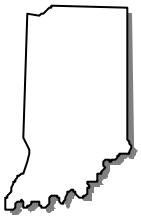
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Providers

Subject: Carve Out and Self-Referral Education

Overview

This bulletin contains information from the Hoosier Healthwise Managed Care Program about how managed care entities handle prior authorization (PA) and member self-referral services (including carve-out services) for Hoosier Healthwise managed care. Within each section of this bulletin, the differences between each managed care network, or plan, are described, as well as the fee-for-service PA process performed by the State's PA contractor, Health Care Excel (HCE). HCE reviews PA requests for both fee-for-service and primary care case management (PCCM), but not for managed care organizations (MCOs) in risk based managed care (RBMC). It is important to understand that in Prime*Step*/PCCM, PA is not the same as a primary medical provider (PMP) referral such as in the certification code process.

Note: The information presented in this bulletin does not change existing policy or procedure in IHCP or other provider publications.

Future Changes: This bulletin represents current policies and procedures effective the date of this publication. Any changes or updates resulting from the 2002 legislative session will be submitted in a future bulletin. MCO network providers will be advised of changes by their contracting MCO.

Carved Out Services

Indiana Health Coverage Programs (IHCP) members enrolled in a Hoosier Healthwise MCO are eligible to receive some services that are not the financial responsibility of the MCO. These are referred to as *carved out services* and are adjudicated by the IHCP according to traditional IHCP fee-for-service guidelines. MCO members can obtain covered IHCP carved-out services from any IHCP enrolled

provider qualified to render the care. Providers of these services submit their claims directly to EDS and are reimbursed on a fee-for-service basis whether or not their services are rendered within a member's MCO network. The carved-out services bypass the managed care edits *2017* and *2018* when rendered by the provider types and specialties identified in Table1.1.

If the services are not carved out, claims submitted to EDS for reimbursement of services rendered to MCO members are systematically denied with edit *2017* or *2018*, dependent upon the claim type. These edits state that the member is enrolled in a RBMC plan with the Hoosier Healthwise program, and the member must seek care from the appropriate MCO.

Excluded Services

Extended long-term care and hospice services are excluded from the Hoosier Healthwise Managed Care Program. Members eligible for these services are disenrolled from Hoosier Healthwise and enrolled in the traditional IHCP, where these services are covered on a fee-for-service basis. Please refer to the directions in *Section 3* of the *Hospice Provider Manual* for directions on how to coordinate hospice member disenrollments. Please refer to the directions in *Chapter 14, Section 8* of the *IHCP Provider Manual* for directions on how to coordinate long-term care member disenrollments.

MCOs can, however, allow members to receive services in a nursing or long-term care facility on a short-term basis of no more than 30 days. In these cases, the MCO is financially responsible for the short-term placement fees.

Self-Referral Services

Hoosier Healthwise members can seek care from any IHCP-enrolled provider qualified to render self-referral services, and without obtaining authorization from their PMP. An MCO may encourage its members to obtain care within its network, but it retains financial responsibility for self-referral services whether or not they are rendered within their network. In the absence of an agreement to the contrary, the MCO must reimburse out-of-network providers at the minimum amount listed on the *IHCP Fee Schedule*. Prime*Step*/PCCM members are not required to obtain certification from their PMP for self-referral services.

Regardless of whether the member is part of an MCO or Prime*Step*/PCCM, certain services provided by a self-referral provider may require PA. Providers should refer to the *Indiana Administrative Code (IAC)* and the *IHCP Provider Manual* for further information. In the case of MCO members, the provider must contact the MCO to obtain PA when required.

Table 1.1 - Summary of Carve-Out and Self-Referral Services by Hoosier Healthwise Delivery System

Services	MCO (RBMC) members	PrimeStep (PCCM) members
Chiropractic Services Services provided by IHCP-enrolled provider specialty 150	Self-referral * Claims go to MCO	Self-referral Claims go to EDS
Dental Services Service provided by IHCP-enrolled provider specialty 270-277	Carve-out Claims go to EDS	Self-referral Claims go to EDS
Diabetes Self-management Training Services Services for procedure code, *Z5021, ¼ hour*, are available on a self-referral basis from any IHCP-enrolled chiropractor, podiatrist, optometrist, or psychiatrist who has had specialized training in the management of diabetes.	Self-referral Claims go to MCO MCOs can require that diabetes self-management training services from other qualified health care professionals be provided within the MCO network. MCOs also can require members to obtain prior approval for payment to out-of-network providers.	Self-referral Claims go to EDS
Emergency Services Services rendered for the treatment of a true or *prudent layperson* emergency.	Self-referral Claims go to MCO Does not include nonemergent services, that must receive PA from the MCO to be paid.	Self-referral Claims go to EDS
Family Planning Services Procedures and diagnosis codes, as defined in the *IHCP Manual*	Self-referral Claims go to MCO	Self-referral Claims go to EDS
HIV/AIDS targeted case management services Procedure code Z5950 HIV/AIDS case management, ¼ hour.	Self-referral Claims go to MCO	Self-referral Claims go to EDS

(Continued)

Table 1.1 - Summary of Carve-Out and Self-Referral Services by Hoosier Healthwise Delivery System

Services	MCO (RBMC) members	PrimeStep (PCCM) members
Individualized Education Plan (IEP) provided by a School Corporation Services provided by a school corporation, IHCP-enrolled provider specialty 120, as part of a student's IEP.	Carve-out Claims go to EDS	Self-referral Claims go to EDS
Behavioral Health Services Services provided by IHCP-enrolled provider specialties 011, 110-117, and 339.	Carve-out Claims go to EDS	Self-referral Claims go to EDS
Pharmacy Services provided by IHCP-enrolled provider specialty 240	Use MCO network Claims go to MCO	Self-referral Claims go to EDS
Podiatric Services Services provided by IHCP-enrolled provider specialty 140	Self-referral * Claims go to MCO	Self-referral Claims go to EDS
Transportation Services provided by IHCP-enrolled provider specialties 260-266	Use MCO network Claims go to MCO	Self-referral Claims go to EDS
Vision care (except surgery) Services provided by IHCP-enrolled provider specialties 180, 190, and 330	Self-referral * Claims go to MCO	Self-referral Claims go to EDS

* Self-referral providers must seek PA before rendering certain self-referral services. Please see the *IAC* and the *IHCP Provider Manual* for further information.

Prior Authorization

Services that require PA for Prime*Step*/PCCM members are the same as those for IHCP traditional Medicaid fee-for-service members. Prior authorization requests are sent to HCE, who determines the medical necessity of the request. Health Care Excel enters the PA information into Indiana*AIM* and notifies the provider requesting the PA, as well as the member, of the denial or approval. Prior authorization

administrative review and appeals procedures are outlined in the *IHCP Manual, Section 6.* Refer to the Prime*Step*/PCCM section that follows for further details about this process and associated requirements.

The MCOs are responsible for determining what services require PA for their members. However, for self-referral services, the MCOs must follow the guidelines for PA under the *IAC* and *IHCP Provider Manual*. The decision by an MCO to authorize, modify, or deny a given request is based upon 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 the following text.

Open Prior Authorizations for Members Who Change Networks

At the time members enter or change a Hoosier Healthwise Managed Care Network, they may have received authorizations for services or procedures that were not completed on the effective date of the enrollment into the new network. The PAs may be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home health care. Requiring a duplicate authorization from the new network places an additional burden on the provider and can result in delayed or inappropriately denied treatments or services for the Hoosier Healthwise member.

Fee-for-service providers, Hoosier Healthwise Managed Care Networks, Prime*Step*, and MCOs, must honor outstanding PAs given within the program for services for the first 30 days of a member's effective date in the new network. **This authorization extends to any service or procedure previously authorized** within the Hoosier Healthwise program, including but not limited to surgeries, therapies, pharmacy, home health care, and physician services. MCOs may be required to reimburse out-of-network providers during the 30-day transition period.

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

Harmony Health Plan Prior Authorization

The following services require PA:

- Elective or scheduled admissions
- Procedures
- Therapies
- Home health services
- Durable medical equipment that exceeds $200
- Services provided by non-network providers

All surgical procedures and elective or scheduled admissions must be precertified with Harmony's Health Services Management Department at least five business days prior to the scheduled date of service. The PMP must contact Harmony's Health Services Management Department for authorization requests for these services at the following numbers:

- Referrals 1-800-504-2766, ext. 2341
- Fax (219) 880-4498
- 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 either by accessing the Harmony Web site at www.harmonyhmi.com or calling the following numbers:

- Provider Services Department 1-800-504-2766
- Department Manager (219) 880-4403
- Fax (219) 880-4498

Managed Health Services Prior Authorization

Managed Health Services (MHS) requires PA or prior notification for certain services and procedures frequently over or under utilized, and costly services needing case management. The PMP or specialist must initiate PA or prior notification of nonemergency procedures, such as elective or routine, at least five working days prior to the requested date of service by contacting the MHS Medical Management Department at 1-800-464-0991. If a provider is unable to request PA or prior notification at least five working days in advance due to the nature of the member's condition, a PA or prior notification request must be initiated as soon as possible. MHS will expedite the request.

The following services require PA:

- Inpatient admissions
- Inpatient acute rehab

- Inpatient acute mental health
- Gastric bypass
- Transplant evaluation and request
- Dental surgery
- Vagus nerve stimulator
- Sleep studies
- Pain clinic
- Therapies, (PT, OT, ST, Cardiac Rehab, Pulmonary Rehab)
- DME, greater than $200
- Skilled nursing facility
- Home health care, except the first 30 days/120 hours post hospitalization
- Orthotics and prosthetics
- Any sterilization procedure
- PMP referral to a specialist (required for all non-network providers and the following specialists regardless of network status):
  - Dermatology
  - Infertility
  - Neuropsychology
  - Maxillofacial surgeon
  - Plastic and reconstructive surgeon
  - Physiatrist
  - Physical medicine
  - Dietician

The following outpatient procedures require PA. All other outpatient surgeries performed at contracted facilities do not require prior approval.

- Blepharoplasty
- Reduction mammoplasty
- Otoplasty
- Removal of non-cancerous skin lesions
- Ligation of varicose veins
- Scar revision
- Rhinoplasty
- Septoplasty
- Wedge resection of the lip

Contact MHS Medical Management, at the following numbers:

- Referrals 1-800-464-0991
- Manager 1-800-944-9661
- Provider Relations Staff 1-800-944-9661

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 Medical Management's policies and procedures. Providers can request additional manuals by contacting MHS Provider Services at 1-800-414-9475.

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. Currently, MDwise has five hospital systems and plans to add more systems in the near future. The following rules must be followed for MDwise patients for PA. Call MDwise at (317) 630-2831 or 1-800-356-1204 with any questions.

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 who makes medical necessity decisions and a medical management staff who handle 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.

There are two ways for providers to access the MDwise Medical Management System:

- Call MDwise at (317) 630-2831 or 1-800-356-1204. The Customer Service staff contacts the hospital system's Medical Management staff for the PA request.
- Access the MDwise Web site at www.mdwise.org and print out a list of PMPs listed by hospital system. To confirm eligibility or find the member's PMP, call the MDwise Medical Management staff directly.

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 practice resources for participating providers. Sections on PA and claims payment procedures are also included. Participating providers can obtain a paper or electronic copy from their MDwise Provider Relations staff. Out-of-network providers can obtain a copy by calling (317) 630-2831 or 1-800-356-1204. All providers will soon be able to access the provider manual from the MDwise Web site at www.mdwise.org

PrimeStep/PCCM Prior Authorization

Indiana Administrative Code 405 IAC 5 provides rules for the PA Department to fulfill its functions. *405 IAC 5-3* sets forth the provisions for PA to be provided. Prior to providing any Medicaid service subject to PA, the provider must submit a properly completed, written IHCP PA request, or a telephone request for certain services, and receive written notice indicating the approval for provision of the service. Approval is given verbally at the time of a telephone request. The IHCP does not reimburse any IHCP service requiring PA that is provided without receiving PA. The provider is responsible for submitting new requests for PA for ongoing services before the current authorization period expires in order to ensure that services are not interrupted. PA is not a guarantee of payment.

PA requests can be submitted in writing, via mail or fax, or by telephone. Only certain services can be requested by fax including acute rehab, transplant, acute inpatient mental health services for approved providers, and pharmacy. The PA Department staff relies on established criteria at the first level of review. These criteria are used as screening guidelines and have been approved by the State. In addition, staff use the portions of the *IAC* that describe guidelines for approval of services and supplies, and relevant written communication or other directives, written or expressed, and approved by the OMPP.

Cases that cannot be approved or modified by the PA reviewer, based upon written criteria, are referred to a PA specialist or PA supervisor for additional review. If the PA specialist or PA supervisor determines there is an issue of medical necessity, the case is referred to the PA director for review. Professional consultants, who perform the second level of review, evaluate cases based upon standards of practice and professional judgment. Providers and members can appeal denials or modifications of services in accordance with *405 IAC 5-7-1*.

Since September 4, 2001, a prescriber's indication of *brand medically necessary* for a prescribed drug requires PA. If a prescriber chooses to specify *brand medically necessary* for a drug, he or she must obtain PA for that brand name drug before the pharmacist can be paid. Refer to Medicaid rule *405 IAC 5-24-8*, PA, and brand name drugs. PA is required only for those drugs that have an established federal upper limit (FUL), maximum allowable cost (MAC), and an *AA* or *AB* rated generic equivalent. The drugs Coumadin®, Dilantin®, Lanoxin®, Premarin®, Provera®, Synthroid®, and Tegretol® are *excluded* from the PA requirement. Details are available in provider bulletin *BT200132*. Anti-depressant, anti-anxiety, and anti-psychotic drugs, as well as cross-indicated drugs are excluded.

Effective January 7, 2002, the *Indiana Rational Drug Program* was implemented. PA is now required for the following eight drugs and three drug classes, Stadol-NS®, Ultram® (tramadol), Synagis®, Respigam®, lactulose, Zithromax®, trenitoin (Retin A®), OxyContin® (oxycodone controlled-release), nonsteroidal anti-inflammatory drugs (including Cox-2 inhibitors), peptic acid disease drugs, and growth hormones.

This program is designed for fee-for-service and Prime*Step/*PCCM including Package C members. The intent of the program is to promote quality of care and control costs. The Indiana Rational Drug Program is carried out in compliance with all applicable provisions of both state and federal law. Prescribing practitioners are responsible for initiating and obtaining PA for all prescriptions issued that require PA. Further information is available in provider bulletin *BT200210*.

Providers should always check Automated Voice Response (AVR) at 1-800-738-6770 before calling the HCE PA Department. Direct further questions to the HCE PA Department at 1-800-457-4518.

If a current PA has expired, providers cannot request a continuation of service by telephone. Continuation of service requests must be received in writing.

A provider has 30 days to submit supporting documentation once an emergency PA is granted.

PA requests may be approved with a retroactive date under the following circumstances:

- Pending a retroactive member eligibility
- Services rendered by a new provider who has not yet received a provider manual
- Services rendered by an out-of-state provider
- Transportation services, one year limit
- Provider is unaware of patient eligibility, patient is incapable of or refuses to provide insurance information