

**Division of Aging Workshop  
Presentation  
June 27, 2014**

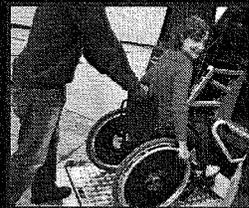


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**Agenda**

- Prior Authorization
  - General Overview
  - Provider Appeals
  - Questions



**Prior Authorization**

ADVANTAGE adjudicates all Traditional Medicaid, Care Select (including Mdwise CS Members), Medicaid Rehabilitation Option (MRO), PRTF PA requests, and Traumatic Brain Injury (TBI) Program admissions



By contract, ADVANTAGE is responsible for:  
Processing PA requests  
Making medical necessity determinations  
PA decisions based on OMPP approved guidelines  
Notifying providers and members of the determination



**Helpful Hints to Get Started for all PA Requests**

- Always verify eligibility on PA submission date and date of service;
- Suspended PA requests must be completed within 30 days by the provider;
- PA decisions made within five (5) business days for CS and Traditional Medicaid;
- Submit PA to the member's health plan;
- Fax the PA form along with supporting documents together

**Web InterChange** -allows providers to submit non-pharmacy PA requests  
**Mail** – Submit PA request form along with supporting documents;  
**Phone** – Urgent PA request as well as Elective Inpatient Admission PA's



## General PA Overview

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

•Since January 1, 2011, only the universal PA form has been accepted by Traditional FFS PA, Care Select & MCE's (HHW & HIP).

•Provider PA decision letters sent to "mail to" address in IndianaAIM or noted on PA request form (Note: Ensure "Mail to" address is updated).

•Please refer to BT201045 for further information.

•Please note: The MCE Outpatient Therapy Request (OTR) PA form must be used when requesting non-MRO behavioral health PA for HHW and HIP members.



## General PA Overview

•Required forms located at [www.indianamedicaid.com](http://www.indianamedicaid.com) in "forms" section;

•Universal PA form for medical and behavioral health (Care Select or Traditional Medicaid only)

- Universal PA form (Instructions)

•Prior Review and Authorization Dental Request form

•Prior Authorization - System Update Request Form

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



## General PA Overview

Determine if a service or item requires PA in Traditional Medicaid and Care Select (CS):

•Use the IHCP fee schedule: [www.indianamedicaid.com](http://www.indianamedicaid.com);

•More information found in the IHCP Provider Manual Ch. 6, Indiana Administrative Code (IAC), bulletins, banner pages, and newsletters;

•Providers can review billing and coverage information in Ch. 8;

•Check PA status using PA inquiry function in Web InterChange PRIOR to contacting the CMO;

•Providers must submit PA supporting documentation via fax or mail;



## General PA Overview

### Supporting PA Documentation

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

#### Examples of Supporting Documentation:

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

Note: The CMOs retain the right to suspend a PA request to request additional information to make medical necessity determinations.



## General PA Overview

The following provider types can submit PA requests via Web InterChange:

- Chiropractor
- Dentist
- Doctor of Medicine
- Doctor of Osteopathy
- Home Health Agency (authorized agent)
- Hospice
- Hospitals
- Optometrist
- Podiatrist
- Psychologist endorsed as a Health Service Practitioner in Psychology (HSPP)
- Transportation providers

NOTE: ALL provider types can check PA request status via Web InterChange.



## General PA Overview

### PA Submission Procedures

Effective November 1, 2013, when PA is required for services rendered to members as FFS & Care Select, the appropriate forms must be completed and submitted to:

#### ADVANTAGE Health Solutions – FFS OR

ATTN: Prior Authorization Dept.  
P.O. Box 40789  
Indianapolis, IN 46240  
Telephone: 1-800-269-5720  
Fax: 1-800-689-2759

#### ADVANTAGE Health Solutions – Care Select

ATTN: Prior Authorization Dept.  
P.O. Box 80068  
Indianapolis, IN 46280  
Telephone: 1-800-784-3981  
Fax: 1-800-689-2759

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



## Provider PA Appeals

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



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



## Administrative Review (1st Level)

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

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

•The CMO or FFS PA vendor medical directors or designees render the administrative review decision of the health plan within seven (7) working days of receipt of all necessary documentation.



## Administrative Review (1st Level)

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



## Administrative Hearing (2nd Level)

- After exhausting the administrative review process (1st Level), providers can further appeal the decision by requesting an administrative hearing conducted between the provider, IFSSA, the CMO or FFS PA vendor, and an Administrative Law Judge (ALJ).
- Provider requests for administrative hearings must be submitted within 30 calendar days of the administrative review decision to this address:
  - Hearings and Appeals Section, MS-04
  - Indiana Family and Social Services Administration
  - 402 W. Washington St, Room W392
  - Indianapolis, IN 46204-2773
- NOTE: The State will schedule a meeting and inform the provider and the CMO or FFS PA vendor of the date, time, and location for the hearing.



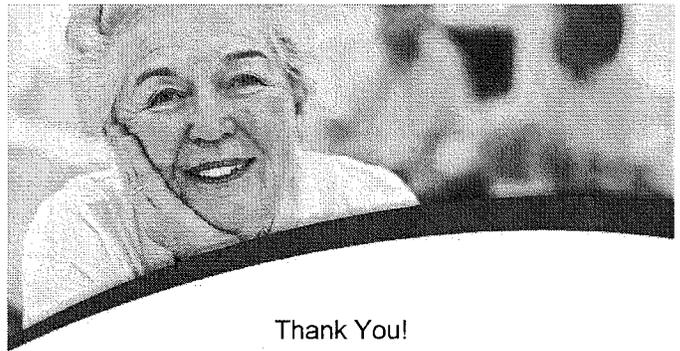
## PA Department Contact Information

ADVANTAGE Health Solutions, Inc.<sup>SM</sup>  
[www.advantageplan.com/advcareselect](http://www.advantageplan.com/advcareselect)

1-800-784-3981 – Care Select PA  
1-800-269-5720 – Traditional PA

•ADVANTAGE adjudicates all Traditional Medicaid, Care Select, Medicaid Rehabilitation Option (MRO), PRTF PA requests, and Traumatic Brain Injury (TBI) Program admissions

•All PA for prescription drugs are processed and adjudicated by Catamaran Corporation and not the CMOs;



Thank You!



ADVANTAGE  
...doing above the service you expect™