IHCP *bulletin*

This bulletin is a correction and clarification of BT201053. This bulletin:

- Clarifies the instances where dual members will need prior authorization (PA)

- Corrects the impact on *Care Select* members

- Clarifies procedures to request a PA

To all providers

Revision: New prior authorization for elective hospital inpatient admission

Effective January 1, 2011, prior authorization (PA) will be required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries, and newborn stays will not require PA. Observation will not require PA.

This applies to members of all ages served by traditional Medicaid, those in the *Care Select* program, and, in some cases, dually eligible members. A member who is dually eligible for Medicare and Medicaid must ask for Medicaid PA for an inpatient stay that is not covered by Medicare. If a stay is covered by Medicare, in full or in part, the member does not require PA. The effective date of January 1, 2011, will apply to inpatient stays with an admit date on or after January 1, 2011.

Providers are required to contact ADVANTAGE Health Solutions[SM] (1-800-784-3981) or MDwise (1-866-440-2449) at least two business days prior to admission. MDwise will provide PA for *Care Select* members who are enrolled with MDwise as their care management organization. All inpatient hospital PAs will be requested via telephone. The facility must call prior to the admission and provide criteria for medical necessity. You may request retroactive PA for dual members if Medicare will not cover the inpatient stay because the member has exhausted his or her Medicare benefit or if the stay is not a Medicare-covered service.

The Indiana Health Coverage Programs (IHCP) follows Milliman guidelines for all nonemergent and urgent care inpatient admissions. If there are already existing IHCP criteria, use that criteria first when determining if admissions are appropriate. If criteria are not available within Milliman or IHCP policy, the IHCP will rely on medical necessity determination of current evidence-based practice. To assure a 48-hour turnaround, the PA request should be made by a clinical staff person. For nonemergent and urgent care admissions that occur outside normal business hours, including weekends and holidays, providers will have 48 hours from the time of admission to request PA.

When requesting a prior authorization, providers must provide the following information:

- Member name and recipient identification number (RID)

- Procedure requested, including Current Procedural Terminology (CPT[®1]) code

- Location service is to be performed (facility)

- Medical condition being treated, including *International Classification of Diseases, Ninth/Tenth Edition, Clinical Modification* (ICD-9/10-CM) code

- Medical necessity of the procedure

- Admitting physician or surgeon

- Date of admission

- The estimated length of stay (LOS)

- National Provider Identifier (NPI)

- If you are requesting retroactive PA for a dually eligible member who has had coverage denied by Medicare, you will also need to provide documentation of that denial.

Additional information will be available in the *IHCP Provider Manual*. The Office of Medicaid Planning and Policy (OMPP) appreciates your cooperation and your continued participation as providers in the IHCP.

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QUESTIONS?

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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