALITY BEDS MEDICAL CLEARANCE FORM

#### M E D I C A L  C L E A R A N C E  F O R M

<table>
<thead>
<tr>
<th>Hospital and Specialty Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section A</strong></td>
</tr>
<tr>
<td>Certification Date: Initial: <strong>/</strong>/__   Revised: <strong>/</strong>/__</td>
</tr>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>RID Number:</td>
</tr>
<tr>
<td>Place of Service:</td>
</tr>
<tr>
<td>Name and address of facility (if applicable)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### Section B

*Information in this section may not be completed by the supplier of the items or supplies*

<table>
<thead>
<tr>
<th>Estimated length of need (number of months______)</th>
<th>DX codes (ICD-9) ____________ __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years______ Lifetime______</td>
<td></td>
</tr>
</tbody>
</table>

Circle Y for Yes, N for No, or NA for Not Applicable for the following questions:

1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?  
   - Y  
   - N  
   - NA

2. Does the patient require, for the relief of pain, positioning of the body in ways not feasible in an ordinary bed?  
   - Y  
   - N  
   - NA

3. Does the patient require the head of the bed elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or aspiration?  
   - Y  
   - N  
   - NA

4. Does the patient require traction that can only be attached to a hospital bed?  
   - Y  
   - N  
   - NA

5. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?  
   - Y  
   - N  
   - NA

6. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?  
   - Y  
   - N  
   - NA
Exhibit VI-25 (Continued)

Section C
*Narrative description of equipment and cost

(1) Narrative description of all items, accessories, and options ordered; and (2) supplier's charges:

<table>
<thead>
<tr>
<th>Section D</th>
<th>*Complete this section if you are supplying or ordering a specialty bed. If supplying or providing a hospital bed, skip to Section E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What diagnosis qualifies this patient for a specialty bed?</td>
<td>ICD-9 code:</td>
</tr>
<tr>
<td>Does this patient have seizures?</td>
<td>Y  N  NA</td>
</tr>
<tr>
<td>Date of last seizure:</td>
<td>How often do seizures occur?</td>
</tr>
<tr>
<td>Has patient sustained injury related to seizure activity?</td>
<td>Y  N  NA</td>
</tr>
<tr>
<td>List three safety factors that have been tried and why they failed?</td>
<td></td>
</tr>
</tbody>
</table>

Does this patient have a history of behavior problems that may result in injury, or a history of falls, respiratory problems, cardiac problems or gastrointestinal problems? | Y  N  NA |

If yes, document all that apply.

Section E: Physician Signature, Attestation, and Date

I certify that I am the physician listed in section A of this form. I have received sections A through E of the certificate of medical necessity (including charges for items ordered). Any statement on my letterhead, attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is Section B is true, accurate and complete to the best of my knowledge, and I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician’s Signature:  Date:
## NEGATIVE PRESSURE WOUND THERAPY
### MEDICAL CLEARANCE FORM

### Section A

<table>
<thead>
<tr>
<th>Certification Date</th>
<th>Initial: / /</th>
<th>Revised: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name</td>
<td>Supplier name</td>
<td>Initial: / /</td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td>Revised: / /</td>
</tr>
<tr>
<td>Phone number</td>
<td>Provider number</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Place of service

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Location (if applicable)</th>
</tr>
</thead>
</table>

### Section B

**Information in this Section May Not Be Completed by the Supplier of the Items/Supplies**

<table>
<thead>
<tr>
<th>Estimated length of stay (Number of months)</th>
<th>Or codes (ICD-9)</th>
</tr>
</thead>
</table>

### Questions

**Y** = Yes, **N** = No, **NA** = Not applicable

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No/NA</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient's nutritional status adequate for wound healing?</td>
<td>Y/N/NA</td>
<td>Describe the diet.</td>
</tr>
<tr>
<td>Has a moist wound environment dressings been tried and failed?</td>
<td>Y/N/NA</td>
<td>If yes, please describe what type of dressing was used.</td>
</tr>
<tr>
<td>Is necrotic tissue present, has debridement been attempted?</td>
<td>Y/N/NA</td>
<td></td>
</tr>
<tr>
<td>Does the patient have osteomyelitis?</td>
<td>Y/N/NA</td>
<td>If yes, what is the treatment regimen?</td>
</tr>
<tr>
<td>Is there a fistula within the vicinity of the wound or cancer in the wound?</td>
<td>Y/N/NA</td>
<td></td>
</tr>
<tr>
<td>Is there a documented history of previous wound management regimen, including wound measurements available for review on request by the HCP?</td>
<td>Y/N/NA</td>
<td></td>
</tr>
</tbody>
</table>

### Section C

#### Wound Description

**Fill this section out for the primary wound and fill out a supplemetal form for each additional wound.**

<table>
<thead>
<tr>
<th>Type of wound (check one)</th>
<th>Wound size:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arteriovenous insufficiency ulcer</td>
<td></td>
</tr>
<tr>
<td>Stage 3 or 4 pressure ulcer</td>
<td>Approximate age of wound</td>
</tr>
<tr>
<td>Chronic ulcer of mixed etiology</td>
<td></td>
</tr>
</tbody>
</table>

**Wound Measurements**

<table>
<thead>
<tr>
<th>Venous stasis ulcer</th>
<th>Current</th>
<th>One month ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropathic ulcer (such as diabetic)</td>
<td>Current</td>
<td>One month ago</td>
</tr>
<tr>
<td>Length (cm)</td>
<td>Width (cm)</td>
<td>Depth (cm)</td>
</tr>
<tr>
<td>Length (cm)</td>
<td>Width (cm)</td>
<td>Depth (cm)</td>
</tr>
</tbody>
</table>

**Exudate**

<table>
<thead>
<tr>
<th>Current</th>
<th>One month ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slight</td>
<td>Slight</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Heavy</td>
<td>Heavy</td>
</tr>
</tbody>
</table>
### Exhibit VI-26 (Continued)

#### Indiana Health Coverage Programs

**Medical Clearance Form (continued)**

#### Negative Pressure Wound Therapy

<table>
<thead>
<tr>
<th>Section D</th>
<th>Complete this section in addition to the previous sections according to the type of wound the patient has. Place an X in the appropriate box.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D1</strong> Complete these questions for Pressure ulcers</td>
<td></td>
</tr>
<tr>
<td>Has the patient been on a turning schedule?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Is the patient using a group 2 or group 3 support surface?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Have moisture and incontinence been appropriately managed?</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

If any of the answers above are answered no and these treatment measures have been considered and ruled out, please explain.

**D2** Complete these questions for Neuropathic ulcers

| Has the patient been on a comprehensive diabetic management program? | Yes ☐ No ☐ |
| Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities? | Yes ☐ No ☐ |

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

**D3** Complete these questions for Surgical or Traumatic wounds

| Does the patient have complications of a surgically created wound? | Yes ☐ No ☐ |
| Does the patient have a traumatic wound? | Yes ☐ No ☐ |

Is there documentation for the medical necessity for accelerated formation of granulation tissue that cannot be achieved by other available topical wound treatments? If yes, please explain.

**D4** Complete these questions for Venous Insufficiency ulcers

| Have compression bandages or garments been consistently applied? | Yes ☐ No ☐ |
| Has leg elevation and ambulation been encouraged? | Yes ☐ No ☐ |

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

**D5** Complete these questions for Arterial or Chronic ulcers

| Has relief of pressure over the wound been achieved? | Yes ☐ No ☐ |
| Have moisture and incontinence been controlled? | Yes ☐ No ☐ |

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

### Section E

<table>
<thead>
<tr>
<th>Physician Signature, Attestation, and Date</th>
</tr>
</thead>
</table>

I certify that I am the physician listed in section A of this form. I have received sections A through E of the certificate of medical necessity. All supplemental attachments and any statement on my letterhead, attached here, have been reviewed and signed by me. I certify that the medical necessity information in Section B through D is true, accurate, and complete to the best of my knowledge, and I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

**Physician Signature:**

**Date:**
## Exhibit VI-26 (Continued)

### Supplemental Section C

**Negative Pressure wound Therapy Supplemental Form**

- **Type of wound (check one)**
  - Arterial insufficiency ulcer
  - Stage 3 or 4 pressure ulcer
  - Chronic ulcer of mixed etiology
  - Venous stasis ulcer
  - Neuropathic ulcer (such as diabetic)
  - Traumatic (such as pre-op graft or flap)
  - Surgically created (such as dehisced)

- **Wound Site**: __________

- **Wound number #**: __________

- **Wound measurements**
  - **Current**
    - Length: __ cm
    - Width: __ cm
    - Depth: __ cm
  - **One month ago**
    - Length: __ cm
    - Width: __ cm
    - Depth: __ cm

- **Exudate**
  - **Current**: __________
  - **One month ago**: __________
    - Sight
      - Heavy
    - Moderate
    - Sight
    - Heavy

### Supplemental Section D

**Complete this section according to the type of wound in addition to the previous sections. Place an X in the appropriate box**

#### Supplemental D1 Complete these questions for Pressure ulcers

- Has the patient been on a turning schedule? Yes [ ] No [ ]
- Is the patient using a group 2 or group 3 support surface? Yes [ ] No [ ]
- Have moisture and incontinence been appropriately managed? Yes [ ] No [ ]

If any of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

#### Supplemental D2 Complete these questions for Neuropathic ulcers

- Has the patient been on a comprehensive diabetic management program? Yes [ ] No [ ]
- Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities? Yes [ ] No [ ]

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

#### Supplemental D3 Complete these questions for Surgical or Traumatic wounds

- Does the patient have complications of a surgically created wound? Yes [ ] No [ ]
- Does the patient have a traumatic wound? Yes [ ] No [ ]

Is there documentation for the medical necessity for accelerated formation of granulation tissue that cannot be achieved by other available topical wound treatments? If yes, please explain.

#### Supplemental D4 Complete these questions for Venous Insufficiency ulcers

- Have compression bandages or garments been consistently applied? Yes [ ] No [ ]
- Has leg elevation and ambulation been encouraged? Yes [ ] No [ ]

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.
### Exhibit VI-26 (Continued)

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>RID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative Pressure wound Therapy Supplemental Form (continued)</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Supplemental D5 Complete these questions for Arterial or Chronic ulcers**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has relief of pressure over the wound been achieved?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have moisture and incontinence been controlled?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

<table>
<thead>
<tr>
<th>Physician Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>
INTERNAL REFERRAL TO MEDICAL POLICY

Reported by External Source: ☐  Internal Source: ☐

I need to discuss with MP Specialist prior to research starting: ☐

Response to be sent to: ________________________________

Response needed by: ________________________________  An initial response will be made by Medical Policy within the 10-day time frame.

Response to be copied to: ________________________________

Internal:

Name of Reporting Department Director/Supervisor: ________________________________

Director/Supervisor Approval: ________________________________

Telephone/Extension: ________________________________

Date of Referral: ________________________________

Initial referral reported by: ________________________________

Date: ________________________________

Prior Authorization #: ________________________________ (as needed)

Recipient #: ________________________________ (as needed)

ICN #: ________________________________ (as needed)

External (provider, provider association):

Name of Concerned Party: ________________________________

Date: ________________________________

Address of Concerned Party: ________________________________

City: ________________________________  State: __________  Zip: __________

Telephone: ________________________________
EXHIBIT VI-27 (continued)

Issue (clear, concise description of the question to be answered):

Intended use of response (recoupment, association meeting, educational):

Qualifying details related to the questions, such as examples of claims:

List and quote all references that you have already reviewed, such as law, provider manual, bulletin:
VII. PRIOR AUTHORIZATION LETTERS

Prior Authorization (PA) letters will be sent to the requesting provider and to the member informing them of review decisions. Initial approval, denial, and modification decision letters are automatically generated from the Indiana AIM system. The PA reviewer enters into the external text citations from the Indiana Administrative Code, and any necessary comments explaining the review decision. This text should be proofread by the reviewer prior to printing. Appropriate dictionaries should be referenced if there is any doubt as to the correct spelling of any text. Supervisors will periodically check external text to ensure accuracy.

Letters to be sent to providers and members will be developed in accordance with the policy and procedure for the development of letters. Letters will be clear, concise, accurate, and free of spelling and typographical errors. They will clearly state any appeal rights to which the member is entitled. Form letters will be approved by the OMPP prior to their adoption and use.

Letters pertaining to Surveillance and Utilization Review cases, and Prior Authorization administrative reviews and Administrative Law Judge hearings will be proofread by three parties prior to being mailed. These letters are “form letters” into which individualized text will be inserted. Refer to the exhibits following this section for examples of letters.

A. Letters will be adopted under the oversight of the PA Manager.

1. Any staff member who identifies the need for a new or revised letter may propose letters.

2. The person who identifies the need will notify the PA Manager, in writing, of the type of letter, the reason for the need, and any suggestions or revisions. A copy of this communication should also be sent to the manager of the involved department.

3. The PA Manager and the appropriate department manager will conduct an evaluation to determine whether a new letter is required. This will be accomplished within five business days of receipt of the request.

4. If it is determined that the letter is not needed, the PA Manager will notify the requesting party of the rationale for not developing a new letter.

5. If it is determined that a new letter is needed, the PA Manager (or designee) will draft a letter.
♦ For revised letters the draft of the current letter should have revisions clearly indicated.

♦ Instructions for completing any blanks in the letter should be included with the draft copy.

6. Factors to consider in the development of the letter include the following:

♦ citation of rules and regulations;
♦ readability;
♦ the audience for whom it is intended;
♦ appeal rights; and
♦ a contact person for questions.

7. The draft letter will be labeled with its indications for usage, and will be routed for comment to the members of the Operations Assessment Committee. The “Letter Approval Form” will accompany the letter.

8. Recommendations for changes can be made on the letter and/or on the “Letter Approval Form.”

9. The completed form should be returned to the PA Manager within 10 business days of routing.

10. The PA Manager will seek to resolve all areas of concern raised by staff prior to finalizing the letter. If substantive or conflicting changes are suggested, the changes will be incorporated and a second draft will be routed.

11. If the changes suggested are not substantive, or subsequent to the routing of the second draft, the changes will be incorporated into the letter, and the letter will be forwarded to the Health Care Excel Central Point of Contact.

12. Whenever appropriate, HCE will coordinate with EDS on new or revised letters.

13. The Central Point of Contact will forward the letter to the Office of Medicaid Policy and Planning for approval.

14. If the OMPP suggests changes, the PA Manager will incorporate these into the letter.
15. Upon receipt of approval from the State, the Program Director will authorize that the letter be adopted for use.

16. Correspondence secretaries and appropriate staff will be notified of the existence and appropriate use of the new letter. This training will occur through staff meetings, routing of the letter with an explanation, or a more formal session, depending upon the complexity of the use of the letter.

17. The letter will be placed in the Letters Manual and the appropriate department manual, and will be available electronically.

18. In the event that a staff member identifies a need to delete an obsolete letter, the person will prepare a written memorandum to the PA Manager. The letter should be specifically identified, and the rationale for the proposed deletion should be included in the memorandum.
VIII. QUALITY MANAGEMENT

The primary objective of Health Care Excel (HCE) will be to administer the Medical Policy and Review Services program in a manner that promotes the timely delivery of appropriate services, supports the objectives and guiding principles of the Indiana Health Coverage Program (IHCP) program, and promotes efficiency and effectiveness throughout the program. HCE will train its staff sufficiently to meet these objectives, and will measure the performance in order to ensure that the objectives are met. The Quality/Training Plan delineates the components of performance and the standards.

A. Training of Prior Authorization Staff

Prior Authorization department staff will be trained in accordance with the guidelines set forth in the Quality/Training Plan. Because the Prior Authorization department is a “front line” area, it is imperative that its employees are well trained and ready to meet the challenges and opportunities which will be presented to them. Employees will be provided with a wide variety of issues, accompanied by examples and practice sessions.

Training will be accomplished through several forums. These will include formal training sessions, training accomplished during staff meetings, and routing and posting of educational materials.

Knowledge will be assessed through the use of pre- and post-training knowledge assessments, return demonstrations, and observation of daily work, among others.

Initial training will consist of elements for which a basic understanding is required for successful implementation of the IHCP Policy and Review Services contract. These elements include training in:

- HCE policies and procedures;
- operation of equipment;
- safety;
- security;
- Quality Management and Performance Standards;
- overview of Indiana Health Coverage Programs;
- partners in the program;
- providers and member constituency groups;
- duties of other contractors;
- overview of Medical Policy and Review Services;
- overview of the Medical Policy department;
♦ overview of the Surveillance and Utilization Review department;
♦ overview of the Prior Authorization department;
♦ customer service attitude;
♦ telephone etiquette;
♦ use of software, including Windows 2000;
♦ Confidentiality Plan;
♦ program integrity (fraud and abuse);
♦ the medical record tracking system;
♦ principles of Continuous Quality Improvement;
♦ HIPAA overview; and
♦ HIPAA Privacy Policies.

In addition to the above-mentioned general training goals, training for prior authorization will include these objectives.

♦ Employees will know the State’s prior authorization requirements.
♦ Reviewers will have a thorough knowledge of the use of medical criteria, why criteria are used, intended uses of criteria, and the mechanics of using criteria, and will utilize the criteria correctly.
♦ PA reviewers and specialists will know how to approve a case.
♦ Employees will implement all HIPAA Privacy requirements into their daily business functions.
♦ PA reviewers and specialists will know what to do if a case does not “meet criteria.”
♦ Employees will be able to use the telephone equipment proficiently, including transferring calls, placing callers on hold (if absolutely necessary), etc.
♦ Employees will have a thorough knowledge of the department’s policies and procedures.
♦ Support staff will appropriately perform mail processing and other related activities.
♦ Employees will identify the appropriate forms, and utilize them correctly.
♦ Reviewers and specialists will have a working knowledge of applicable components of Indiana AIM.
♦ Reviewers, specialists, and support staff will have a thorough working knowledge of the data system and will be proficient in data entry.

♦ The manager and supervisors will be proficient in the use of Excel, in addition to Windows and Word, and other applicable software.

♦ Employees will have relevant knowledge of reporting requirements.

♦ Appropriate employees will have relevant knowledge about the Indiana Administrative Code as it pertains to Indiana Health Coverage Programs.

♦ Reviewers and specialists will have knowledge of the hearings and appeals process.

♦ Employees will be trained in the subsystems for tracking and recording documents and issues.

B. Plan for Remedial Training

Every effort will be made to assist employees to succeed. Remedial training will be available for employees who are at risk of failure.

Knowledge assessments will be administered to establish indicators of adequate understanding to conduct duties. A minimum score of ninety-five percent (95%) will be required to continue to perform without remedial education. Remedial education will be individualized to best match the person’s needs.

In the event that a significant deficiency has been identified, that is beyond the acceptable range of performance, and has not been able to be resolved; a Performance Improvement Plan (PIP) will be developed and implemented. The department director will develop and submit a PIP. In the communiqué requesting the PIP, these features will be incorporated.

♦ How and when the deficiency was identified.

♦ How the deficiency adversely affects the contract performance.

♦ A statement that the PIP needs to meet the needs of the department while addressing the problem.

♦ A statement that the PIP must be submitted to the Program Director within 10 (ten) calendar days.

♦ An offer to assist in the development of the PIP.
The process for corrective action has been delineated in the Quality Management Plan.

C. Training of Consultants

Physicians and other consultants will receive training pertinent to their business function duties. In addition to business-function-specific education, all consultants will receive an orientation to HCE and to the Indiana Health Coverage Programs. A reference manual will be created, and will be available for their use. This manual will provide an overview of the program, the stakeholders, and a discussion for each of Medical Policy, Prior Authorization, and Surveillance and Utilization Review.

The comprehensive approach to program education will facilitate the provision of individual services across the business functions. Particular attention will be given to issues associated with program integrity (fraud and abuse). Where statistical techniques are important, an explanation will be provided and supported through the use of an experienced program reviewer. All training will be conducted prior to the initiation of services.

Independent consultants and reviewers will be subject to standards of professional performance. The Medical Director will have an important role in the training, monitoring, and feedback associated with these consultants. Performance will be evaluated through random or focused reviews conducted under the direction of the Medical Director. Individuals who establish and maintain a poor performance will no longer be used in the program.

D. Performance Management

It is understood that each person employed by Health Care Excel, to fulfill this contractual obligation, possesses a personal and professional interest in ensuring that the administration of the Medical Policy and Review Services contract is successful, innovative and rewarding. It is imperative that each employee understands and respects the contract requirements and feels an obligation to assist in the improvement of processes used to administer the contract. Health Care Excel is receptive to suggestions for the enhancement of current functions, the betterment of written policies and criteria, and the upgrading of the overall effectiveness of the Medical Policy and Review Services program.

To ensure the contract obligations are met efficiently and timely, the internal Quality Management Plan will provide the framework that monitors internal process performance and provides information to:

♦ support and foster continuous quality improvement;
♦ develop and implement processes that ensure all activities run efficiently, comply with the contract, and are consistent with IHCP goals and objectives;
♦ maintain activities within a permissible range of deviation with minimum effort;
♦ improve the reliability, accuracy, consistency, and timeliness of data and information; and
♦ promote the IHCP program through the provision of credible services.

For each business function, the monitoring plan establishes a control process which meets the following objectives.

♦ Identifies what is subject to control and the elements measured through monitoring the organization’s and individual’s performances; monitoring the specific inputs, processes, and/or outcomes; and recognizing the most vital elements that account for most of the variations in performance.

♦ Sets the control standards (including tolerance limits) through the use of measures that permit a determination if performance is acceptable and if the quality and quantity of the output are adequate to support organizational and program objectives.

♦ Identifies the information to be collected and how performance will be measured (e.g., what is being done and what should be done).

♦ Determines the reason for deviations, through an assessment of the causes of any deviations from the standards.

♦ Provides appropriate and timely feedback on performance.

♦ Identifies and monitors improvement actions, through decisions on the best course of action for eliminating deviations or for exceeding current performance.

Health Care Excel will monitor review staff for appropriateness of decisions, timeliness of review, and accuracy of data entry. These monitoring activities will be the responsibility of the PA Supervisors, under the direction of the PA Manager.
IX. PERFORMANCE MEASUREMENT

The primary objectives of HCE are to administer the Medical Policy and Review Services Program in a manner that promotes the timely delivery of appropriate services, supports the objectives and guiding principles of the IHCP program, and promotes efficiency and effectiveness throughout the program.

It is imperative that each employee understands and respects the contract requirements and feels an obligation to assist in the improvement of processes used to administer the contract. HCE is receptive to suggestions for the enhancement of current functions.

A. Departmental Internal Quality Control

To ensure the contract obligations are met efficiently and timely, an internal Quality Management Plan will provide the framework that monitors internal process performance and provides information to:

♦ support and foster continuous quality improvement;
♦ develop and implement processes that ensure all activities run efficiently, comply with the contract, and are consistent with IHCP goals and objectives;
♦ maintain activities within a permissible range of deviation with minimum effort;
♦ improve the reliability, accuracy, consistency, and timeliness of data and information; and
♦ promote the IHCP program through the provision of credible services.

For each business function, the monitoring plan establishes a control process, which meets the following objectives.

♦ Identifies what is subject to control and the elements measured through monitoring organization and individual performances, specific inputs, processes, and/or outcomes, and recognition of the most vital elements that account for variations in performance.
♦ Sets control standards (including tolerance limits) through the use of measures that permit a determination if performance is acceptable and if the quality and quantity of the output are adequate to support organizational and program objectives.
♦ Identifies the information to be collected and how performance will be measured (i.e., what is being done and what should be done).

♦ Determines the reason for variations, through an assessment of the causes of deviation from the standard.

♦ Provides appropriate and timely feedback on performance.

♦ Identifies and monitors improvement actions through decisions on the best course of action for eliminating deviations or for exceeding current performance.

♦ On a monthly basis, the PA supervisor will audit four cases per PA staff. The audit process will measure all PA requirements, and customer service. All scores must be at 95% or higher. If not, remedial training will take place.

Performance indicators will be based on measurements associated with numerical ratings (volume, timeliness, number of complaints about performance, etc.) as well as feedback from more subjective factors (opinions about performance from surveys, State officials, other contractors and partners, providers, beneficiaries, and other sources). Monthly department performance reports will be submitted to the Program Director and other members of the Operations Assessment Committee. For each standard, the variance (exception) will be accompanied by comments explaining the cause and action, if any needed to address the variance.

In addition to departmental performance indicators, HCE’s internal quality control plan for review staff in the SUR and PA departments is designed to provide an objective, consistent and accurate method of assessing and improving performance of individual reviewers. The plan involves sampling four cases per reviewer on a monthly basis; re-review of those cases by supervisors using a standardized rating form; entry of re-review results into a database or analysis; and an intervention plan for individuals whose performance is unacceptable under the direction of the PA Manager.

The following table depicts individual performance standards.
In the event that a significant deficiency is identified that is beyond the acceptable range of performance and has not been able to be resolved, a performance improvement plan (PIP) will be developed and implemented. The department director will develop and submit a PIP.

### Business Function Performance Standards

In addition to the individual internal quality control elements, each department has responsibility for business function standards. They have been listed below with a short description of how the performance of the function will be measured and the standard to which the measure will be compared along with the method of securing the information. Some measures are not department specific, e.g., annual business plan or annual customer service plan. These are measured broadly to ensure a global perspective to quality management. The knowledge that one department functioned correctly is not sufficient if the global outcome is inadequate.

It is the responsibility of each department Manager to maintain a database of the standards and measurements listed in **Table IX-2**. Reports are submitted to the Program Director five working days following the end of the reporting period.
<table>
<thead>
<tr>
<th>Prior Authorization</th>
<th>Business Function</th>
<th>Measurement</th>
<th>Standard</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>maintenance of required staffing levels and types</td>
<td>Maintenance of required staffing levels and types</td>
<td>The number of actual required staff days, by type in each month will be divided by the required staff days each month.</td>
<td>95% or above</td>
<td>PBM quarterly staff report</td>
</tr>
<tr>
<td>maintenance of staff competency</td>
<td>Maintenance of staff competency</td>
<td>Average test scores for the quarter.</td>
<td>95% or above</td>
<td>IQC quarterly report</td>
</tr>
<tr>
<td>creation and maintenance of PA work plan</td>
<td>Creation and maintenance of PA work plan</td>
<td>Plan and updates submitted to the State timely.</td>
<td>98%</td>
<td>QM quarterly report</td>
</tr>
<tr>
<td>adequacy and accuracy of PA deliverables subject to State review and approval</td>
<td>Adequacy and accuracy of PA deliverables subject to State review and approval</td>
<td>Number of approved PA deliverables submitted to the State timely divided by the number of deliverables due.</td>
<td>98%</td>
<td>QM quarterly report</td>
</tr>
<tr>
<td>production of required PA reports on required production cycles</td>
<td>Production of required PA reports on required production cycles</td>
<td>Number of reports produced timely in the month of submission by the number of PA reports scheduled for the month.</td>
<td>95% or above</td>
<td>QM monthly report</td>
</tr>
<tr>
<td>responsiveness within three business days to State inquiries</td>
<td>Responsiveness within three business days to State inquiries</td>
<td>Number of non-State inquiries answered within three business days divided by the number of State requests made.</td>
<td>95% or above</td>
<td>QM quarterly report</td>
</tr>
<tr>
<td>responsiveness within 10 (ten) business days to other inquiries</td>
<td>Responsiveness within 10 (ten) business days to other inquiries</td>
<td>Number of non-State inquiries answered within 10 (ten) business days divided by the number of non-State requests made.</td>
<td>95% or above</td>
<td>QM quarterly report</td>
</tr>
<tr>
<td>contributions to annual business plan</td>
<td>Contributions to annual business plan</td>
<td>Approved elements submitted to the State timely.</td>
<td>98%</td>
<td>QM report</td>
</tr>
<tr>
<td>contributions to annual customer service plan</td>
<td>Contributions to annual customer service plan</td>
<td>Approved elements submitted to the State timely.</td>
<td>98%</td>
<td>QM report</td>
</tr>
<tr>
<td>adequacy of PA criteria</td>
<td>Adequacy of PA criteria</td>
<td>The number of cases referred out of the first level of review because of inadequacy of criteria divided by the number of cases reviewed.</td>
<td>20% or less</td>
<td>QM quarterly report</td>
</tr>
<tr>
<td>Business Function</td>
<td>Measurement</td>
<td>Standard</td>
<td>Outcome</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------</td>
<td></td>
</tr>
<tr>
<td>Timeliness of telephone services</td>
<td>The number of calls answered within two minutes divided by the number of calls.</td>
<td>95% or greater</td>
<td>ACD report</td>
<td></td>
</tr>
<tr>
<td>Adequacy and timeliness of entry into IndianaAIM</td>
<td>Number of PA requests entered into the IndianaAIM PA system on-line within two business days of receipt divided by the number of PA requests received.</td>
<td>95% or greater</td>
<td>QM monthly report</td>
<td></td>
</tr>
<tr>
<td>Adequacy and timeliness of entry into IndianaAIM</td>
<td>Number of PA requests entered into the IndianaAIM PA system on-line within seven business days of receipt divided by the number of PA requests received.</td>
<td>100%</td>
<td>QM quarterly report</td>
<td></td>
</tr>
<tr>
<td>Avoidance of management of backlogs</td>
<td>Current work in progress minus average work in progress divided by average work in progress.</td>
<td>30% or less</td>
<td>QM quarterly report</td>
<td></td>
</tr>
<tr>
<td>Adequacy of PA decisions</td>
<td>Number of PA cases monitored and found to be correct divided by the number of PA cases monitored.</td>
<td>95% or above</td>
<td>IQC report</td>
<td></td>
</tr>
<tr>
<td>Timeliness of case dispositions (within 10 business days of receipt)</td>
<td>Number of PA requests completed within 10 (ten) business days of receipt divided by the number of PA requests received.</td>
<td>95% or above</td>
<td>QM quarterly report</td>
<td></td>
</tr>
<tr>
<td>Availability to participate in appeals, hearings</td>
<td>Number of times appropriate person participates in an appeal or hearing divided by the number of request for appearance.</td>
<td>98% or above</td>
<td>QM quarterly report</td>
<td></td>
</tr>
</tbody>
</table>
X. CONFIDENTIALITY

All employees, consultants, and reviewers are subject to confidentiality standards and guidelines at Health Care Excel. Implementation of the Privacy Act under the Health Insurance Portability and Accountability Act (HIPAA) adds to the confidentiality requirements necessary for the Prior Authorization department. Under the provisions of covered entities, the Prior Authorization department is an extension to the Indiana Health Coverage Programs and must adhere to the additional requirements of the Privacy Act.

The Prior Authorization department frequently handles and accesses confidential and protected health information material. The Prior Authorization department implements several measures, which in combination, provide for the security of the confidential material. (Additional security and confidentiality is outlined in the Facility and Security Plan.)

♦ All employees, consultants, and reviewers will be subject to the provisions of the Indiana Medical Policy and Review Services (IMPRS) Privacy Manual. After receiving education in confidentiality, each employee will be requested to initially sign, and re-affirm on an annual basis, his or her understanding and compliance with the confidentiality requirements.

♦ The departmental entrances are labeled with restricted access. No unauthorized person is permitted beyond the restricted access areas without supervision from a Health Care Excel employee. All visitors and/or guests are required to sign-in on an attendance roster located in the lobby. All visitors and guests must be accompanied by an authorized Health Care Excel employee at all times when in the restricted areas.

♦ All employees must have a name badge visible to identify themselves as Health Care Excel employees.

♦ The Prior Authorization department accesses and maintains confidential material. Usernames and passwords are required to access this material. No employee is permitted to share his or her username or password with anyone else. Unattended computer terminals are to be secured from unauthorized access into the system.

♦ The Prior Authorization department must access the IndianaAIM database, maintained by EDS, to process prior authorization requests for medical review. Additional usernames and passwords are used to access this system. Passwords are changed every 30 (thirty) days and/or as needed. No employee is permitted to share his or her username or password with anyone else.
The Prior Authorization department frequently maintains and handles confidential paperwork that can include faxes and copies of protected health information. All fax machines will be located in an enclosed area and checked for incoming faxes every 15 (fifteen) minutes. The PA requests are then placed in folders to maintain privacy and confidentiality. All confidential material will be maintained within the restricted or secured areas of Health Care Excel. Confidential material must always be concealed from plain view. Locked, confidential bins are available in each department for disposal and shredding of confidential paperwork and material. All confidential material should be placed in these labeled bins for proper disposal of protected health information. At no time should protected health information or confidential material be disposed of in regular trash bins.

All breaches of confidentiality are to be reported to the Manager of Prior Authorization, the Program Director, or alternative Director. Additional information regarding confidentiality and security is outlined in the Facilities and Security Plan, Quality Management Plan, the Peer Review and Consultant handbook, and IMPRS Privacy Manual.
XI. HIPAA GUIDELINES FOR PRIOR AUTHORIZATION OPERATIONS

The HIPAA Privacy Rule requires the Indiana Health Coverage Programs (IHCP), as a health plan, to provide protection and security to a member’s protected health information (PHI) that is transmitted or maintained in any form, including oral communication. A member’s PHI includes the demographic information, RID number, claim information and documentation to support reimbursement of a claim. For a complete definition of protected health information, refer to the Indiana Medical Policy and Review Services (IMPRS) Privacy Manual. The policies and procedures contained within this manual will guide the HCE staff member in determining the steps to take when asked to provide a member’s PHI to the member, the member’s personal representative, or to another external agency or entity requesting the information.

If a member calls the PA department requesting information regarding an existing PA, the reviewer will verify the members, name, address, RID number and social security number or members birth date. In all cases of a member requesting access to PHI, the HCE employee will not provide member PHI, but will refer the request to the IHCP Privacy Unit. The Privacy Unit has been established to act as the gatekeeper of member PHI, and all requests, with very few exceptions, must be routed through the unit.

The Privacy Rule also requires each staff member to be aware of the PHI that they use in their daily work activities. Not only must the staff member protect the member’s information in regard to requests, but also in their work functions and environment. These requirements are known as the administrative, technical, and physical safeguards. These safeguards include the access of a member’s PHI, the copying and faxing of PHI, and the proper disposal of PHI documents.

The following table explains the PA privacy procedures.

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R1 – 4/28/2006 XI-1
### TABLE XI-1

**PRIOR AUTHORIZATION DEPARTMENT**

<table>
<thead>
<tr>
<th>Policy Requirement</th>
<th>Responsible Position(s)</th>
<th>Procedure/Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Employee</td>
<td>PA Supervisor</td>
<td>All new PA employees will be trained on PA privacy policies and computer based Web training as part of the department orientation. The employee will be presented with a computer certificate of successful completion of the Web based training.</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing Education</td>
<td>PA Supervisor/department Manager</td>
<td>Employees will attend privacy training as needed due to changes in the Privacy Rule.</td>
</tr>
<tr>
<td>Tracking of Education</td>
<td>PA Supervisor/department Manager</td>
<td>The PA Director will track all PA privacy training in the PHI database.</td>
</tr>
<tr>
<td><strong>Responses to Inquires for PHI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals to the IHCP Privacy Office</td>
<td>PA Supervisor/ Manager</td>
<td>All requests for PHI received by the PA department will be forwarded to the IHCP Privacy Office first for verification. Once the release is approved by the IHCP Privacy Office, PA will respond to the inquiry.</td>
</tr>
<tr>
<td>Responses to Legislative Inquires</td>
<td>PA Supervisor/ Manager</td>
<td>All PA Legislative Inquires regarding PHI will not be responded to until the signed written authorization release from the member is received.</td>
</tr>
</tbody>
</table>
| Departmental Designated Record Set | PA Supervisor/ Manager | PA department designated record set consists of any information used to support a PA decision about a member request.  
- **Paper PA form including Medical Clearance Forms.**  
- Screen prints of any PA Indiana4IM windows used to support a PA decision.  
- Medical records used by the IHCP to make decisions about the member’s PA request, such as patient notes or any attachments are considered part of the designated record set. |
<table>
<thead>
<tr>
<th>Policy Requirement</th>
<th>Responsible Position(s)</th>
<th>Procedure/Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication of PHI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paper Communication</td>
<td>All staff</td>
<td>All paper PA requests are received via sealed envelope and will be protected in a cover folder to prevent any inadvertent disclosure of PHI to an unauthorized individual.</td>
</tr>
<tr>
<td>Fax Communication</td>
<td>All staff</td>
<td>All fax cover sheets will contain the HCE privacy tag; all PHI information will have a cover letter with it. All fax machines will be located in an out of sight area and checked by PA staff every 15 (fifteen) minutes and distributed to the appropriate personnel. All PA faxes are received face down so PHI is not exposed.</td>
</tr>
<tr>
<td>Oral Communication</td>
<td>All staff</td>
<td>All oral communication can be discussed between PA reviewers and other IMPRS staff members as necessary to complete their daily work functions. PHI verbal exchange can occur between the covered entity and its business associates. Member identity will be verified via data match which includes member name, RID, address, and date of birth or social security number, in IndianaAIM during any PA telephone inquiry.</td>
</tr>
<tr>
<td>E-mail Communication</td>
<td>All staff</td>
<td>All PA e-mails will contain the IMPRS privacy tag and will be monitored and used only as necessary to complete requested work functions.</td>
</tr>
</tbody>
</table>
### TABLE XI-1 (Continued)

<table>
<thead>
<tr>
<th>Policy Requirement</th>
<th>Responsible Position(s)</th>
<th>Procedure/Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Computer Access</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly <em>IndianaAIM</em> Profile Reviews</td>
<td>PA Supervisor/ Manager</td>
<td>All <em>IndianaAIM</em> Profiles will be reviewed on a quarterly basis and updated as needed allowing only the minimum necessary use of PHI in order to carry out their job duties.</td>
</tr>
<tr>
<td>Quarterly CRLD Profile Reviews</td>
<td>Manager</td>
<td>CRLD Profiles will be reviewed on a quarterly basis and updated as needed allowing only the minimum necessary use of PHI in order to carry out their job duties.</td>
</tr>
<tr>
<td>Quarterly Business Objects Profile Reviews</td>
<td>PA Supervisor/ Manager</td>
<td>Business Object Profiles will be reviewed on a quarterly basis and updated as needed allowing only the minimum necessary use of PHI in order to carry out their job duties.</td>
</tr>
<tr>
<td>CPU Password Protection</td>
<td>PA Supervisor/ Manager</td>
<td>All PA computers will have a password protection installed and will be set to lock after five minutes of non-use.</td>
</tr>
<tr>
<td><strong>Department Physical Safeguards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department Visitors</td>
<td>All staff</td>
<td>All visitors to the PA unit will check in at the HCE receptionist desk. A visitor tag will be issued and a HCE employee will accompany them at all times.</td>
</tr>
<tr>
<td>Fax Machine Access</td>
<td>All staff</td>
<td>All PHI information via fax, printer and copier are kept out of sight and are monitored by PA staff during working hours.</td>
</tr>
<tr>
<td>Printer Access</td>
<td>All staff</td>
<td>All PHI information via fax, printer and copier are kept out of sight and are monitored by PA staff during working hours.</td>
</tr>
<tr>
<td>Copier Access</td>
<td>All staff</td>
<td>All PHI information via fax, printer and copier are kept out of sight and are monitored by PA staff during working hours.</td>
</tr>
<tr>
<td>Printed PHI</td>
<td>All staff</td>
<td>All PHI information that is printed will be retrieved at the time of printing.</td>
</tr>
<tr>
<td>PHI to be Shredded</td>
<td>All staff</td>
<td>All PHI that needs to be disposed of will be placed in the locked shredder bins located within the PA department.</td>
</tr>
<tr>
<td>Receipt of Incoming Mail Containing PHI</td>
<td>All staff</td>
<td>All incoming mail that contains PHI will be immediately placed in a covered folder or container.</td>
</tr>
</tbody>
</table>
### TABLE XI-1 (Continued)

<table>
<thead>
<tr>
<th>Policy Requirement</th>
<th>Responsible Position(s)</th>
<th>Procedure/Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forwarding of Outgoing Mail Containing PHI</td>
<td>All staff</td>
<td>All outgoing mail that contains PHI will be stamped confidential prior to leaving the PA department.</td>
</tr>
<tr>
<td>Department Closing Procedures</td>
<td>PA Supervisor</td>
<td>No unattended PHI will be left out in the open. All file cabinets will be closed at the end of business day. All paper, fax, copy machines, and desks will not have PHI left visible. It is the responsibility of the closing supervisor to do a walk through to ensure that no PHI is left in visible sight.</td>
</tr>
<tr>
<td>PHI at Off-Site Work Sites</td>
<td>All staff</td>
<td>PHI at off-site work sites will be maintained in the trunk of a vehicle. PHI is not to be shared with family members, friends or others. PHI must not be copied to a staff member’s home computer, nor may it be e-mailed to a home computer. The staff member’s direct supervisor will approve all work that is to be taken home.</td>
</tr>
</tbody>
</table>

### Sanctions

<table>
<thead>
<tr>
<th>Identification of Violations</th>
<th>All staff</th>
<th>All violations will be reported to the Department Manager immediately upon identifying or suspecting a violation of the Privacy Rule on the HCE specified form.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigating Violations</td>
<td>Manager</td>
<td>The Department Manager will conduct an investigation to determine if an actual violation of the Privacy Rule occurred.</td>
</tr>
<tr>
<td>Recommendations of Necessary Sanctions</td>
<td>Contract Director/Manager</td>
<td>The Contract Director will make any recommendations to the Department Manager about the type of sanction an employee should receive based on the specific violation of the Privacy Rule. Sanctions will be implemented by the Department Manager in conjunction with the Contract Director.</td>
</tr>
</tbody>
</table>
A. Paper Communication

Hard copy documents containing PHI must be protected from inadvertent or inappropriate disclosure. HCE staff who are not required to use PHI in their work functions are prohibited from PHI access, unless prior approval has been received from their direct supervisor. Each PA staff member must practice appropriate safeguards to prevent unwarranted disclosure to non-PA department HCE staff members.

No unattended PHI is to be left on the top of filing cabinets, on the floor, or in an unattended cubicle. All PHI is to be maintained in file folders that will help prevent inadvertent access to someone walking through the area. The PHI can be maintained in the cubicle overhead rack or on the desk of a staff member as long as the PHI is not visible.

PHI is to be placed in a locked shred bin for destruction. No PHI is to be thrown in the open trash receptacle or in an open shred box. At the end of the workday, the work area must be reviewed to determine if any open and accessible PHI is visible to an unauthorized user. All PHI is to be maintained in file folders, binders, in cubicle overheads, or out of view. The chance of incidental disclosure must be kept to a minimum in order to meet HIPAA Privacy requirements.

B. Fax Communication

A cover sheet containing the following statement must accompany all fax communication containing PHI, to any entity outside of HCE:

This facsimile transmission (and attachments) contains protected health information (PHI) from HCE, which is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited. Any unintended recipient should contact HCE by telephone at 317-347-4500 immediately so that the transmission can be retrieved.

Fax documents containing PHI must be protected from inadvertent or inappropriate disclosure. HCE staff who are not required to use PHI in their work functions are prohibited from PHI access, unless prior approval has been received from their direct supervisor. Each PA staff member must practice appropriate safeguards to prevent unwarranted disclosure to non-PA department HCE staff members.
All fax machines must be located in an attended area, eliminating the inadvertent disclosure of member PHI to an unintended recipient of the information. Information requested by fax will be retrieved from the fax machine immediately by the intended recipient or will be delivered to the recipient by an authorized staff member. If a staff member is faxing information to an authorized recipient of the PHI, the fax machine is not to be left unattended during the faxing. The staff member should also confirm the fax number of the recipient prior to sending the fax.

The PA staff members will retrieve printed PHI from the printer or copier at the time of printing. No member PHI, including an original document for copying, is to be left at the printer or copier.

C. Oral Communication

PA department staff members can discuss member PHI with other IMPRS staff members, the OMPP staff, and other IHCP contractor staff as necessary to complete their daily work functions. Such sharing of PHI must not occur with HCE staff members who are not employed by, or performing work on behalf of, the IMPRS contract. HCE staff members can share PHI with business associates who are contracted with HCE to perform a business function on behalf of HCE in the completion of IHCP related work. PHI must not be discussed outside of the HCE designated workspace unless in discussion with OMPP staff members, other IHCP contractors, or in response to OMPP approved activities.

D. E-mail Communication

Until all HIPAA Security Rule provisions are implemented, senders must monitor their e-mail communication of PHI and ensure that PHI is used only as necessary to complete required work functions. When appropriate, other alternative methods for PHI communication should be used. All e-mail communication will include a confidentiality disclosure statement that automatically populates the signature field of any e-mail generated. The confidentiality disclosure will include the following statement:

This message (and attachments) may contain protected health information from Health Care Excel (HCE), and is covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521. This information is intended only for the use of the individual or entity named in this e-mail. Any unintended recipient is hereby notified that the information is privileged and confidential. Any use, disclosure, or reproduction of this information is prohibited. Any unintended recipient should contact HCE by telephone at (317) 347-4500 or by e-mail immediately and delete the original message.
It is the responsibility of all IHCP staff and contractor staff to reasonably protect all members PHI from inappropriate use or disclosure. All IHCP member PHI in written, electronic, or oral form is protected by the Privacy Rule and must be safeguarded in the work place and in the daily job functions of all HCE staff members.

E. Computer Safeguards

HCE staff members must use the password protection function for their computer when left unattended. All computer systems will be set with a screen saver that initiates when the system is left unattended for five minutes. This screen saver will require a password to unlock.

All employee IndianaAIM profiles will be reviewed on a quarterly basis and updated as necessary by the PA Manager.

F. Sanctions

Any unauthorized use or disclosure by a HCE staff member will be subject to the sanctions set forth by HCE for breach of security or privacy.

1. The HCE staff member must contact the PA Manager immediately upon identifying or suspecting a violation of the Privacy Rule.

2. The PA Manager will conduct an investigation to determine if an actual violation of the Privacy Rule occurred. If a violation has occurred, the Program Director will determine the severity of the violation and coordinate with the PA Manager to determine what actions are to be taken as a result of the violation. The following factors will be taken into consideration when an employee has committed a violation of the Privacy Rule.

   • The severity of the violation – specifically what PHI information was used or disclosed.
   • Whether the violation was intentional or unintentional.
   • Whether the violation indicates a pattern or practice of improper use or disclosure of PHI.
   • Whether the employee received previous verbal or written warnings about violations of the Privacy Rule.
3. The Contract Director will make a recommendation to the PA Manager about the type of sanction an employee should receive based on the specific violation of the Privacy Rule. The recommendation will vary based on the severity of the violation. However, the recommendation could include the following:

- Additional privacy training for the employee specific to the identified violation.
- Verbal counseling.
- Performance Improvement Plan.
- Termination of Employment.

4. The PA Manager and the Contract Director will maintain written documentation about violations of the Privacy Rule for six years.
# TABLE XI-2

## Protected Health Information Requirements and Disclosures

<table>
<thead>
<tr>
<th>Disclosure</th>
<th>Authorization Required</th>
<th>Tracking Required</th>
<th>Minimum Necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>To a member</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>To a member’s legal guardian or personal representative</td>
<td>No</td>
<td>See notes 7 &amp; 8</td>
<td>No</td>
</tr>
<tr>
<td>To a member’s health care provider (for treatment purposes)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>To a member’s attorney</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>To member’s legislative representative</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>To a deceased member’s personal representative</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>For payment purposes (for the IHCP or the requesting covered entity)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>For health care operation purposes (for the IHCP or the requesting covered entity)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Required by law</td>
<td>No</td>
<td>See Note 2</td>
<td>Limited to the relevant requirements of the Privacy Rule</td>
</tr>
<tr>
<td>For public health activities</td>
<td>No</td>
<td>Yes</td>
<td>Limited to the relevant requirements of the Privacy Rule</td>
</tr>
<tr>
<td>For law enforcement purposes</td>
<td>No</td>
<td>Yes</td>
<td>Limited to the extent reasonable for the purpose sought</td>
</tr>
<tr>
<td>For health oversight activities</td>
<td>No</td>
<td>Yes 3</td>
<td>Yes</td>
</tr>
<tr>
<td>For Worker’s Compensation activities</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>To the Secretary of HHS</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>De-identified information</td>
<td>No</td>
<td>No</td>
<td>See Note 4</td>
</tr>
<tr>
<td>Limited data set 5</td>
<td>No</td>
<td>No</td>
<td>See Note 6</td>
</tr>
<tr>
<td>By a whistleblower</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>By a workforce victim</td>
<td>No</td>
<td>No</td>
<td>Limited to the req. in 45 CFR 164.502(j)</td>
</tr>
<tr>
<td>Prior to April 14, 2003</td>
<td>N/A</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Note 1: The IHCP Privacy Unit must review ALL psychotherapy note disclosures. Psychotherapy notes can be disclosed without member authorization ONLY for the following specific treatment, payment, and health care operations:

♦ Use by the originator of the psychotherapy notes for treatment

Note 2: Limited to the relevant requirements of the Privacy Rule

Note 3: Limited to the extent reasonable for the purpose sought

Note 4: Limited to the relevant requirements of the Privacy Rule

Note 5: Limited to the req. in 45 CFR 164.502(j)

Note 6: Limited to the relevant requirements of the Privacy Rule
♦ Use or disclosure by the IHCP to defend itself in a legal action or proceeding brought by the member

♦ A use or disclosure permitted with respect to the oversight of the health care provider originating the psychotherapy notes.

Note 2: The IHCP Privacy Unit must review all disclosures for law enforcement purposes. The tracking requirement is dependent upon the member’s status and the nature of the disclosure.

Note 3: The tracking may be temporarily suspended when requested by the health oversight agency or official.

Note 4: Individually identifiable information is removed before disclosure. The IHCP Privacy Office must review deidentified disclosures.

Note 5: The IHCP Privacy Office must review all limited data set requests and disclosures. May only be used for research, public health, or health care operation purposes of covered entities.

Note 6: Select direct identifiers are removed from information before disclosure.

Note 7: Verify member name, address, RID number, and either the Social Security number or birth date. Verify all information to member information on IndianaAIM, and if possible, verify parental information in IndianaAIM if available (for example, if the mother has name and RID number under Recipient Mother RID window). Provide only limited information in response to a telephone inquiry including the following:

♦ Program eligibility information

♦ Coverage or benefit limitation information

♦ Basic billing information (for example, claim payment)

Do NOT provide diagnosis codes, procedure codes, or any specific information over the phone.

Note 8: If the information does not match, the caller will be instructed to contact the IHCP Privacy Unit.
FIGURE XI-1

Process Flow for Written and Telephone Inquiries

Call received into OMPP

Member identity verified *

OMPP can respond

No tracking required

Question regarding other PHI issue

Call referred to/coordinated with the Privacy Unit

Call received into EDS Privacy Unit

Member identity verified *

Call completed

Member calls in with PHI question, related to treatment or payment

Call received into ACS

Member identity verified *

ACS can respond

No tracking required

Question regarding other PHI issue

Call referred to/coordinated with the Privacy Unit

Call received into HCE

Member identity verified *

Question regarding PA

PA Unit can respond

No tracking required

Question regarding other PHI issue

* Use Protected Health Information (PHI) Inquiry Grid
QUICK HIPAA GUIDELINES

The Health Insurance Portability and Accountability Act (HIPAA) requires us to protect the privacy of health information for Medicaid members. Health information about a member is “Protected Health Information” (PHI).

We may use this information as necessary to do our jobs, as long as it is for Treatment, Payment or Operations (TPO). We may discuss PHI with a patient if we have verified their identity. We may work with our Business Associates, such as EDS, ACS, and OMPP.

Do not make any other use or disclosure without the express approval of a Department Director.

Be careful with oral, written, computer, and fax communications to protect the privacy of patients. There are legal penalties for violating HIPAA rules.

Contacts for HIPAA Privacy

EDS will be staffing a privacy office to handle member questions and requests related to HIPAA privacy. The following are examples of what will be handled by this office.

- General questions from members regarding HIPAA privacy.
- Requests for a copy of the Notice of Privacy Practices (NPP).
- Member requests for a copy of their Protected Health Information (PHI).
- Member requests to correct their PHI.
- Member complaints in regard to the handling of their PHI.
- Member requests for an accounting of whom has received their PHI.
- Member requests to restrict the use of their PHI.
- Member requests to receive their PHI or NPP in some alternative form.

If you have questions or concerns related to HIPAA privacy, please contact your Department Director.

Do not refer members to OMPP. Refer members who have questions or specific requests to:

IHCP Privacy Office
P.O. Box 7260
Indianapolis, IN 46207-7260
317-488-5018
1-800-457-4584
Index

1

1261A
Certification of Need..III-76 to III-80
Completed Certification of Need..III-17
PA assignment number…III-60
pending…III-45
psychiatric admissions…III-82
submit within 10 business days..IV-24

2

278 Transaction
administrative review…IV-2,8
IndianaAIM support…I-2
pre-certification…III-76
process of mailed PA…III-6
request authorization…III-2
submit correct form…I-3, III-1
submitting attachments…III-6
system update…III-66
transaction process…III-25

A

Appeals (cont’d)
provider appeal…IV-6
reviewer support…II-2
suspension request…IV-5

C

Confidentiality
employees and consultants…X-1
notice on HCE forms…VI-7 to VI-23
plan…I-3

Consultants
avoiding review errors…III-75, III-124
confidentiality…I-3, X-1
impartial review…IV-9
input on criteria…III-3
referral to…III-74
training of… VIII-4

D

Decision codes…III-43
Decision letters…III-12, III-51

E

EDS
coordination with…I-2, II-1, III-1
decision letter…III-80, III-92, III-95
IndianaAIM database…X-1
LOC department…III-97
Location 22 Flowchart…III-118
new or revised letters…VII-2
PA appeal window… IV-14
primary coordination…II-2
provider enroll…III-38
recoupment specialist…III-109
Faxing
change hospice provider…III-90
claims face sheet…III-117
completed request form…I-3
confidential…X-2, XI-3
consultant decision…III-75, IV-4
documents to consultants…III-32
fax communication form…VI-39
fax communication form…VI-39
fax processing…III-1, III-38
inpatient psych fax form…VI-7
internal grievance…III-72
letter of intent…IV-1
location of fax machines…XI-7
PA fax machines…II-6, X-2
PA number assigned…III-10
PHI…XI-4, XI-6
pre-certification…III-76
prior to admission…III-17
privacy rule…XI-1
requests…III-16
response to inquiry report…V-1
search for requests…III-55
submit paper…III-19
support specialists…II-2
tracking requests…III-23

Forms
decision…III-47, IV-11
employees use of…VIII-2
exhibits…VI-4 to VI-55
hospice packet…III-96
medical clearance submitted…III-8
PA information…III-8
physician certification due…III-89
privacy notice…VI-3
require correction…III-93
sample forms…VI-1 to VI-56

Grievance

HIPAA
278 transaction…III-25
confidentiality…X-1
e-mail confidentiality notice…XI-8
guidelines…XI-1
operations manual…I-4
PHI…XI-6
Quick Reference…XI-13
stands for…X-1
training staff…VIII-1

Hospice
authorization of services…III-86
change in status form…VI-32
change in status…III-98
change of provider…III-97
discharge form…VI-30
dually-eligible form…VI-26
election form…VI-24
IAC conditions…III-107
IHCP reimbursement…III-84
member home…III-86
member revocation…III-97
physician certification form…VI-27
plan of care form…VI-28
process initial request…III-91
provider change request form…VI-33
re-elect benefit…III-95
re-enroll in program…III-96
review of services…III-83
revocation form…VI-31
telephone routed calls…III-47

Inpatient
emergency, out of state…III-108
fax privileges…III-17
hospice rate…III-85
hospital admission…III-21, III-52,
III-77, IV-1
I

Inpatient (cont’d)
   pending status…III-17, III-36
   psychiatric facility…III-16
   psychiatric fax form…VI-6
   reimbursement…III-76
   respite care…III-85
   review process…III-3
   stay no longer necessary…III-2

L

Letters
   administrative review…IV-18 – IV-56
   duplicate…IV-11
   information for review…III-124
   mailed within 24 hours…III-12, III-51
   of intent…IV-1
   PA letters…VII-1
   resolution…IV-15
   revised letters…VII-2

Liability
   EDS, Third-Party…II-2
   PA, Third-Party…III-113
   protection from…III-73

Location 22
   cases suspended…III-116
   flowchart…III-118
   procedure table…III-117

Long Term Acute Care…III-119

M

Medical rationale… III-123

Medical Records
   designated record set…XI-2
   maintained by provider…III-3

Medical Records (cont’d)
   processed by support staff…III-37
   requested for hearings…IV-17
   retro review…III-37
   review process…III-78

O

Out of State Services
   exemption hospital stay…III-2
   review of services…III-107
   for TBI…III-108, III-110
   state placement…III-111
   prior authorization…III-111

P

Performance Measurement
   Business Function Performance Standards…IX-3
   primary objectives…IX-1

Q

Quality Management
   breaches of confidentiality…X-2
   corrective action…VIII-3
   global prospective…IX-3
   internal quality control…IX-1
   monitor internal performance…VIII-5
   performance management…VIII-4
   remedial training…VIII-3
   training of consultants…VIII-4
   training of staff…VIII-1

R

Referrals
   referral to SUR…III-113
S
System Update…III-66

W
Web interChange…III-28

referral to SUR form…III-115
## APPENDIX A

### PRIOR AUTHORIZATION OPERATIONS MANUAL DOCUMENTATION CHANGES

<table>
<thead>
<tr>
<th>DATE OF REVISION</th>
<th>REVISION NUMBER</th>
<th>REVISED AND/OR NEW PAGES</th>
<th>DESCRIPTION</th>
<th>APPROVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/31/2007</td>
<td>R3</td>
<td>III-87</td>
<td>Added “The hospice election form must be signed on the first day of care or signed on a date prior to the date in the future the member or his POA designate as the first day of hospice care.” to first paragraph.</td>
<td></td>
</tr>
<tr>
<td>1/31/2007</td>
<td>R4</td>
<td>III-92</td>
<td>Added bullet “FSSA DA Hospice Policy Analyst may direct PA contractor to update screens based on clarifications obtained while working with hospice providers and contracted nursing facilities in unique circumstances, such as when a discharge/transfer has a gap in service dates.”</td>
<td></td>
</tr>
<tr>
<td>1/31/2007</td>
<td>R3</td>
<td>III-98 d., e., &amp; f.</td>
<td>Added: d. Verify that the hospice revocation form is complete and signed by the member and a witness.  e. Verify that the hospice discharge form is complete and signed by the hospice medical director or the hospice patient care coordinator.  f. Proceed to the LOC window to change the hospice member’s responsible provider. If the LOC segment does not match, alert the policy analyst at FSSA, Division of Aging, 317-233-1956. The FSSA policy analyst will coordinate with the administrative assistant with FSSA Division of Aging to research and resolve the discrepancy.</td>
<td></td>
</tr>
<tr>
<td>1/31/2007</td>
<td>R4</td>
<td>III-99, e.</td>
<td>Changed to: “alert the policy analyst at FSSA, Division of Aging, 317-233-1956. The FSSA policy analyst will coordinate with the administrative assistant with FSSA Division of Aging to research and resolve the discrepancy.”</td>
<td></td>
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