Prior Authorization Trends

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
Current as of November 19, 2019

Managed Care Medicaid Programs

- Healthy Indiana Plan
  - 418,933 members
  - Ages 19-64
- Hoosier Care Connect
  - 90,399 members
  - Individuals of all ages with special health care needs
- Hoosier Healthwise
  - 601,446 members
  - Children up to age 19

Managed Care Health Plans

- Anthem
- CareSource
- Managed Health Services
- MDwise

Prior Authorization Process

- Prior Authorization is the request for a specific set of services within a specific time period.

Prior Authorization Process

- Each Managed Care health plan determines the services that need prior authorization
- Why a health plan may include services on a prior authorization list:
  - Ensure members are getting the most appropriate treatment
  - Prevent fraud
  - Find and direct members to care management sooner

Examples of Services Commonly Requiring Authorization

- MRI, PET Scans, Echocardiogram
- Bariatric Surgery
- Home Health
- Rehabilitation services
- Expensive DME, such as certain wheelchairs
- Orthotics and prosthetics over certain cost limits
- Pain management programs

Prior Authorization Process

- Prior Authorization requests are always first reviewed for completeness by the managed care health plan.
- If the authorization is not complete or illegible it will be returned to the provider.

Prior Authorization Process

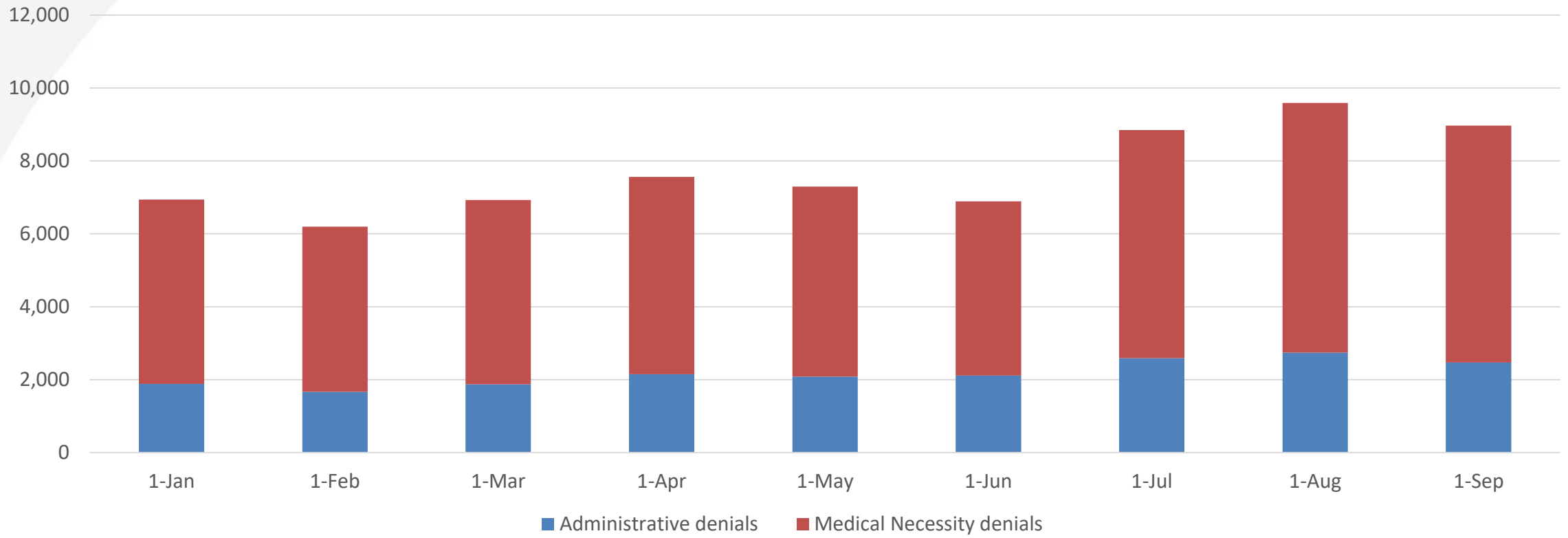
- If an authorization contains the necessary information, a clinical review is done to be sure the service is medically necessary.
- If the initial reviewer determines the service is not medically necessary a physician must complete a review of the authorization to determine whether to approve the service.

Oversight

- Quarterly reports
- Ad hoc data requests and monthly onsites
- External quality review

Prior Authorizations by Program, Quarter 3 2019

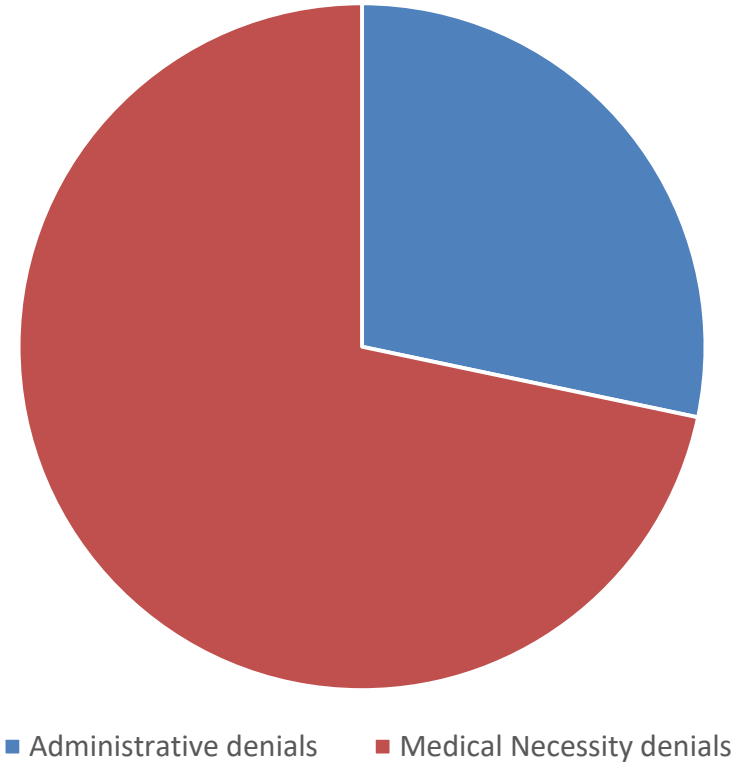
Prior Authorization denial breakdown



Why might services be denied?

- Request does not meet medical necessity
- Clinical information was not provided (medical necessity denial)
- Late notification
- Non-covered benefits
- Member is not with the health plan
- Missing information
- Out of network provider when in network provider is available

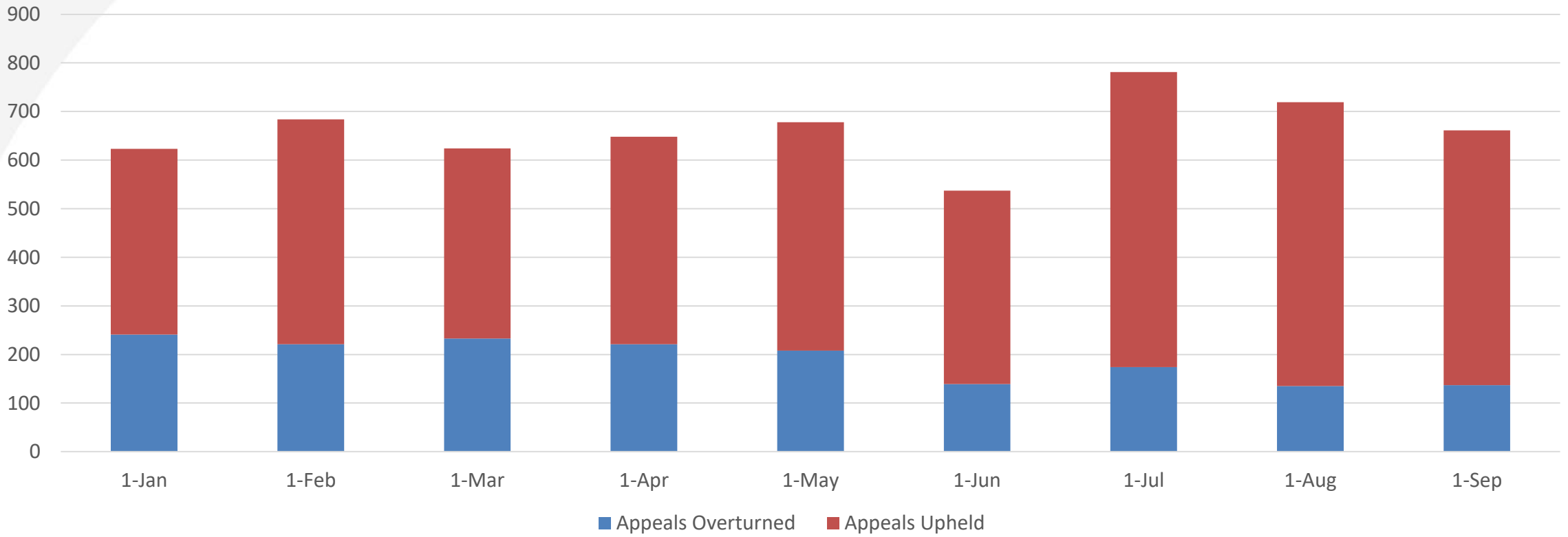
Prior Authorization denial breakdown



Appealing A Prior Authorization

- Prior Authorization appeals are always reviewed by a different physician than who reviewed the initial request
- Providers also have other opportunities such as:
  - Reconsideration
  - Peer to peer

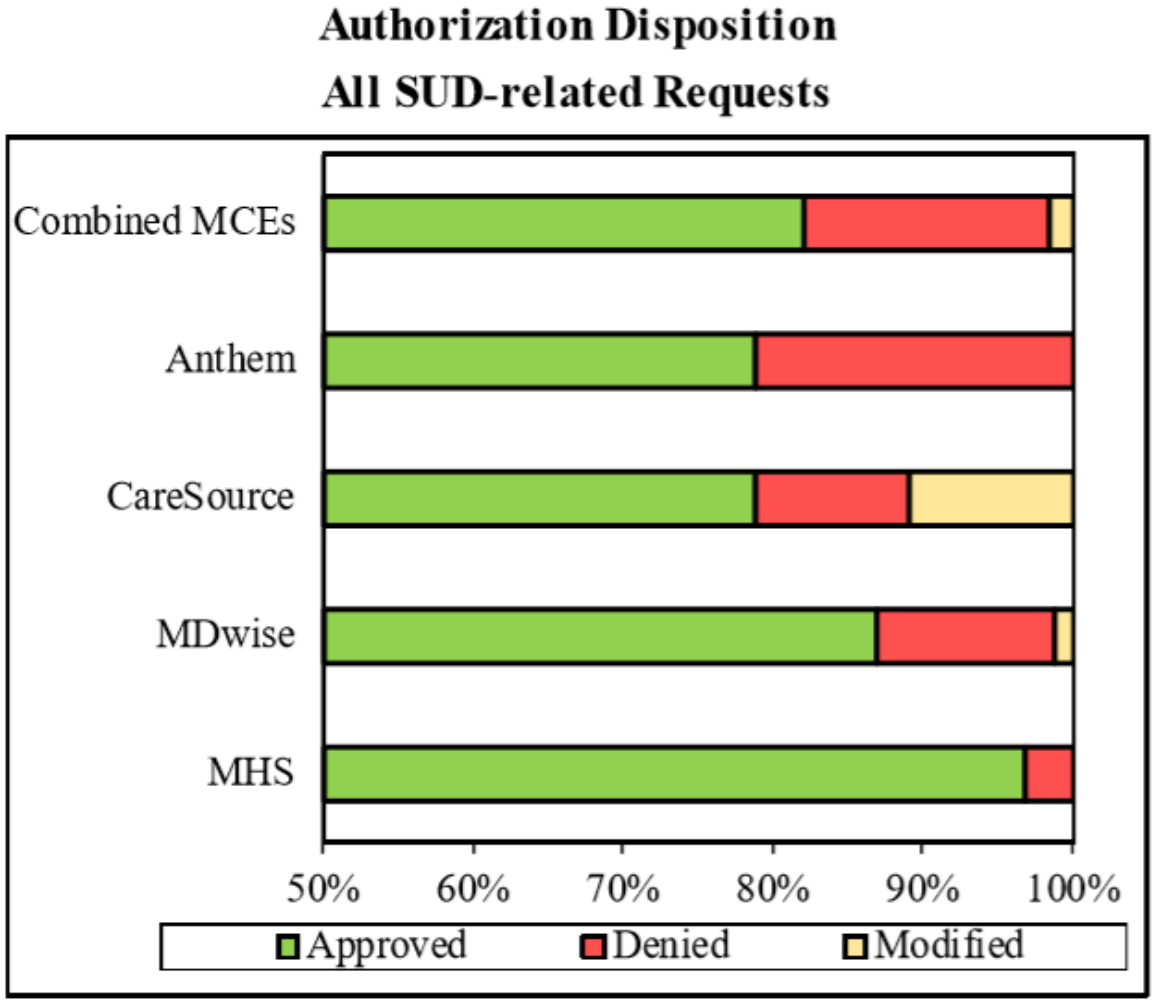
Prior Authorization Appeals



SUD Authorization Review

- In July 2019 external review organization Burns and Associates completed the first part of an authorization review specific to substance use disorder. The data reviewed was from 2018.
- Burns and Associates randomly selected 30 substance use authorizations, 24 denied and 6 approved to review onsite at each MCE.
- Burns and Associates also reviewed trends for all substance use authorizations.

SUD Authorization Review



Findings

- The reviewers found the MCEs were reporting to OMPP accurately the type of authorization, disposition status, and turn-around time.
- Of the denied authorizations reviewed 85% were because of medical necessity
  - Dr. Sajiv John an addiction specialist from Porter-Starke agreed with the MCE decision in 93 out of 97 cases

Findings

- Some denial letters were found to have deficiencies, lacking detail on what criteria were used to make the decision
  - As a result OMPP undertook a project with the MCEs on improving these letters

Thank you!