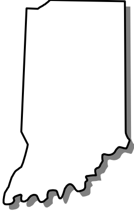

PROVIDER BULLETIN

BT200362 OCTOBER 1, 2003

To: All Providers

Subject: Prior Authorization for Hoosier Healthwise Managed Care Organizations

Overview

This bulletin provides updated information from the Office of Medicaid Policy and Planning (OMPP) about prior authorization (PA) in the Hoosier Healthwise managed care organizations (MCOs) originally published in an Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200231*, dated June 20, 2002. This bulletin was issued to explain PA and member self-referral services, including carve-out services, for the Hoosier Healthwise managed care program.

Prior Authorization

Services requiring PA for Prime*Step* Primary Care Case Management (PCCM) members are the same as those for IHCP Traditional Medicaid fee-for-service (FFS) members. PA requests should be sent to Health Care Excel (HCE) to determine the medical necessity of the request. HCE enters the PA information in Indiana*AIM* and notifies the provider requesting the PA, as well as the member, of the denial or approval. PA administrative review and appeal procedures are outlined in Chapter 6, Section 6 of the *IHCP Provider Manual.*

The MCOs are responsible for determining what services require PA for its members. However, for self-referral services, the MCOs must follow the guidelines for PA listed in the Indiana Administrative Code (IAC) and the *IHCP Provider Manual*. The MCOs decision to authorize, modify, or deny a given request is based on medical necessity, reasonableness, and other criteria. Requests for reviews and appeals must be sent to the appropriate MCO. Further details about PA requirements for MCO members are provided in this bulletin.

Open Prior Authorizations for Members Who Change Networks

At the time members enter or change a Hoosier Healthwise managed care plan, the member may have received authorizations for services or procedures that were not completed on the effective date of the enrollment in the new plan. The PA could be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home health care. Requiring a duplicate authorization from the new network puts an additional burden on the provider and can result in delayed or inappropriately denied treatments or services for the Hoosier Healthwise member. Therefore, fee-for-service providers, Hoosier Healthwise MCOs, and Prime*Step* must honor outstanding PAs given within the program for services in the first 30 days of a member's effective date in the new network. **This authorization extends to any service or procedure previously authorized** in the Hoosier Healthwise program including, but not limited to, surgeries, therapies, pharmacy, home

health care, and physician services. MCOs must reimburse out-of-network providers during the 30-day transition PA period following appropriate claims submission.

> *Note: Eligibility must be verified before rendering services to determine in which plan the member is enrolled and to which benefits the member is entitled.*

Harmony Health Plan Prior Authorization

The following services for members enrolled in the Harmony Health Plan require PA:

- Elective or scheduled admissions, such as acute, subacute, observation, or rehabilitation
- All outpatient procedures, such as services not performed in a physician's office
- Sleep studies
- Physical therapy (PT), occupational therapy (OT), speech therapy (ST), cardiac rehabilitation, or pulmonary rehabilitation
- Home health services
- Durable medical equipment (DME) with a cost that exceeds $200
- DME with a rental cost less than $200 with an anticipated rental time period greater than six months
- Services provided by non-network providers, except for self-referral services
- Non-emergency transfers
- Specialty referrals such as the following services:
  - Dermatology
  - Plastic surgery
  - Maxillofacial surgery
  - Physical medicine and/or physiatrist
- Non-formulary/Preferred Drug List (PDL) medications

Referrals from the primary medical provider (PMP) to network specialists do not require PA for the plan. All surgical procedures and elective or scheduled admissions must be precertified through Harmony Health Services Management Department at least five business days before the scheduled date of service. The PMP must contact one of the following numbers for the Harmony Health Services Management Department to obtain authorization for these services:

- Referrals 1-800-504-2766, ext. 2341
- Fax 1-800-608-8157
- Manager (219) 880-4400

Harmony Health Plan provider manuals are distributed with the implementation of each new contract and during provider orientation. Participating providers can request a provider manual or formulary either by accessing the Harmony Health Plan Web site at www.harmonyhmi.com or by calling provider services at 1-800-504-2766.

Table 1 – Harmony Health Plan – PA Summary

Category of Service	Requires Prior Authorization
Physician services	Dermatology, plastic surgery, maxillofacial surgery, physical medicine and/or physiatrist, and non-network providers
Inpatient admissions	Yes, including non-emergency transfers
Outpatient procedures	Services not performed in a physician's office
Pharmacy	Non-formulary/PDL medications
Therapies	Yes
Home health care	Yes
Nursing facility	Yes
Durable medical equipment	Purchase greater than $200 Rental below $200 with a rental time greater than six months
Transportation	Over 50 miles or out-of-state
Services provided by non-network providers (except self-referral services)	Yes
Other	Sleep studies
Web site	www.harmonyhmi.com
Phone numbers	Provider services at 1-800-504-2766 Referrals at 1-800-504-2766, ext. 2341 Fax at 1-800-608-8157 Health Services Manager at (219) 880-4400

Managed Health Services Prior Authorization

Managed Health Services (MHS) recognizes the burden that PA places on its providers and has eliminated the authorization requirements for most services except for the following services:

- Elective or scheduled admissions to any facility
- Certain specialty services such as therapies, orthotics, prosthetics, and so forth

For a list of specific services requiring PA, please refer to the *Managed Health Service's Provider Manual* or call the MHS Medical Management Department referral line at 1-800-464-0991.

PMP referrals to contracted specialists do not require PA by the health plan, **with some exceptions.** The PMP is approved by the health plan to give the referral authorization. PMP referrals to non-contracted providers, and specific contracted providers, require authorization from MHS.
For more information about the MHS PA process contact MHS medical management at 1-800-464-0991.

Each MHS contracted provider is given an *MHS Provider Manual*, a quick reference guide, and a comprehensive orientation containing critical information about how and when to interact with the Medical Management Department. The manual also outlines the medical management policies and procedures. Participating providers can obtain additional information by accessing the MHS Web site at www.managedhealthservices.com or by calling provider services at 1-800-944-9661.

Table 2 – Managed Health Services – PA Summary

Category of Service	Requires PA
Physician Services	Selected in and out of network physician services requires MHS authorization
Inpatient admissions	Yes
Outpatient procedures	Selected in and out of network services require MHS authorization
Pharmacy	Selected medications. See the MHS formulary/PDL
Therapies	Yes
Home health care	Yes
Nursing facility	Yes
Durable medical equipment	Yes
Transportation	Over 50 miles, excess of 20 trips per rolling 12-month period, and out of state transportation
Services provided by non-network providers, except self-referral services	Yes
Other	Orthotics, prosthetics, and sleep studies
Web site	www.managedhealthservices.com
Phone numbers	Provider services at 1-800-944-9661 Medical management at 1-800-464-0991

MDwise Prior Authorization

MDwise operates on a hospital delivery system model. All MDwise PMPs and their patients are assigned to a hospital-based integrated system and must obtain care through their assigned hospital system. Currently, MDwise has eight hospital systems, but could add more systems in the future. The following PA rules apply to MDwise patients:

- In the MDwise plan, medical management decisions are made as close to the patient and the PMP as possible.
- Each MDwise hospital delivery system has a medical director making medical necessity decisions, and a medical management staff that handles PA determinations.
- MDwise medical management staff must approve all PA requests.
- PMPs are involved in authorization decisions, but the PMP's response does not constitute PA for a service.

The following information lists two ways for providers to access the MDwise Medical Management System:

- Visit the MDwise Web site at www.mdwise.org to access an online member identification system that can be used to determine the correct MDwise hospital system for a particular member. This online system should only be used after the provider has checked IHCP eligibility using one of the eligibility verification systems (EVS) such as the automated voice response (AVR) system. The MDwise Web site provides the name of the member's PMP, the delivery system, the claims address and phone number, and the phone number for PA. To sign up for a user name and password, please call MDwise at (317) 630-2831 in the Indianapolis local area or 1-800-356-1204.

- If a provider does not have Internet access or has an urgent PA request, such as when the member is present at the provider site, the provider can call MDwise at the telephone numbers previously listed. The customer service staff will connect the provider to the appropriate hospital system's medical management staff for the PA request.

The *MDwise Provider Manual* contains important contact information, and a program and benefits overview, as well as participating provider duties, quality improvement, member education programs, member rights and responsibilities, complaint procedures, practice guidelines, and other valuable resources for participating providers. Sections about PA and claims payment procedures are also included. The *MDwise Provider Manual* can be accessed on the Internet at www.mdwise.org, or participating MDwise providers can obtain a paper or electronic copy of the manual from the MDwise provider relations staff. Out-of-network providers can obtain a paper copy by calling MDwise at (317) 630-2831 in the Indianapolis local area or 1-800-356-1204. Questions about MDwise programs can also be answered by calling these telephone numbers.

Table 3 – MDwise – PA Summary

Category of Service	Requires Prior Authorization
Physician services	In network: Yes, for some specialty services – contact MDwise Out-of-network or non-contract physicians: Yes, for all except self-referral services or prudent layperson emergency. This is the same as the IHCP
Inpatient admission	Yes, within 24 hours of admission for an emergency admit
Outpatient procedures	Yes
Pharmacy	On selected drugs, see MDwise formulary/PDL at: www.mdwise.org
Therapies	Yes
Home health care	Yes
Nursing facility	Yes
Durable medical equipment	Yes
Transportation	PA if over 50 miles or out-of-state, or over the 20 trip limit
Services provided by non-network providers, except self-referral services	Yes, for all except self-referral surgeries or prudent layperson emergency. This is the same as the IHCP.
Other	Self-referral surgeries. This is the same as the IHCP.
Web site	www.mdwise.org
Phone numbers	Provider services and medical management at (317) 630-2831 in the Indianapolis local area or 1-800-356-1204.

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