Prior Authorization Process

Indiana Medicaid Advisory Committee Meeting – May 23, 2019

Prior Authorization Process Overview

Maggie Moss

Director of Medical Operations

MDwise

Prior Authorization

What is it?

- The MCEs use a nationally recognized set of care guidelines to review for authorization. All MCEs are moving to MCG guidelines on 7/1/19.
- Additional considerations:
  - ASAM
  - IAC
  - Right Choices Program
  - Clinical Guidance
  - DUR Board
  - Medicaid Contract
  - IHCP Provider Reference Modules
  - IHCP Bulletins and Banners

Prior Authorization

Why have it?

- Care Management / Disease Management
- Quality of Care
- Medical necessity of services requested
- Appropriate length of stay / length of service
- Utilization of Services (under and over)
- Fraud, Waste, and Abuse (FWA)
- Health Outcomes
- Early Detection
- Monitor for discharge needs

Prior Authorization

When is it needed?

- Inpatient care – *always*
- Continuation of emergent care
- Surgery
- SUD (In-patient detox, residential treatment, partial hospitalization and intensive out-patient)
- Changes in level of care
- Non-contracted providers
- Right Choices Program
- and more…

Prior Authorization

When is it *not* needed?

- Preventative services
- Self-referral services
- Emergencies
- Home health post-discharge
- Preferred drug list
- And more…

Prior Authorization

Where is the information?

- Code of federal regulations (CFR)
- Indiana administrative code (IAC), 405 IAC 5-3
- IndianaMedicaid.com
  - Banners, bulletins, medical policy manual, PA module, etc.
- MCE websites

Prior Authorization

Where is the information?

- MCE Websites, for *all* the programs:

  - HIP Plus (x4)
  - HIP Basic (x4)
  - HIP State Plan Plus (x4)
  - HIP State Plan Basic (x4)
  - HIP Maternity (x4)
  - HIP Plus Copay (x4)
  - Presumptive Eligibility (x4)
  - Hoosier Healthwise (x4)
  - Hoosier CareConnect (x2)

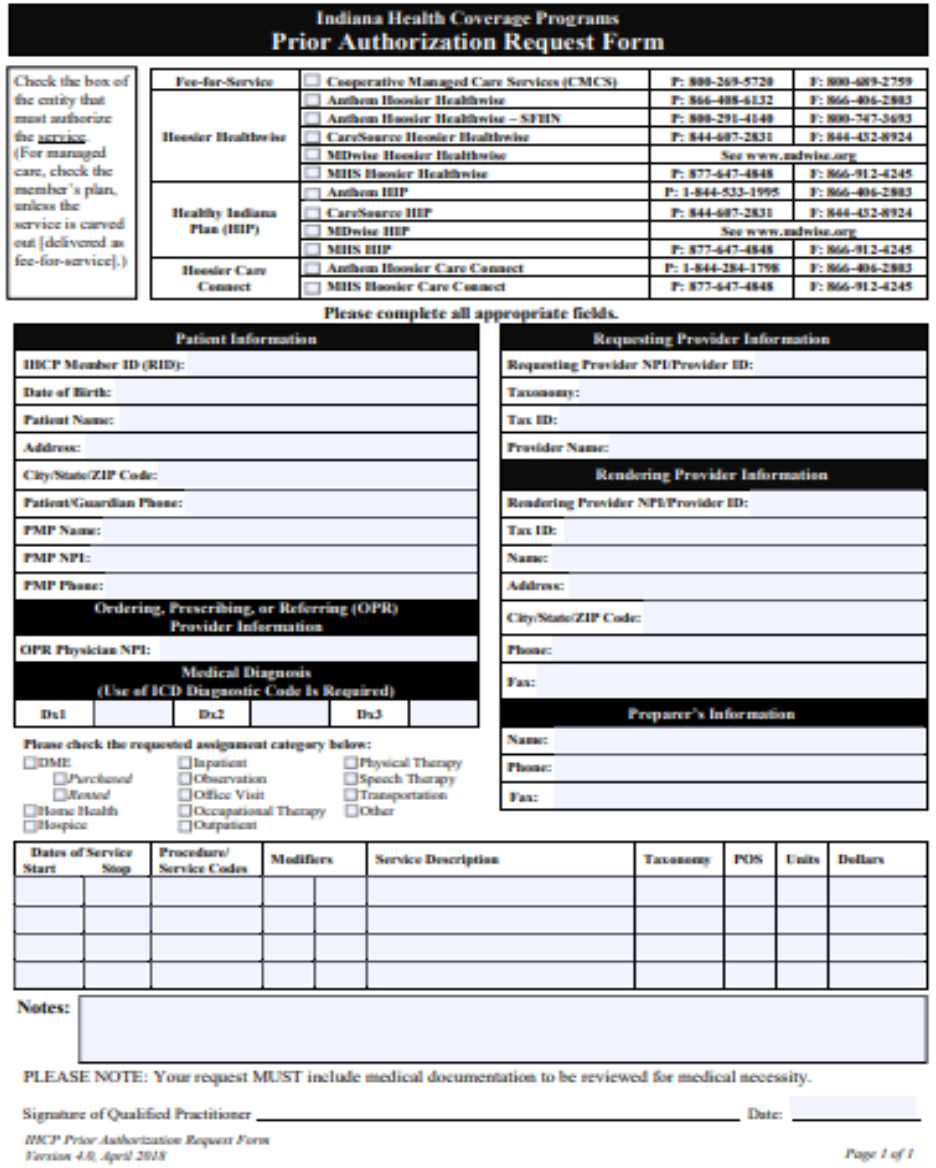
34 Programs!

Don’t forget: fee-for-service, Medicaid rehabilitation option, waiver programs, and others…

Prior Authorization

Where is the information?

The Universal PA Form



Indiana Health Coverage Programs
Prior Authorization Request Form

Check the box of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

Fee-for-Service	☐ Cooperative Managed Care Services (CMCS)	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	☐ Anthem Hoosier Healthwise	P: 866-488-6132	F: 866-406-2803
	☐ Anthem Hoosier Healthwise – SFBN	P: 800-291-4140	F: 800-747-3693
	☐ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	☐ MDwise Hoosier Healthwise	See www.mdwise.org	
	☐ MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	☐ Anthem HIP	P: 1-844-533-1995	F: 866-406-2803
	☐ CareSource HIP	P: 844-607-2831	F: 844-432-8924
	☐ MDwise HIP	See www.mdwise.org	
	☐ MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	☐ Anthem Hoosier Care Connect	P: 1-844-284-1798	F: 866-406-2803
	☐ MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245

Please complete all appropriate fields.

Patient Information

IHCP Member ID (RID):
Date of Birth:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:

Ordering, Prescribing, or Referring (OPR) Provider Information

OPR Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)

Dx1		Dx2		Dx3	

Requesting Provider Information

Requesting Provider NPI/Provider ID:
Taxonomy:
Tax ID:
Provider Name:

Rendering Provider Information

Rendering Provider NPI/Provider ID:
Tax ID:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information

Name:
Phone:
Fax:

Please check the requested assignment category below:

☐ DME
☐ *Purchased*
☐ *Rented*
☐ Home Health
☐ Hospice
☐ Inpatient
☐ Observation
☐ Office Visit
☐ Occupational Therapy
☐ Outpatient
☐ Physical Therapy
☐ Speech Therapy
☐ Transportation
☐ Other

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	POS	Units	Dollars

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____

IHCP Prior Authorization Request Form
Version 4.0, April 2018

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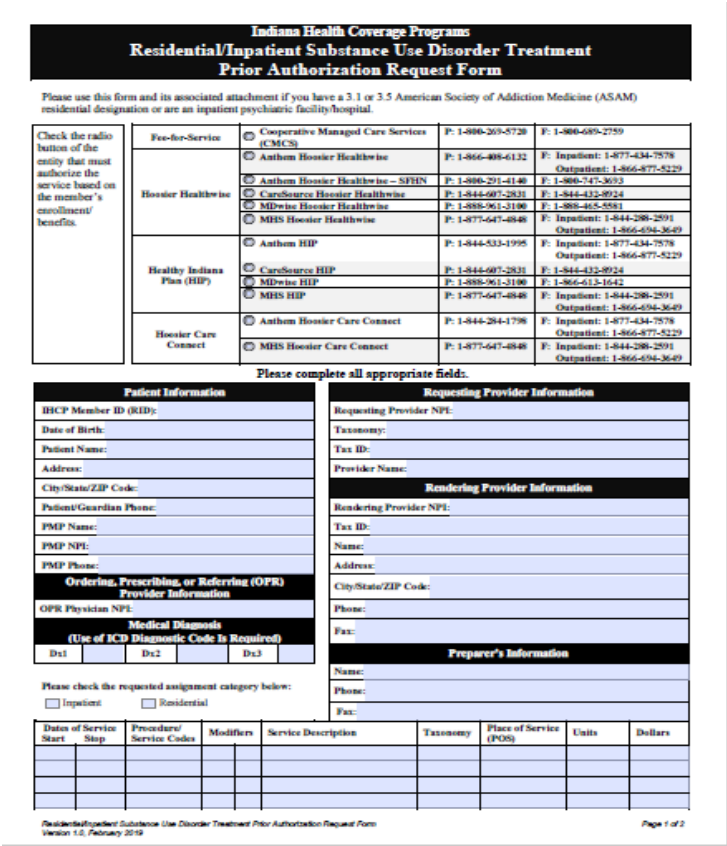
Prior Authorization for IP/RTF SUD

Where is the information?

The Universal SUD PA Form

The Initial SUD Assessment Form

Source: Bulletin BT201906



Indiana Health Coverage Programs
Residential/Inpatient Substance Use Disorder Treatment
Prior Authorization Request Form

Please use this form and its associated attachment if you have a 3.1 or 3.5 American Society of Addiction Medicine (ASAM) residential designation or are an inpatient psychiatric facility/hospital.

Check the radio button of the entity that must authorize the service based on the member's enrollment/ benefits.

Fee-for-Service	Cooperative Managed Care Services (CMCS)	P: 1-800-269-5720	F: 1-800-689-2759
Hoosier Healthwise	Anthem Hoosier Healthwise	P: 1-866-408-6132	F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229
	Anthem Hoosier Healthwise – SFHN	P: 1-800-291-6140	F: 1-800-747-3693
	CareSource Hoosier Healthwise	P: 1-844-607-2831	F: 1-844-432-8924
	MDwise Hoosier Healthwise	P: 1-888-961-3100	F: 1-888-465-5581
	MHS Hoosier Healthwise	P: 1-877-647-4848	F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649
Healthy Indiana Plan (HIP)	Anthem HIP	P: 1-844-533-1995	F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229
	CareSource HIP	P: 1-844-607-2831	F: 1-844-432-8924
	MDwise HIP	P: 1-888-961-3100	F: 1-866-613-1642
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	MHS Hoosier Care Connect	P: 1-877-647-4848	F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649

Please complete all appropriate fields.

Patient Information
IHCP Member ID (RID):
Date of Birth:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:

Ordering, Prescribing, or Referring (OPR) Provider Information
OPR Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)
Dx1 | Dx2 | Dx3

Requesting Provider Information
Requesting Provider NPI:
Taxonomy:
Tax ID:
Provider Name:

Rendering Provider Information
Rendering Provider NPI:
Tax ID:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:
☐ Inpatient ☐ Residential

Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Modifiers	Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form Version 1.0, February 2019

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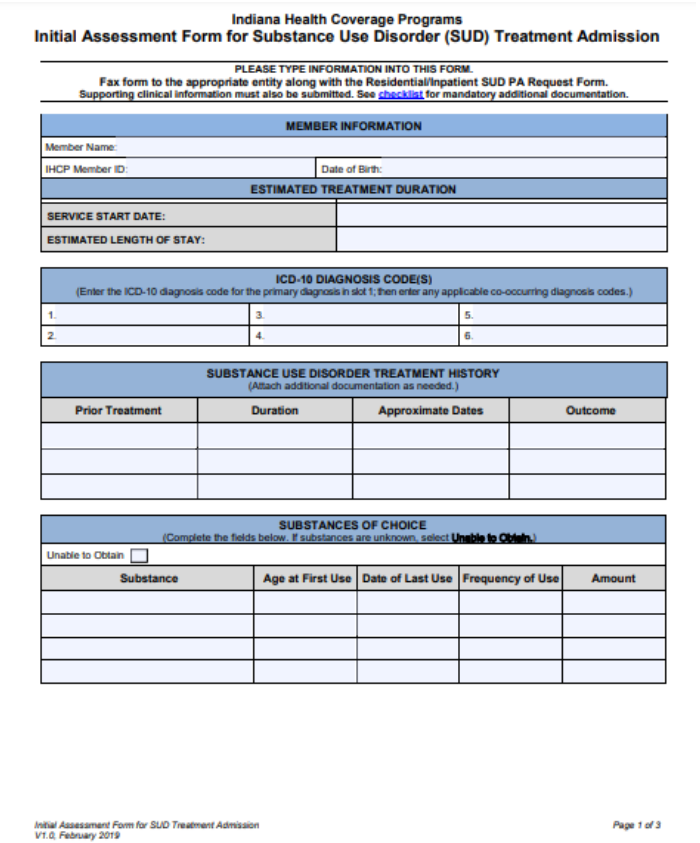


Indiana Health Coverage Programs
Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission

PLEASE TYPE INFORMATION INTO THIS FORM.
Fax form to the appropriate entity along with the Residential/Inpatient SUD PA Request Form.
Supporting clinical information must also be submitted. See checklist for mandatory additional documentation.

MEMBER INFORMATION
Member Name:
IHCP Member ID: | Date of Birth:

ESTIMATED TREATMENT DURATION
SERVICE START DATE:
ESTIMATED LENGTH OF STAY:

ICD-10 DIAGNOSIS CODE(S)
(Enter the ICD-10 diagnosis code for the primary diagnosis in slot 1; then enter any applicable co-occurring diagnosis codes.)

1.	3.	5.
2.	4.	6.

SUBSTANCE USE DISORDER TREATMENT HISTORY
(Attach additional documentation as needed.)

Prior Treatment	Duration	Approximate Dates	Outcome

SUBSTANCES OF CHOICE
(Complete the fields below. If substances are unknown, select **Unable to Obtain.**)
Unable to Obtain ☐

Substance	Age at First Use	Date of Last Use	Frequency of Use	Amount

Initial Assessment Form for SUD Treatment Admission V1.0, February 2019

Page 1 of 3

Prior Authorization Process

- Providers request authorization by submitting the Universal PA form to MCE. Certain services may require a different form, such as SUD.
  - The processes and timelines outlined in this presentation are the same for physical and behavioral health/SUD requests.
- Authorization requests are reviewed for completeness and clinical documentation provided administrative guidelines are met (ex. member eligibility).
- Either the IHCP guideline (if applicable) or a national clinical guideline such as MCG is applied to the request and clinical information.
- If criteria or guideline is not met, the case is pended to a physician for review.
- The prior authorization requirements and the process to obtain prior authorization is available on each MCE website.

Authorizations and Notifications of Action

- Determinations to deny or reduce the request for authorization results in written notification to the member and provider of the decision, rationale for the decision, the criteria or guideline applied and not met, and the appeal rights.
- Member Notifications of Action are written at a 5th grade reading level and do not utilize acronyms, abbreviations or codes not explained in the letter.
- If a denial is issued, the member and provider have the right to request a copy of the review file and a copy of the criteria or guideline used.
- Providers are offered the right to speak with the reviewing physician also called a Peer to Peer. Some MCEs also have a reconsideration process where new clinical information can be reviewed.

Authorization Timeframes

- Non-emergent pre-service requests for authorization are completed within **7 calendar days** of receiving all necessary information.
  - This timeline may be extended by 14 calendar days if the member of provider requests an extension or more information is needed.
- Urgent pre-service requests for authorization are completed **within 3 calendar days** (72 hours) of receiving all necessary information.
  - This timeline may be extended by 7 calendar days if the member of provider requests an extension or more information is needed.
- Prior authorization decisions are communicated to the provider via fax or letter and must be communicated within the timeframes above.

The Intake Process

Cameual Wright, MD

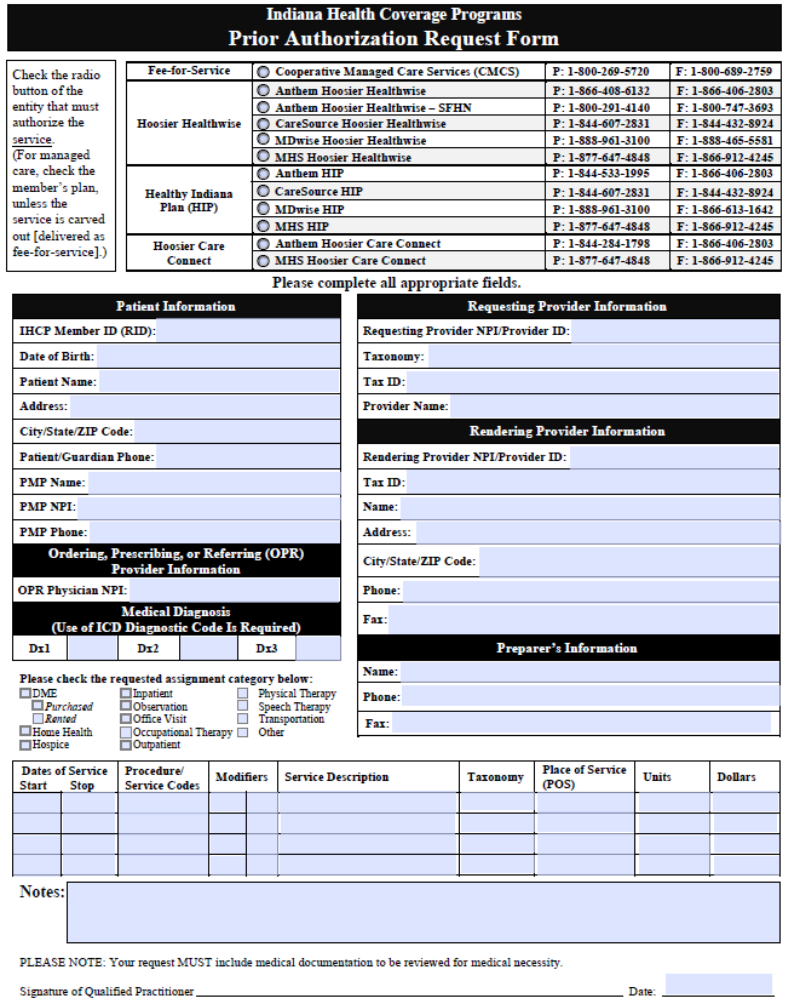
Medical Director

CareSource

Intake Process

Prior Authorization

Title	Version Date
IHCP Applied Behavioral Analysis (AB	July 2018
IHCP Fast Track Notification Form	February 2019
IHCP Full Eligibility Notification Form	February 2019
IHCP Prior Authorization Request Fo	January 2019
IHCP Prior Authorization Request Fo (universal PA form - instructions)	February 2019
IHCP Prior Authorization Dental Requ	April 2018
IHCP Prior Authorization Dental Requ	April 2018
IHCP Prior Authorization - System Up	November 2017
IHCP Residential/Inpatient Substance	February 2019
IHCP Initial Assessment Form for Sub	February 2019
IHCP Reassessment Form for Contin	February 2019



Indiana Health Coverage Programs
Prior Authorization Request Form

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Please complete all appropriate fields.

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PMP Phone:

Ordering, Prescribing, or Referring (OPR) Provider Information
OPR Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)
Dx1 Dx2 Dx3

Requesting Provider Information
Requesting Provider NPI/Provider ID:
Taxonomy:
Tax ID:
Provider Name:

Rendering Provider Information
Rendering Provider NPI/Provider ID:
Tax ID:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:
DME (Purchased, Rented) Home Health Hospice Inpatient Observation Office Visit Occupational Therapy Outpatient Physical Therapy Speech Therapy Transportation Other

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date:

Intake Process

Indiana Health Coverage Programs
Prior Authorization Request Form

Check the radio button of the entity that must authorize the service.
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Intake Process

Required Elements:

- Patient Information
  - RID, DOB, Patient Name, Address, Phone, and PMP, if applicable
- Provider Information
  - NPI/PID, Taxonomy, Tax ID, Provider Name
- Treatment Information
  - Dates of Service, CPT/HCPCS code, modifiers, description, place of service
- Authorized provider signature (MD, DO, DDS, HSPP, etc.) per Indiana Administrative Code 405 IAC 5-3-10

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Intake Process

Reasons for denials or delays

Medical Necessity Denials:

- Request does not meet medical necessity per MD (1)
- Lack of clinical documentation (2)
- Out of network provider when there are in-network options

Administrative Denials:

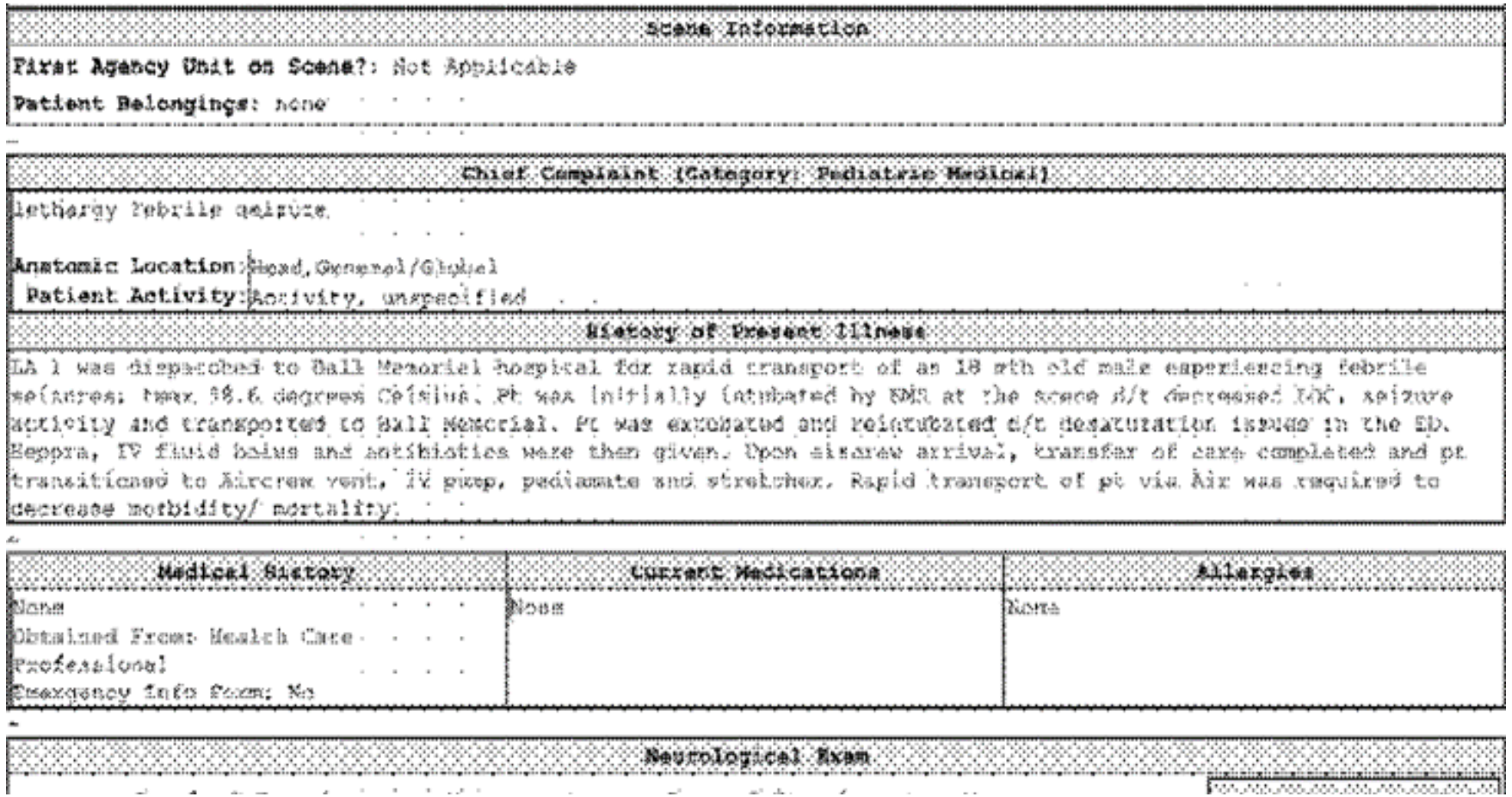
- Late notification (3)
- Retroactive submission outside of 60 days
- Non-covered benefits
- Member not covered/incorrect MCE

Delays:

- Dollar amount not included (Medical Equipment)
- Dates of service overlap with existing treatment, e.g. home health visits for the same dates as inpatient admission
- Authorization request doesn’t match diagnosis

Intake Process

Example of an illegible document submitted:



Scene Information

First Agency Unit on Scene?: Not Applicable

Patient Belongings: none

Chief Complaint (Category: Pediatric Medical)

lethargy febrile seizure

Anatomic Location: Head, General/Global

Patient Activity: Activity, unspecified

History of Present Illness

LA 1 was dispatched to Ball Memorial hospital for rapid transport of an 18 mth old male experiencing febrile seizures; temp 39.6 degrees Celsius. Pt was initially intubated by EMT at the scene d/t decreased LOC, seizure activity and transported to Ball Memorial. Pt was extricated and reintubated d/t desaturation issues in the ED. Keppra, IV fluid bolus and antibiotics were then given. Upon aircrew arrival, transfer of care completed and pt transitioned to Aircrew vent, IV pump, pediamate and stretcher. Rapid transport of pt via Air was required to decrease morbidity/ mortality.

Medical History	Current Medications	Allergies
None Obtained From: Health Care Professional Emergency Info Form: No	None	None

Neurological Exam

Intake Process

Additional Resources

- IHCP Quick Reference Guide
  - https://www.in.gov/medicaid/files/quick%20reference.pdf
- CareSource
  - https://www.caresource.com/in/providers/provider-portal/prior-authorization/medicaid/
- Anthem
  - https://mediproviders.anthem.com/in/Pages/prior-authorization.aspx
- Mdwise
  - https://www.mdwise.org/MediaLibraries/MDwise/Files/For%20Providers/Forms/Prior%20Authorization/Provider_PA_guide.pdf
- MHS
  - https://www.mhsindiana.com/providers/prior-authorization.html
- IHCP Prior Authorization Manual
  - https://www.in.gov/medicaid/files/prior%20authorization.pdf

Appealing a Decision

Ryan Venis, MD

Medical Director

Anthem

Criteria Used to Make PA Decisions

- State Contract, Policy, Manual
- MCG
- Health Plan Policies, Vendor Guidelines

Types of Denials

- Medical Necessity Denials: case is reviewed against evidence based criteria.
- Benefit Denials: case is reviewed against member benefits.
- Administrative Denials: case was not properly received, benefits are non-covered or member is ineligible.

Options for provider after receiving initial determination

- If you agree with the health plan decision, no additional steps are required.
- If you disagree with the health plan decision, the following options are available:
  - Reconsideration
  - Peer to Peer
  - Appeal
    - Standard vs Expedited appeal
    - External Independent Review—case reviewed by physician independent of MCE (clinical)
    - State Fair Hearing—case reviewed by an Administrative Law Judge (procedural)
- Reconsideration and Peer to Peer options are not available for administrative denials. Administrative denial reasons must be overturned before a request is reviewed for medical necessity reasons.

Appeal Process for In-Network and Out-of-Network Providers

MCE	In-Network	Out-of-Network
Anthem	• Within 60 days from the notice of action, providers must submit their request for appeal in writing by fax or mail. • The directions for filing an appeal are included in every adverse determination letter sent to provider and member.	• Within 60 days from the notice of action, providers must submit their request for appeal in writing by fax or mail. • The directions for filing an appeal are included in every adverse determination letter sent to provider and member.
CareSource	• Within 60 days from the notice of action, submit a clinical appeal form along with the member's consent form. • The directions for filing an appeal are included in every adverse determination letter sent to provider and member.	• Within 60 days from the notice of action, submit a clinical appeal form along with the member's consent form. • The directions for filing an appeal are included in every adverse determination letter sent to provider and member.
MDwise	• Providers must submit their request for appeal in writing either by fax or mail. • The directions for filing an appeal are included in every adverse determination letter sent to the provider.	• Providers must submit their request for appeal in writing either by fax or mail. • The directions for filing an appeal are included in every adverse determination letter sent to the provider.
MHS	• Providers filing an appeal on behalf of a member can submit requests by mail, fax, email, or phone call within 60 calendar days. • The process is communicated by phone call to the provider and the UM denial letter. • The appeal process can be found in the Provider Manual for Par Providers and on MHS' website.	• Providers filing an appeal on behalf of a member can submit requests by mail, fax, email, or phone call within 60 calendar days. • The process is communicated by phone call to the provider and the UM denial letter. • The appeal process can be found on MHS' website.

Reconsideration

- Most cases that are denied have insufficient clinical information.
- Reconsideration is the process that allows providers/facilities to send more clinical documentation for review (via fax or online portal).
  - Anthem and MHS use the Peer to Peer and a reconsideration process in addition to the appeals process.
  - CareSource and MDwise use Peer to Peer and the appeals process.
- Providers have seven days from the day of denial to submit additional clinical information.
- At the health plan, the nurse and physician review the new clinical information.
- The physician renders a decision: approve or uphold the denial.
- A provider may still perform a Peer to Peer or an appeal in addition to the reconsideration.
- These processes and timelines are the same for both physical health and behavioral health/SUD reconsiderations.

Peer to Peer

- When cases are denied a provider (MD, DO, NP, PA) can also request a “Peer to Peer” (P2P) conversation with the reviewing physician to discuss the case.
  - Anthem requires a P2P request to be made within **7 business days** of a denial.
  - CareSource requires a P2P request to be made within **5 business days** of a denial.
  - Mdwise requires a P2P request to be made within **7 business days** of a denial.
  - MHS requires a P2P request to be made within **10 calendar days** of a denial.
- This is an opportunity to add/clarify information, put forward unique clinical circumstances, etc.
- We ask providers to share 2-3 preferred days/times to receive a call back from the health plan. The reviewing physician makes two attempts to reach provider at provider’s preferred day/time/number and will leave his/her own call back number if connection was not made.
- These processes and timelines are the same for both physical health and behavioral health/SUD peer to peer consultations.

Appeal

- If a provider is still unsatisfied with the decision on the case after reconsideration and/or Peer to Peer, an appeal request can be made.
- Per State guidance, the appeal needs to be submitted within 60 calendar days from the date on the Denial Letter.
- Standard appeal decision needs to be completed within 30 business days.
- Expedited appeal decision needs to be completed within 48 hours.
  - An appeal needs to be expedited when normal appeal time would jeopardize the life, health, or safety of a member.
- Appeals are always reviewed by different physician reviewer than initial reviewer.
- Appeals are reviewed by a physician reviewer with experience with condition.
- Specialty review can be requested by provider.
- These processes and timelines are the same for both physical health and behavioral health/SUD appeals.

Definition of Appeals

Appeal is defined as a request for review of an action and/or request to change a previous decision. An action, as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined the State; or
- Failure of an MCE to act within the required timeframes.
- For a resident of a rural area with only one MCE, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Prior Authorization Appeals Timeline

- Appeals must be initiated within **60 calendar days** of the denial to be considered.
- MCE will acknowledge an appeal was received within **3 business days.**
- MCE will send decision letter within **5 business days** of the clinical decision/determination, not to exceed the 30 days to complete the appeal.
- Please note, this is different than a claim appeal request which is **67 calendar days**.

Retro-eligibility Process

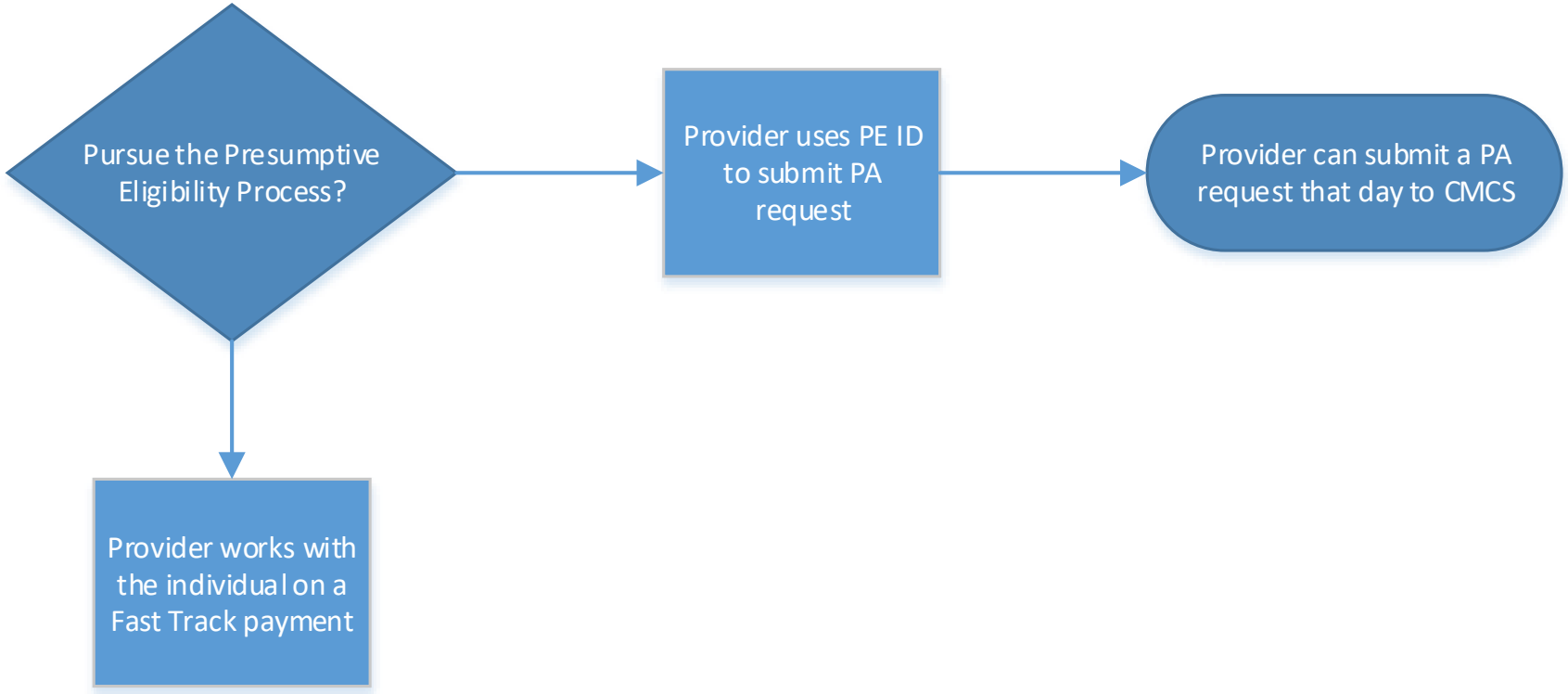
Michael Cook
OMPP

Problem

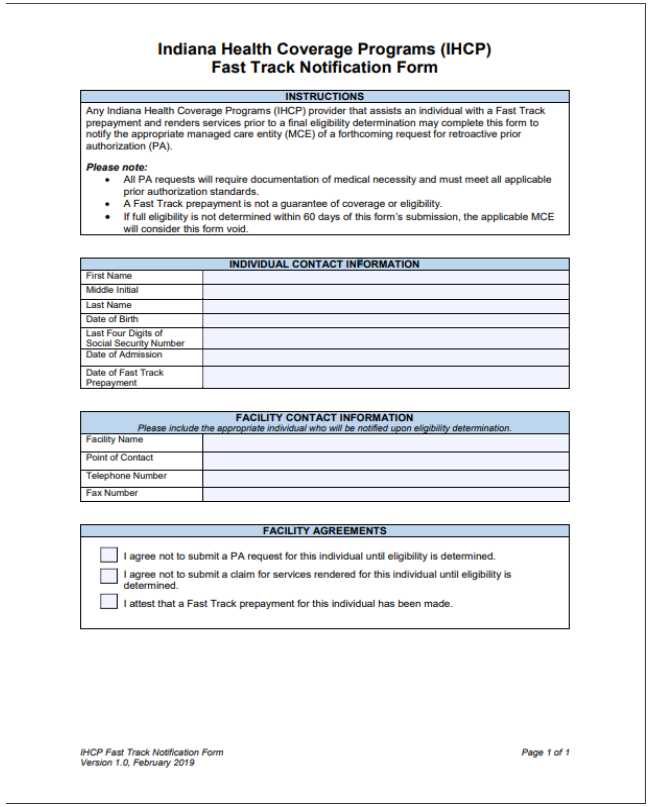
- Individuals are not eligible/not loaded into the system on date of service
  - ➢ No record of individual = no prior authorization

- Heavily impacts HIP members seeking inpatient care

Fast Track Prior Authorization Process



Initial Fast Track Notification Form



Indiana Health Coverage Programs (IHCP)
Fast Track Notification Form

INSTRUCTIONS
Any Indiana Health Coverage Programs (IHCP) provider that assists an individual with a Fast Track prepayment and renders services prior to a final eligibility determination may complete this form to notify the appropriate managed care entity (MCE) of a forthcoming request for retroactive prior authorization (PA). ***Please note:*** • All PA requests will require documentation of medical necessity and must meet all applicable prior authorization standards. • A Fast Track prepayment is not a guarantee of coverage or eligibility. • If full eligibility is not determined within 60 days of this form's submission, the applicable MCE will consider this form void.

INDIVIDUAL CONTACT INFORMATION	
First Name	
Middle Initial	
Last Name	
Date of Birth	
Last Four Digits of Social Security Number	
Date of Admission	
Date of Fast Track Prepayment	

FACILITY CONTACT INFORMATION *Please include the appropriate individual who will be notified upon eligibility determination.*	
Facility Name	
Point of Contact	
Telephone Number	
Fax Number	

FACILITY AGREEMENTS

- ☐ I agree not to submit a PA request for this individual until eligibility is determined.
- ☐ I agree not to submit a claim for services rendered for this individual until eligibility is determined.
- ☐ I attest that a Fast Track prepayment for this individual has been made.

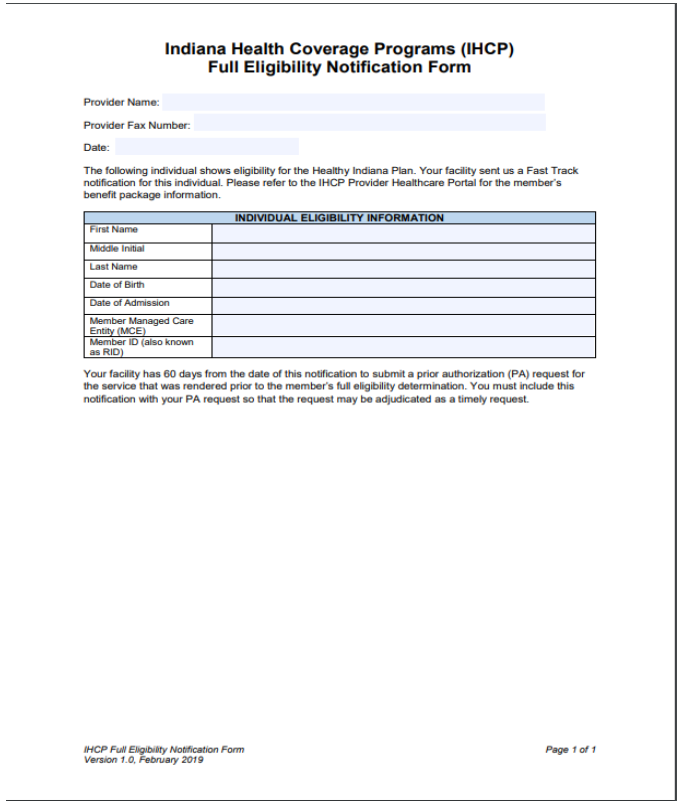
IHCP Fast Track Notification Form
Version 1.0, February 2019

Page 1 of 1

Provider faxes a Fast Track Notification to the appropriate MCE → MCE uses an internal process to monitor the individual's eligibility

IMPORTANT NOTE: Provider must submit Fast Track Notification to MCE within 5 days of rendering the service.

Found Eligible for Coverage?



Indiana Health Coverage Programs (IHCP)
Full Eligibility Notification Form

Provider Name:

Provider Fax Number:

Date:

The following individual shows eligibility for the Healthy Indiana Plan. Your facility sent us a Fast Track notification for this individual. Please refer to the IHCP Provider Healthcare Portal for the member's benefit package information.

INDIVIDUAL ELIGIBILITY INFORMATION	
First Name	
Middle Initial	
Last Name	
Date of Birth	
Date of Admission	
Member Managed Care Entity (MCE)	
Member ID (also known as RID)	

Your facility has 60 days from the date of this notification to submit a prior authorization (PA) request for the service that was rendered prior to the member's full eligibility determination. You must include this notification with your PA request so that the request may be adjudicated as a timely request.

IHCP Full Eligibility Notification Form
Version 1.0, February 2019

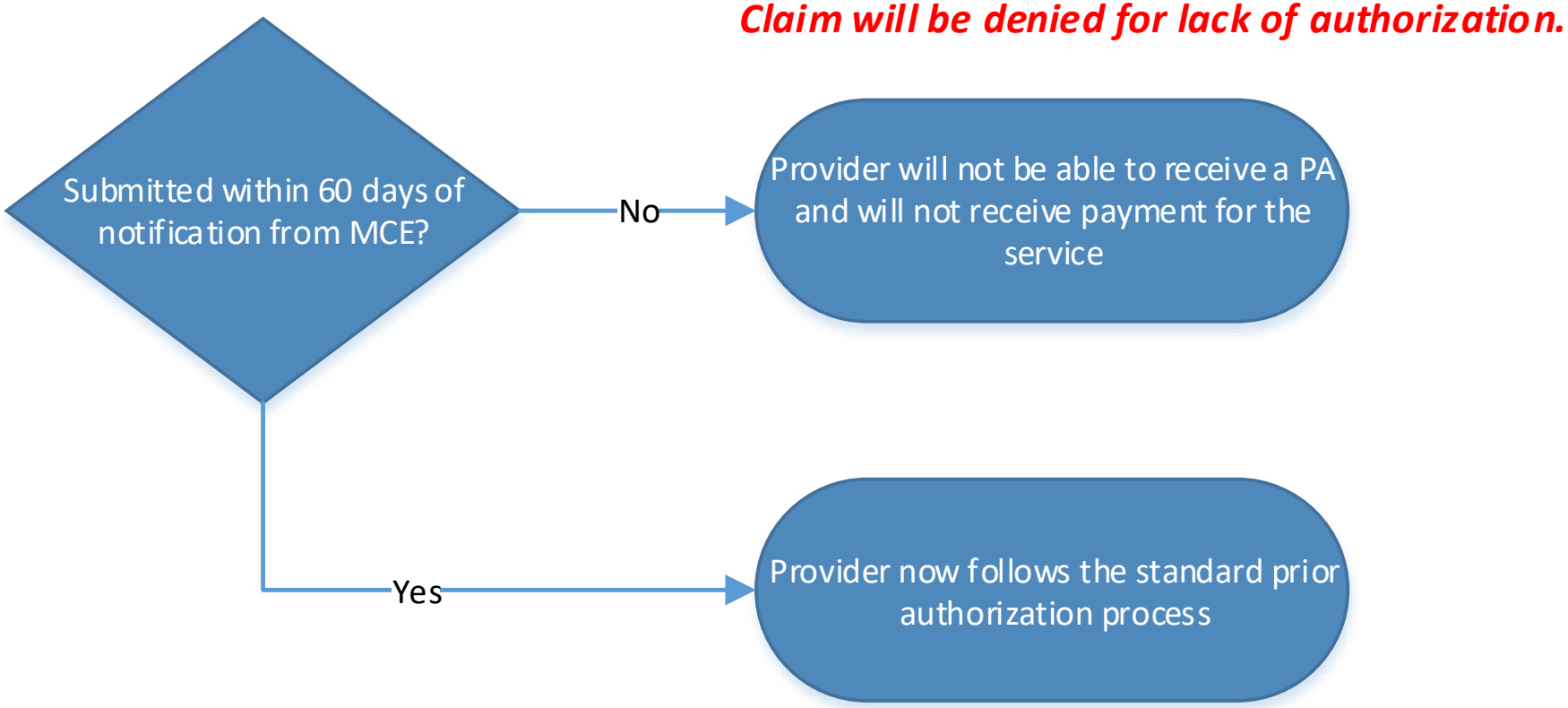
Page 1 of 1

MCE notification within seven days of eligibility discovery.

MCE faxes the provider a notification of the member's eligibility → Provider now has a RID with which to submit a PA request → Provider should submit both the PA request form and the provider notification from the MCE

IMPORTANT NOTE: Provider has 60 days from the receipt of the notification from the MCE to submit a prior authorization request.

Submitted Request Timely?



Other Fixes

- PE Adult into fee-for-service

- Clarification of Hoosier Healthwise members during retroactive eligibility period

Concurrent Review

Pat Richards
Senior Vice President, Medical Management
MHS

What is concurrent review?

- Concurrent Review is the process of reviewing inpatient admissions (IP, BH and SUD) for medical necessity of requested continued stays, as well as evaluating the correct level of care and post discharge needs. Post discharge needs may include:
    - Transfer to a lower level of care such as IOP, PHP, SUD residential, rehab, Long-term care (LTACH), Skilled Nursing Facility
    - Home Care
    - DME
    - Medical supplies

Concurrent Review Process

- Requests for continued stay must be submitted prior to the last approved day.
- The clinical information is reviewed against national clinical guidelines (MCG).
- If the clinical information does not meet the guideline, the clinician refers the case to a physician reviewer who will utilize the guideline and clinical judgement to determine the medical necessity of the continued stay.
- If approved the reviewer will assign the next review date based on the member's clinical status.
- If continued stay is denied, the requesting physician is offered a peer to peer discussion.

How do providers obtain concurrent review?

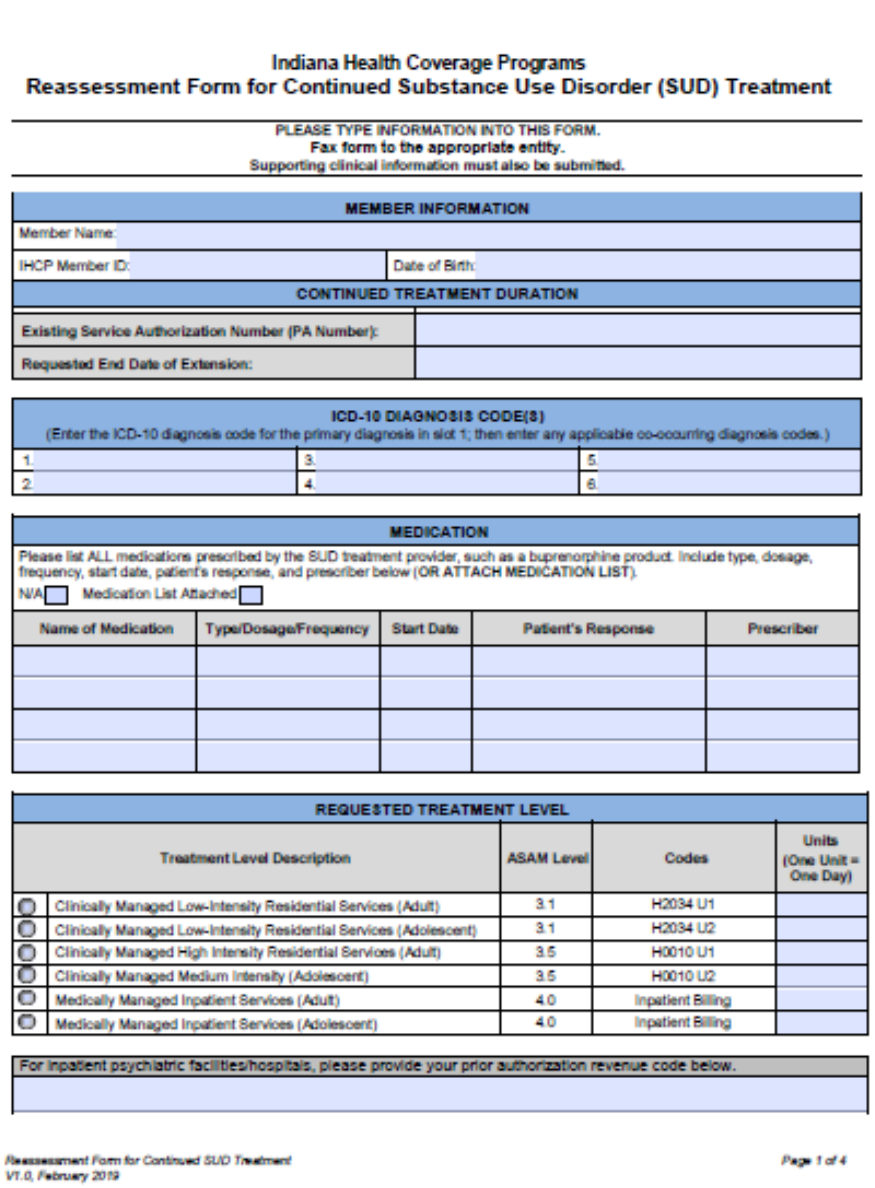
- After the initial review is completed, provider is notified of the number of days approved and the next review date.
- Providers may fax the request, with the needed clinical information, to the health plan intake fax number (or use the respective MCE web based portal).
- Providers may also call in the information to the health plan. (Anthem does not accept verbal clinical information. This must be submitted via fax or web.)
- MCEs encourage providers to submit all needed clinical information upfront.
- These processes and timelines are the same for both physical health and behavioral health/SUD concurrent reviews.

Concurrent Review for Continued IP SUD

Where is the information?

The Universal Reassessment Form for Continued SUD Treatment

Source: Bulletin BT201906



Indiana Health Coverage Programs
Reassessment Form for Continued Substance Use Disorder (SUD) Treatment

PLEASE TYPE INFORMATION INTO THIS FORM.
Fax form to the appropriate entity.
Supporting clinical information must also be submitted.

MEMBER INFORMATION	
Member Name:	
IHCP Member ID:	Date of Birth:

CONTINUED TREATMENT DURATION	
Existing Service Authorization Number (PA Number):	
Requested End Date of Extension:	

ICD-10 DIAGNOSIS CODE(S) (Enter the ICD-10 diagnosis code for the primary diagnosis in slot 1; then enter any applicable co-occurring diagnosis codes.)		
1.	3.	5.
2.	4.	6.

MEDICATION

Please list ALL medications prescribed by the SUD treatment provider, such as a buprenorphine product. Include type, dosage, frequency, start date, patient's response, and prescriber below (OR ATTACH MEDICATION LIST).

N/A ☐ Medication List Attached ☐

Name of Medication	Type/Dosage/Frequency	Start Date	Patient's Response	Prescriber

REQUESTED TREATMENT LEVEL

	Treatment Level Description	ASAM Level	Codes	Units (One Unit = One Day)
○	Clinically Managed Low-Intensity Residential Services (Adult)	3.1	H2034 U1	
○	Clinically Managed Low-Intensity Residential Services (Adolescent)	3.1	H2034 U2	
○	Clinically Managed High Intensity Residential Services (Adult)	3.5	H0010 U1	
○	Clinically Managed Medium Intensity (Adolescent)	3.5	H0010 U2	
○	Medically Managed Inpatient Services (Adult)	4.0	Inpatient Billing	
○	Medically Managed Inpatient Services (Adolescent)	4.0	Inpatient Billing	

For inpatient psychiatric facilities/hospitals, please provide your prior authorization revenue code below.

Reassessment Form for Continued SUD Treatment
V1.0, February 2019

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What is the process for concurrent review?

- Our nursing staff reviews the clinical information against national clinical guidelines (MCG) for medical necessity.
- If guidelines are not met the request is sent to a Medical Director for review.
- The Medical Director will review against the guidelines and use clinical judgment to make a determination for continued stay. The Medical Director will approve or deny the request.
- If a denial determination is made, the treating physician is offered a Peer to Peer discussion with the Medical Director. After discussion the Medical Director may approve or deny.
- If a denial determination is made after the Peer to Peer discussion, the provider may request an appeal.
- If the denial is upheld after the Peer to Peer discussion, or no Peer to Peer is requested, the denial will be upheld.
- The provider and member are given their appeal rights in writing within 1 business day of the completed request.

What are the timeframes around concurrent review?

- Concurrent Review determinations are made within 1 business day of receiving all of the clinical information needed to make a determination.
- This timeline is the same for both physical health and behavioral health/SUD concurrent reviews.

Health Plan Data

Q4 2018 Anthem HIP

	Type of Authorization			Contract Arrangement		Total
Description	**Pre-Service**	**Concurrent Review**	**Retrospective**	**In Network**	**Out of Network**	
Total Number of Auths Submitted in Reporting period	**37,168**	**31,667**	**3,817**	**69,389**	**3,263**	**72,652**
Total Number of Auths Adjudicated in Reporting Period	**36,049**	**30,383**	**3,500**	**66,912**	**3,020**	**69,932**
Total Number Approved	**30,384**	**21,372**	**2,646**	**52,309**	**2,093**	**54,402**
Total Number Fully Denied	**5,146**	**8,473**	**705**	**13,434**	**890**	**14,324**
Total Number Modified	**519**	**538**	**149**	**1169**	**37**	**1,206**
% Approved	**84.3%**	**70.3%**	**75.6%**	**78.2%**	**69.3%**	**77.8%**
% Fully Denied	**14.3%**	**27.9%**	**20.1%**	**20.1%**	**29.5%**	**20.5%**
% Modified	**1.4%**	**1.8%**	**4.3%**	**1.7%**	**1.2%**	**1.7%**
Average Number of Days to Process	**1.73**	**0.61**	**0.95**	**1.16**	**2.26**	**1.2**
Number of Prior Auths Processed Timely	**35,852**	**29,665**	**3,473**	**66,015**	**2,975**	**68,990**
Percent (%) Processed Timely	**99.45%**	**97.64%**	**99.23%**	**98.66%**	**98.51%**	**98.65%**
Total Number of Appeals Filed due to a Denied/Modified Authorization	**146**	**0**	**5**	**138**	**13**	**151**

Q4 2018 Anthem Hoosier Healthwise

	Type of Authorization			Contract Arrangement		Total
Description	Pre-Service	Concurrent Review	Retrospective	In Network	Out of Network	
Total Number of Auths Submitted in Reporting period	9,862	5,273	790	14,684	1,241	15,925
Total Number of Auths Adjudicated in Reporting Period	9,613	5,151	672	14,315	1,121	15,436
Total Number Approved	8,735	3,720	464	11,970	949	12,919
Total Number Fully Denied	785	1,397	198	2,225	155	2,380
Total Number Modified	93	34	10	120	17	137
% Approved	90.87%	72.22%	69.05%	83.62%	84.66%	83.69%
% Fully Denied	8.17%	27.12%	29.46%	15.54%	13.83%	15.42%
% Modified	0.97%	0.66%	1.49%	0.84%	1.52%	0.89%
Average Number of Days to Process	1.80	0.69	0.32	1.25	2.89	1.39
Number of Prior Auths Processed Timely	9,522	5,036	668	14,118	1,108	15,226
Percent (%) Processed Timely	99.05%	97.77%	99.40%	98.62%	98.84%	98.64%
Total Number of Appeals Filed due to a Denied/Modified Authorization	39	0	4	30	13	43

Q4 2018 Anthem Hoosier Care Connect

	Type of Authorization			Contract Arrangement		Total
Description	Pre-Service	Concurrent Review	Retrospective	In Network	Out of Network	
Total Number of Auths Submitted in Reporting period	19,853	16,385	1,403	35,776	1,865	37,641
Total Number of Auths Adjudicated in Reporting Period	19,327	15,526	1,265	34,372	1,746	36,118
Total Number Approved	16,775	11,402	866	27,645	1,398	29,043
Total Number Fully Denied	2,164	3,845	306	5,990	325	6,315
Total Number Modified	388	279	93	737	23	760
% Approved	86.80%	73.44%	68.46%	80.43%	80.07%	80.41%
% Fully Denied	11.20%	24.76%	24.19%	17.43%	18.61%	17.48%
% Modified	2.01%	1.80%	7.35%	2.14%	1.32%	2.10%
Average Number of Days to Process	1.93	0.61	1.18	1.3	2.17	1.44
Number of Prior Auths Processed Timely	19,198	15,185	1,251	33,914	1,720	35634
Percent (%) Processed Timely	99.33%	97.80%	98.89%	98.67%	98.51%	98.66%
Total Number of Appeals Filed due to a Denied/Modified Authorization	79	1	8	82	6	88

Q4 2018 CareSource HIP

	Type of Authorization			Contract Arrangement		Total
Description	Pre-Service	Concurrent Review	Retrospective	In Network	Out of Network	
Total Number of Auths Submitted in Reporting period	5503	4318	326	9112	1035	10147
Total Number of Auths Adjudicated in Reporting Period	5652	4353	388	9315	1078	10393
Total Number Approved	4687	2998	325	7247	763	8010
Total Number Fully Denied	964	1304	63	2042	289	2331
Total Number Modified	1	51	0	26	26	52
% Approved	82.93%	68.87%	83.76%	77.80%	70.78%	77.07%
% Fully Denied	17.06%	29.96%	16.24%	21.92%	26.81%	22.43%
% Modified	0.02%	1.17%	0.00%	0.28%	2.41%	0.50%
Average Number of Days to Process	2.30	0.59	13.46	1.68	4.14	5.82
Number of Prior Auths Processed Timely	5623	4087	380	9118	972	10090
Percent (%) Processed Timely	99.49%	93.88%	97.94%	97.89%	90.16%	97.08%
Total Number of Appeals Filed due to a Denied/Modified Authorization	24	0	0	24	0	24

Q4 2018 CareSource Hoosier Healthwise

	Type of Authorization			Contract Arrangement		Total
Description	Pre-Service	Concurrent Review	Retrospective	In Network	Out of Network	
Total Number of Auths Submitted in Reporting period	1986	1069	211	2865	401	3266
Total Number of Auths Adjudicated in Reporting Period	2049	1074	232	2942	413	3355
Total Number Approved	1815	843	198	2560	296	2856
Total Number Fully Denied	233	231	34	381	117	498
Total Number Modified	1	0	0	1	0	1
% Approved	88.58%	78.49%	85.34%	87.02%	71.67%	85.13%
% Fully Denied	11.37%	21.51%	14.66%	12.95%	28.33%	14.84%
% Modified	0.05%	0.00%	0.00%	0.03%	0.00%	0.03%
Average Number of Days to Process	3.09	0.63	10.81	2.52	4.81	4.37
Number of Prior Auths Processed Timely	2031	1042	227	2898	402	3300
Percent (%) Processed Timely	99.12%	97.02%	97.84%	98.50%	97.33%	98.36%
Total Number of Appeals Filed due to a Denied/Modified Authorization	4	0	0	4	0	4

Q4 2018 MDwise Healthy Indiana Plan (HIP)

	Type of Authorization			Contract Arrangement		Total
Description	**Pre-Service**	**Concurrent Review**	**Retrospective**	**In Network**	**Out of Network**	
Total Number of Auths Submitted in Reporting period	**31,362**	**3,923**	**2,557**	**33,140**	**4,702**	**37,842**
Total Number of Auths Adjudicated in Reporting Period	**31,341**	**3,922**	**2,554**	**33,122**	**4,695**	**37,817**
Total Number Approved	**22,963**	**3,514**	**2,112**	**24,704**	**3,885**	**28,589**
Total Number Fully Denied	**7,150**	**381**	**422**	**7,279**	**674**	**7,953**
Total Number Modified	**1,228**	**27**	**20**	**1,139**	**136**	**1,275**
% Approved	**73.27%**	**89.60%**	**82.69%**	**74.58%**	**82.75%**	**75.60%**
% Fully Denied	**22.81%**	**9.71%**	**16.52%**	**21.98%**	**14.36%**	**21.03%**
% Modified	**3.92%**	**0.69%**	**0.78%**	**3.44%**	**2.90%**	**3.37%**
Average Number of Days to Process	**1.77**	**1.15**	**12.04**	**2.01**	**4.42**	**4.278**
Number of Prior Auths Processed Timely	**31,270**	**3,907**	**2,553**	**33,045**	**4,684**	**37,729**
Percent (%) Processed Timely	**99.77%**	**99.62%**	**99.96%**	**99.77%**	**99.77%**	**99.77%**
Total Number of Appeals Filed due to a Denied/Modified Authorization	**301**	**2**	**32**	**244**	**91**	**335**

Q4 2018 MDwise Hoosier Healthwise (HHW)

	Type of Authorization			Contract Arrangement		Total
Description	Pre-Service	Concurrent Review	Retrospective	In Network	Out of Network	
Total Number of Auths Submitted in Reporting period	11,420	2,061	1,714	12,627	2,568	15,195
Total Number of Auths Adjudicated in Reporting Period	11,418	2,061	1,713	12,265	2,567	15,192
Total Number Approved	9,321	1,849	1,549	10,438	2,281	12,719
Total Number Fully Denied	1,591	166	134	1,673	218	1,891
Total Number Modified	506	46	30	514	68	582
% Approved	81.63%	89.71%	90.43%	82.68%	88.86%	83.72%
% Fully Denied	13.93%	8.05%	7.82%	13.25%	8.49%	12.45%
% Modified	4.43%	2.23%	1.75%	4.07%	2.65%	3.83%
Average Number of Days to Process	2.29	1.29	7.79	2.49	4.42	3.656
Number of Prior Auths Processed Timely	11,394	2,057	1,713	12,599	2,563	15,162
Percent (%) Processed Timely	99.79%	99.81%	100.00%	99.79%	99.84%	99.80%
Total Number of Appeals Filed due to a Denied/Modified Authorization	84	0	16	70	30	100

Q4 2018 MHS Healthy Indiana Plan (HIP)

	Type of Authorization			Contract Arrangement		Total
Description	**Pre-Service**	**Concurrent Review**	**Retrospective**	**In Network**	**Out of Network**	
Total Number of Auths Submitted in Reporting period	**18,480**	**3,459**	**840**	**18,461**	**4,318**	**22,779**
Total Number of Auths Adjudicated in Reporting Period	**18,317**	**3,388**	**863**	**18,385**	**4,183**	**22,568**
Total Number Approved	**12,604**	**2,977**	**522**	**12,764**	**3,339**	**16,103**
Total Number Fully Denied	**5,005**	**131**	**312**	**4,816**	**632**	**5,448**
Total Number Modified	**708**	**280**	**29**	**805**	**212**	**1,017**
% Approved	**68.81%**	**87.87%**	**60.49%**	**69.43%**	**79.82%**	**71.35%**
% Fully Denied	**27.32%**	**3.87%**	**36.15%**	**26.20%**	**15.11%**	**24.14%**
% Modified	**3.87%**	**8.26%**	**3.36%**	**4.38%**	**5.07%**	**4.51%**
Average Number of Days to Process	**1**	**0**	**6**	**1**	**1**	**2**
Number of Prior Auths Processed Timely	**18,158**	**2,889**	**835**	**17,864**	**4,018**	**21,882**
Percent (%) Processed Timely	**99.73%**	**87.45%**	**93.53%**	**97.70%**	**98.65%**	**96.96%**
Total Number of Appeals Filed due to a Denied/Modified Authorization	**64**	**38**	**4**	**44**	**62**	**106**

Q4 2018 MHS Hoosier Healthwise (HHW)

	Type of Authorization			Contract Arrangement		Total
Description	**Pre-Service**	**Concurrent Review**	**Retrospective**	**In Network**	**Out of Network**	
Total Number of Auths Submitted in Reporting period	**8,070**	**1,817**	**3,008**	**10,293**	**2,602**	**12,895**
Total Number of Auths Adjudicated in Reporting Period	**7,970**	**1,745**	**3,007**	**10,201**	**2,521**	**12,722**
Total Number Approved	**5,956**	**1,546**	**2,177**	**7,526**	**2,153**	**9,679**
Total Number Fully Denied	**1,777**	**53**	**686**	**2,208**	**308**	**2,516**
Total Number Modified	**237**	**146**	**144**	**467**	**60**	**527**
% Approved	**74.73%**	**88.60%**	**72.40%**	**73.78%**	**85.40%**	**76.08%**
% Fully Denied	**22.30%**	**3.04%**	**22.81%**	**21.64%**	**12.22%**	**19.78%**
% Modified	**2.97%**	**8.37%**	**4.79%**	**4.58%**	**2.38%**	**4.14%**
Average Number of Days to Process	**2**	**0**	**5**	**1**	**1**	**2**
Number of Prior Auths Processed Timely	**7,920**	**1,592**	**2,894**	**9,939**	**2,467**	**12,406**
Percent (%) Processed Timely	**99.37%**	**91.23%**	**96.24%**	**97.43%**	**97.86%**	**97.52%**
Total Number of Appeals Filed due to a Denied/Modified Authorization	**38**	**20**	**4**	**24**	**38**	**62**

Q4 2018 MHS Hoosier Care Connect (HCC)

	Type of Authorization			Contract Arrangement		Total
Description	Pre-Service	Concurrent Review	Retrospective	In Network	Out of Network	
Total Number of Auths Submitted in Reporting period	13,710	3,545	782	12,131	5,906	18,037
Total Number of Auths Adjudicated in Reporting Period	13,492	3,476	793	12,047	5,714	17,761
Total Number Approved	9,790	2,949	478	8,640	4,577	13,217
Total Number Fully Denied	3,197	140	287	2,872	752	3,624
Total Number Modified	505	387	28	535	385	920
% Approved	72.56%	84.84%	60.28%	71.72%	80.10%	74.42%
% Fully Denied	23.70%	4.03%	36.19%	23.84%	13.16%	20.40%
% Modified	3.74%	11.13%	3.53%	4.44%	6.74%	5.18%
Average Number of Days to Process	2	0	5	1	1	2
Number of Prior Auths Processed Timely	13,315	2,945	753	11,485	5,528	17,013
Percent (%) Processed Timely	98.69%	84.72%	94.96%	95.33%	96.74%	95.79%
Total Number of Appeals Filed due to a Denied/Modified Authorization	69	37	5	38	73	111