MHS Prior Authorizations

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Agenda

- Prior Authorization (PA)
- Online Prior Authorization Tool
- What You Need to Know
- Online Provider Portal Services
- Telephonic and Fax Authorizations
- Appeals Process
- MHS Team
- Questions and Answers

Prior Authorization

Prior Authorization

MHS Medical Management will review state guidelines and clinical documentation. Medical Director input will be available if needed.

- PA for observation level of care (**up to 72 hours for Medicaid)**, diagnostic services do not require an authorization for contracted facilities.

- If the provider requests an inpatient level of care for a covered/eligible condition, but procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.

Prior Authorization

Inpatient Services:

- MHS no longer accepts phone calls and only accepts notification of an inpatient admission via fax, using the IHCP universal prior authorization form, or via the MHS Secure Provider Portal.
- Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245 or upload via the MHS Secure Provider Portal.

Prior Authorization

Outpatient Services:

- All elective procedures that require prior authorization must have request to MHS at least **two business days** prior to the date of service.
- All ER services do not require prior authorization, but admission must be called into MHS Prior Authorization Department within **two business days** following the admit.
- Members **must** be Medicaid Eligible on the date of service.
- Prior Authorizations are not a guarantee of payment.

Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims.

Prior Authorization

Transfers:

- MHS requires **notification and approval** for all transfers from one facility to another at least two business days in advance.
- MHS requires **notification** within two business days following all emergent transfers. Transfers include, but are not limited to:
  - Facility to facility
  - Higher level of care changes require PA and it is the responsibility of the transferring facility to obtain.

Prior Authorization

Services that require prior authorization regardless of contract status:

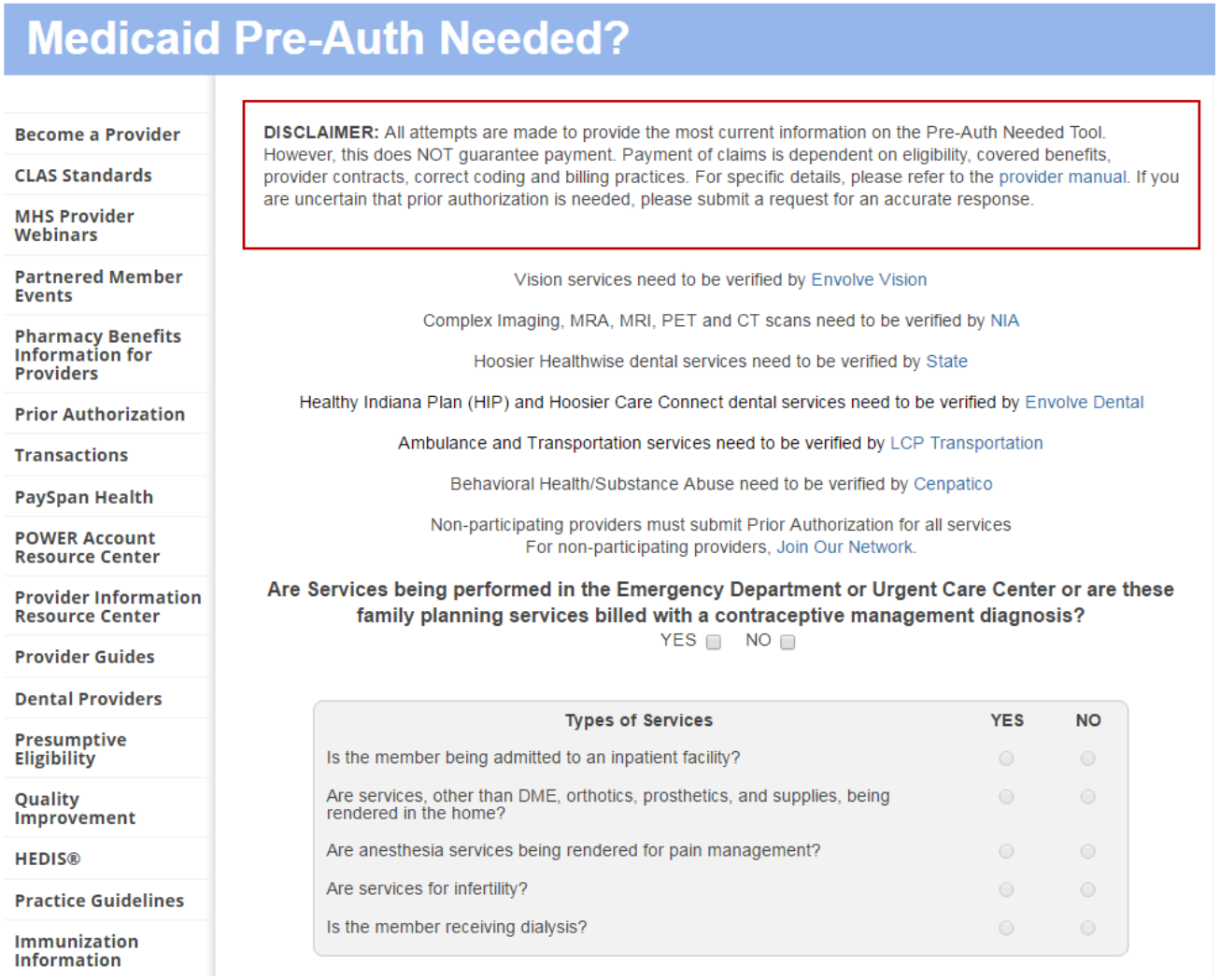
- Injectable drugs (see mhsindiana.com/provider-guides for up-to-date list of codes)
- Nutritional counseling (unless diabetic)
- Pain management programs, including epidural, facet and trigger point injections
- PET, MRI, MRA and Nuclear Cardiology/SPECT scans
- Cardiac rehabilitation
- Hearing aids and devices
- Home and Institutional hospice (coverage varies by product)
- In-home infusion therapy
- Orthopedic footwear
- Respiratory therapy services
- Pulmonary rehabilitation
- Home care (except after an IP admission with benefit limitations)
- Physical Therapy, Occupational, and Speech Therapy

Prior Authorization

Is Prior Authorization Needed?

- MHS website: mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers

Online Prior Authorization Tool



Online Prior Authorization Tool

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	◉
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	◉
Are anesthesia services being rendered for pain management?	○	◉
Are services for infertility?	○	◉
Is the member receiving dialysis?	○	◉

Enter the code of the service you would like to check:

99394 | Check

N
No

99394 - PREV VISIT EST AGE 12-17

No Pre-authorization required for all providers.

What You Need to Know

Self-Referral Services

Exceptions to prior authorization requirements.

Members can see these specialists and get these services without a direct referral from their PMP:

- Podiatrist
- Chiropractor
- Family planning
- Immunizations
- Routine vision care
- Routine dental care
- Behavioral health by type and specialty
- HIV/AIDS case management
- Diabetes self management

Benefit limitations apply

National Imaging Associates (NIA)

Physical, Occupational and Speech Therapy

- Utilization management of these services is managed by NIA.
- Prior authorization for PT, OT, and ST services is required to determine whether services are medically necessary and appropriate; determination is made by MHS not NIA.
- All Health Plan approved training/education materials are posted on the NIA website, www.RadMD.com. For new users to access these web-based documents, a RadMD account ID and password must be created.

Chiropractors rendering therapy services are exempt from the NIA program.

NIA

Outpatient Radiology PA Requests

- MHS partners with NIA for outpatient Radiology PA Process
- PA requests must be submitted via:
  - NIA Web site at RadMD.com
  - 1-866-904-5096

Not applicable for ER and Observation requests

Durable & Home Medical Equipment

Requests should be initiated via **MHS secure portal.**

Prior authorization required by the **ordering physician** for all non-participating DME providers.

- **Web Portal**: Simply go to mhsindiana.com, log into the Secure Provider Portal, and click on “Create Authorization.” Choose DME and you will be directed to the Medline portal for order entry.
- **Fax Number:** 1-866-346-0911
- **Phone Number:** 1-844-218-4932

Turning Point

Musculoskeletal Safety & Quality Program

MHS has entered into an agreement with Turning Point Healthcare Solutions, LLC to implement a Musculoskeletal Safety and Quality Program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.

- Emergency Related Procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.
- Clinical Policies are available by contacting TurningPoint at 574-784-1005 for access to digital copies.
- **TRAINING:** Informational webinars are available! Please register at: https://register.gotowebinar.com/rt/7079530369468972290.

Turning Point

Cardiovascular Authorizations

- Effective May 1, 2020 Managed Health Services has delegated its utilization management function to TurningPoint for cardiac services. The physician/ providers office who requests the procedure should request the prior authorization.

- Services that require prior authorization:

  Cardiac Surgical Procedures:
  Automated Implantable Cardioverter Defibrillator
  Leadless Pacemaker
  Pacemaker
  Revision or Replacement of Implanted Cardiac Device
  Coronary Artery Bypass Grafting (Non Emergent)
  Coronary Angioplasty and Stenting
  Non-Coronary Angioplasty and Stenting

- **Emergent surgeries do not require a prior authorization.**

- Web Portal Intake: myturningpoint-healthcare.com Telephone Intake: 574-784-1005 | 855-415-7482

PA Documentation Needed

Bariatric Surgery:

- Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, and psychologist report.

Pain Management:

- Must have documentation of at least six weeks of therapy on area receiving treatment.
- Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies.
- Include prior injection test results for injection series.

Home Health:

- Physician's orders and signed plan of care, including most recent MD notes about the issue at hand.
- Home care plan, including home exercise program.
- Progress notes for medical necessity determination.

Sub Acute Care

Managed Health Services (MHS) provides health coverage for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect. MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in subacute facilities at least every 3-5 days. It is important that you provide a complete current clinical update on our member's status at each review.

- The review should include current information (within one day) on:
- Member's condition
- Level of functioning (prior to admission)
- Medications
- Therapies provided
- Participation in therapies
- Progress toward goals
- New or amended goals
- Updates from care conferences
- Updates to our member's plan of care
- Discharge plans and needs identified (home health/DME, etc.)
- Anticipated discharge date
- Indiana Code requires that individuals requesting a nursing facility admission to a Medicaid-certified NF meet a nursing facility level of care (*405 IAC 1-3-1* and *405 IAC 1-3-2*.). A PASRR is required before admission and must be submitted with the admission request and when updated according to IAC requirements.
- Please submit this information as requested by MHS nurse reviewer every 3-5 days.

Prior Authorization (PA) Request

MHS strives to return a decision on **all** PA requests within **two business days** of Request. Providers can **update** previously approved PAs **within 30 days** of the original date of service prior to claim denial for changes to:

- Dates of Service
- CPT/HCPCS codes
- Provider MHS has up to **seven days** to render PA decisions.

- PA approval requires the need for medical necessity.
- Medical Management **does not** verify eligibility or benefit limitations: Provider is responsible for eligibility and benefit verification
- ***Denied Authorizations*** *must follow the authorization appeal process, not the claims appeal process, claims appeals can not change the status of a denied authorization.*

Providers may make corrections to the existing PA as long as the claim has not been submitted.

Continuity of Care PA Request

- MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.

Reference: MHS Provider Manual Chapter 6

Pharmacy Requests

MHS Pharmacy Benefit Manager is Envolve
Envolve Pharmacy Solutions:

- Preferred Drug Lists and authorization forms are available at mhsindiana.com/provider/pharmacy:
  - PA requests
  - Phone 1-866-399-0928
  - Fax non specialty drugs 1-866-399-0929
  - Specialty drugs 1-866-678-6976
  - pharmacy.envolvehealth.com
- Formulary integrated into many Electronic Health Records (EHR) solutions
- Online PA submission available through CoverMyMeds:
  - covermymeds.com
- Online PA forms for Specialty Drugs on mhsindiana.com

Behavioral Health Prior Authorization

Facility Services Requiring Prior Auth:

- Inpatient Admissions
- Intensive Outpatient Treatment (IOT)
- Partial Hospitalization SUD Residential Treatment

Behavioral Health Prior Authorization

Prior Authorization Professional Services Requiring Prior Auth:

Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month rolling year without authorization)

Behavioral Health Outpatient Therapy “BHOP Therapy” (Limited to 20 visits per member, per practitioner, per 12 month rolling period)

Electroconvulsive Therapy

Psychological Testing

- Unless for Autism: then no auth is required

Developmental Testing, with interpretation and report (non-EPSDT)
Neurobehavioral status exam, with interpretation and report

Neuropsych Testing per hour, face to face

- Unless for Autism: then no auth is required
- Non-Participating Providers only

ABA Services

Behavioral Health Prior Authorization

- Please call MHS Care Management for inpatient and partial hospitalization authorizations at 1-877-647- 4848.
- MHS Authorization forms may be obtained on our website: https://www.mhsindiana.com/providers/behavioral-health/bhprovider-forms.html
- Outpatient Treatment Request (OTR) Form; Fax: 1-866-694-3649
- Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency - Fax: 1-866-694-3649
- Applied Behavioral Analysis Treatment (OTR) - Fax: 1-866-694-3649
- Psychological & Neuropsych Testing Authorization Request Form - Fax: 1-866- 694-3649
- Residential/Inpatient Substance Use Disorder Treatment Prior Auth Form –
- Fax Inpatient: 1-844-288-2591; Fax Outpatient: 1-866-694-3649
- If using the IHCP Universal form, please fax to the numbers listed above to reduce fax transfers.

Behavioral Health Prior Authorization

Limitations on Outpatient Mental Health Services

Effective 12/15/18, Managed Health Services (MHS) has begun applying this limitation for claims with dates of service (DOS) on or after 12/15/18. Claims exceeding the limit will deny EX Mb: Maximum Benefit Reached.

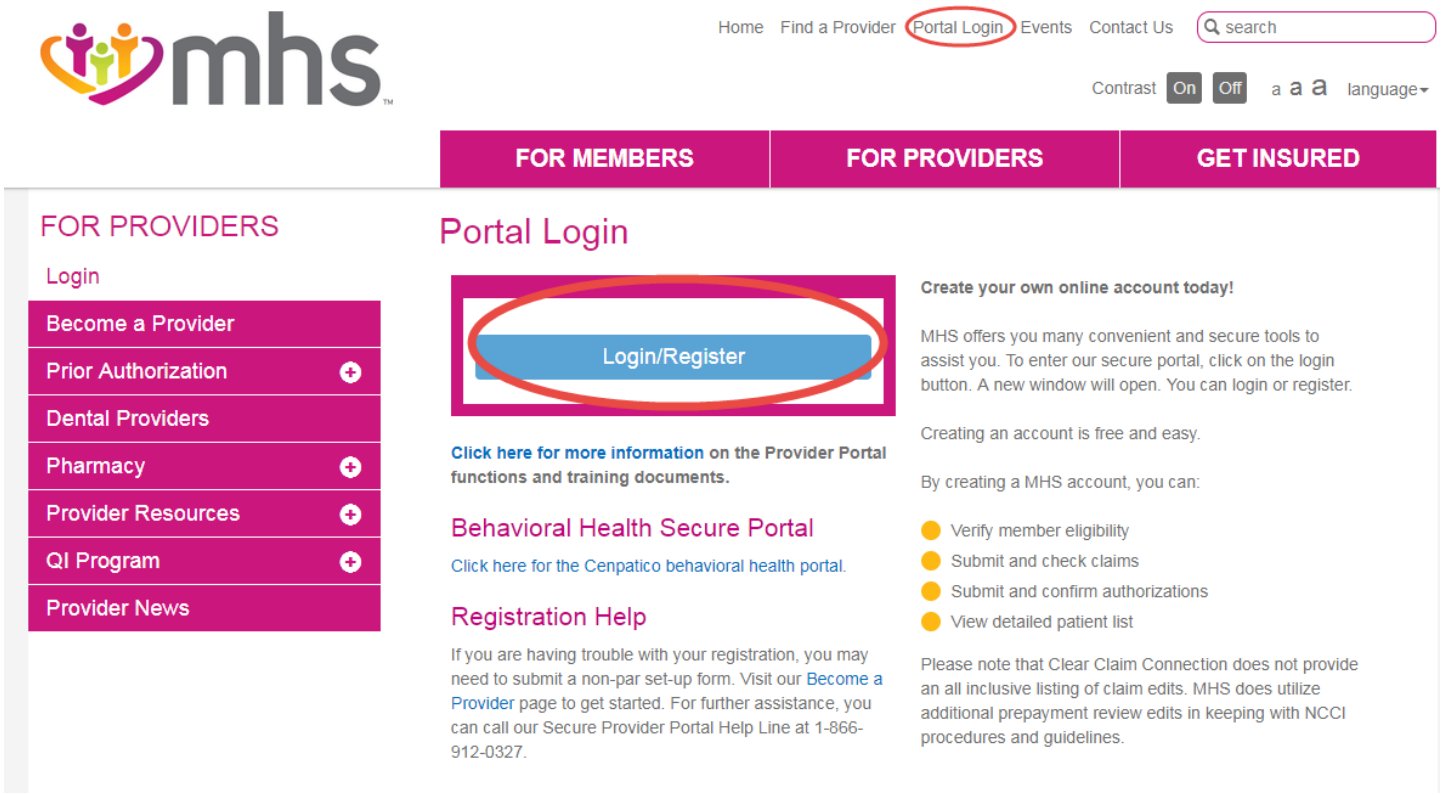
- If the member requires additional services beyond the 20 unit limitation, providers may request prior authorization for additional units. Approval will be given based on the necessity of the services as determined by the review of medical records.
- Providers will need to determine if they have provided 20 units to the member in the past rolling 12 months (starting with DOS 12/15/18) to determine if a prior authorization request is needed.
- “Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the CMS-1500 claim form (Box 24J).
- This change is related to professional services being billed on CMS 1500.

MHS Secure Provider Portal

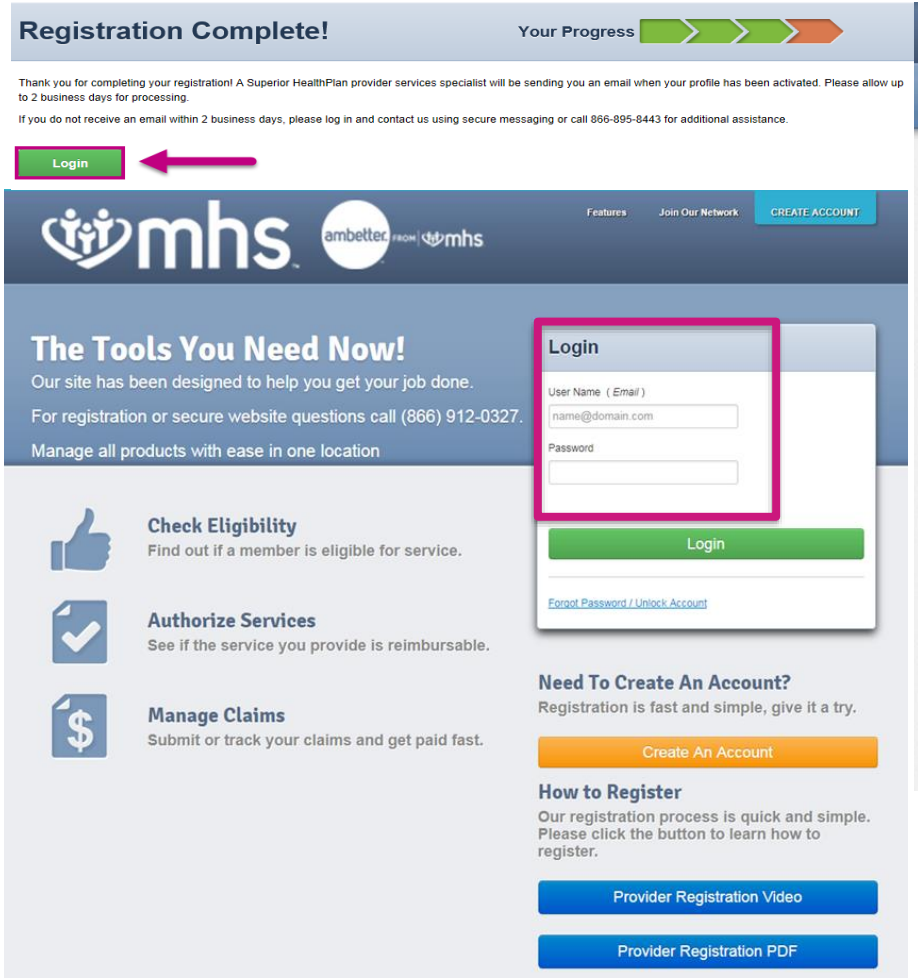
Web Portal Authorizations

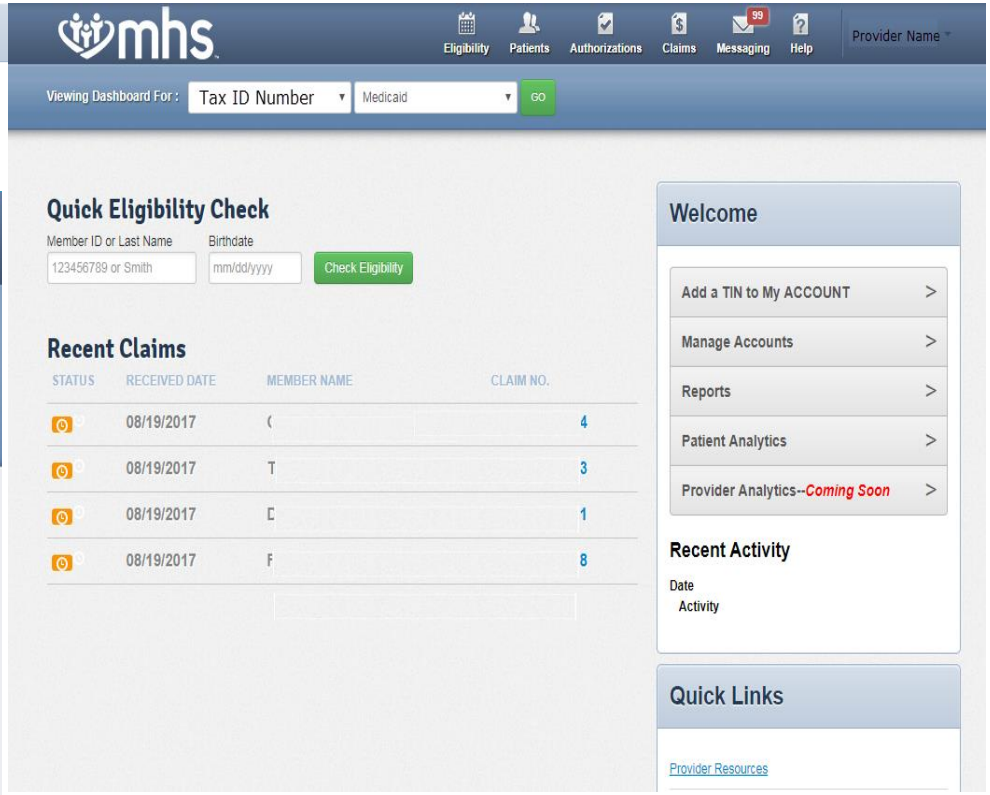
- Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at mhsindiana.com/login:
  - When using the portal, providers can upload supporting documentation directly.
- **Exceptions**: Must submit Inpatient, hospice, home health and biopharmacy PA requests via **fax 1-866-912-4245**
- Providers can check the authorization status on the portal.

Secure Portal Registration and Login



Registration

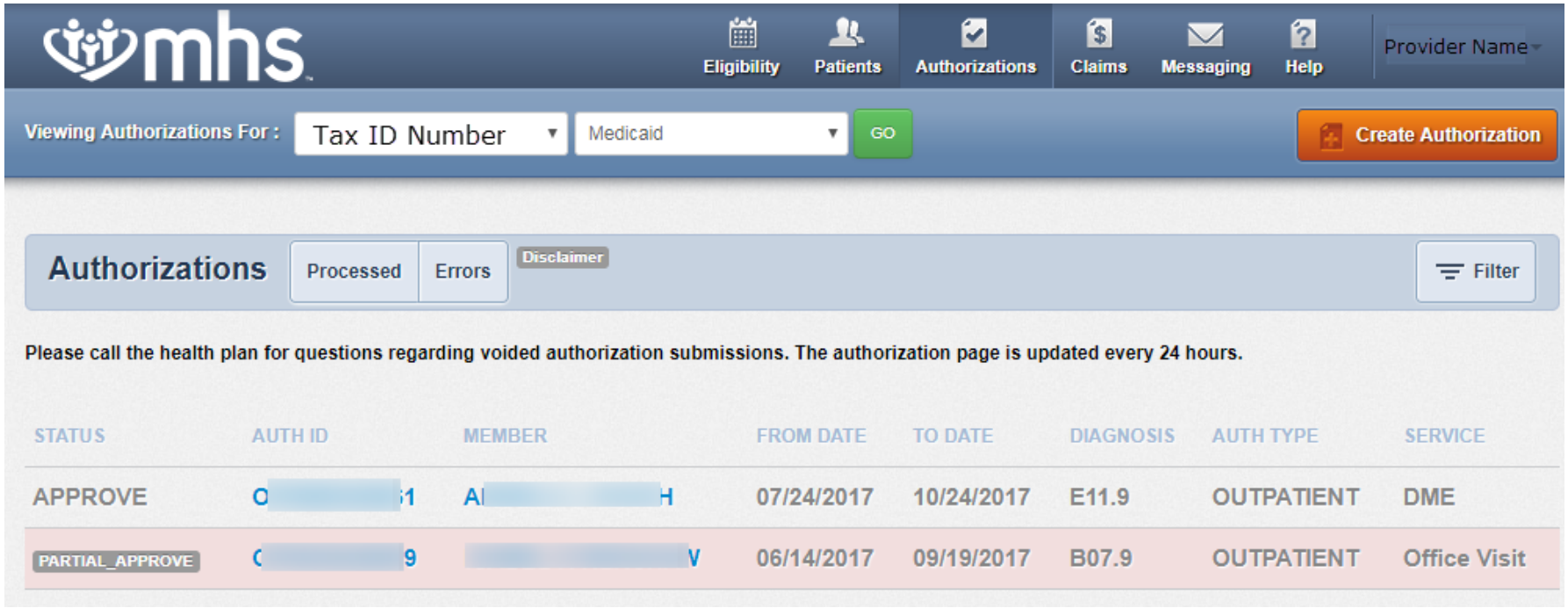




Please allow 24-48 hours for your account to be verified. An email will be sent once access to the portal tools have been granted to the respective account.

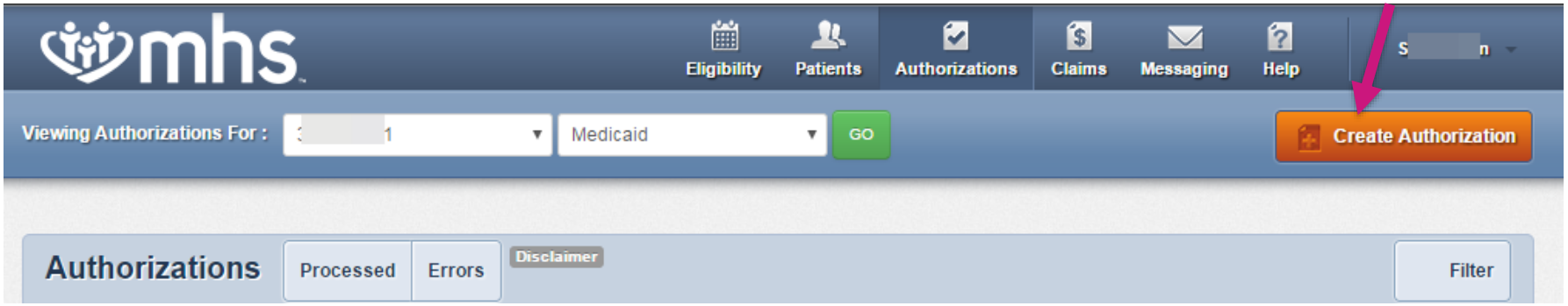
Authorizations:

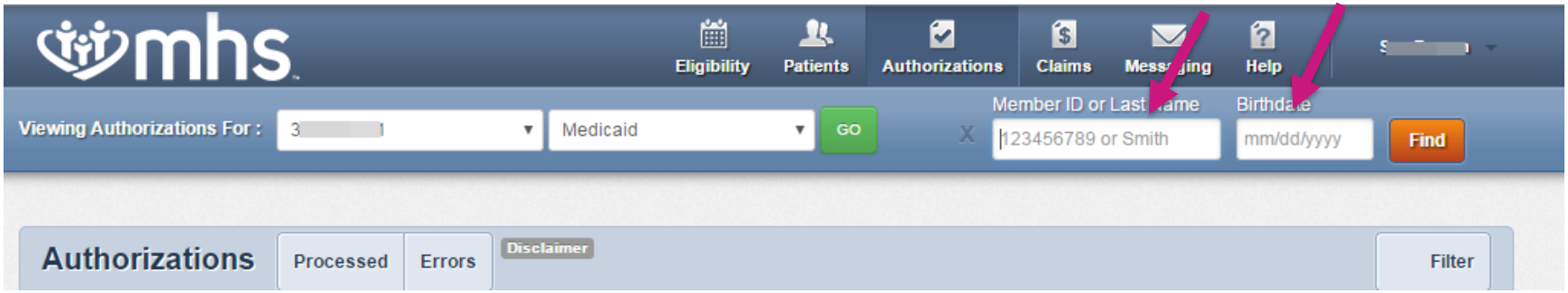
- View, create and filter group authorizations



Creating a New Authorization

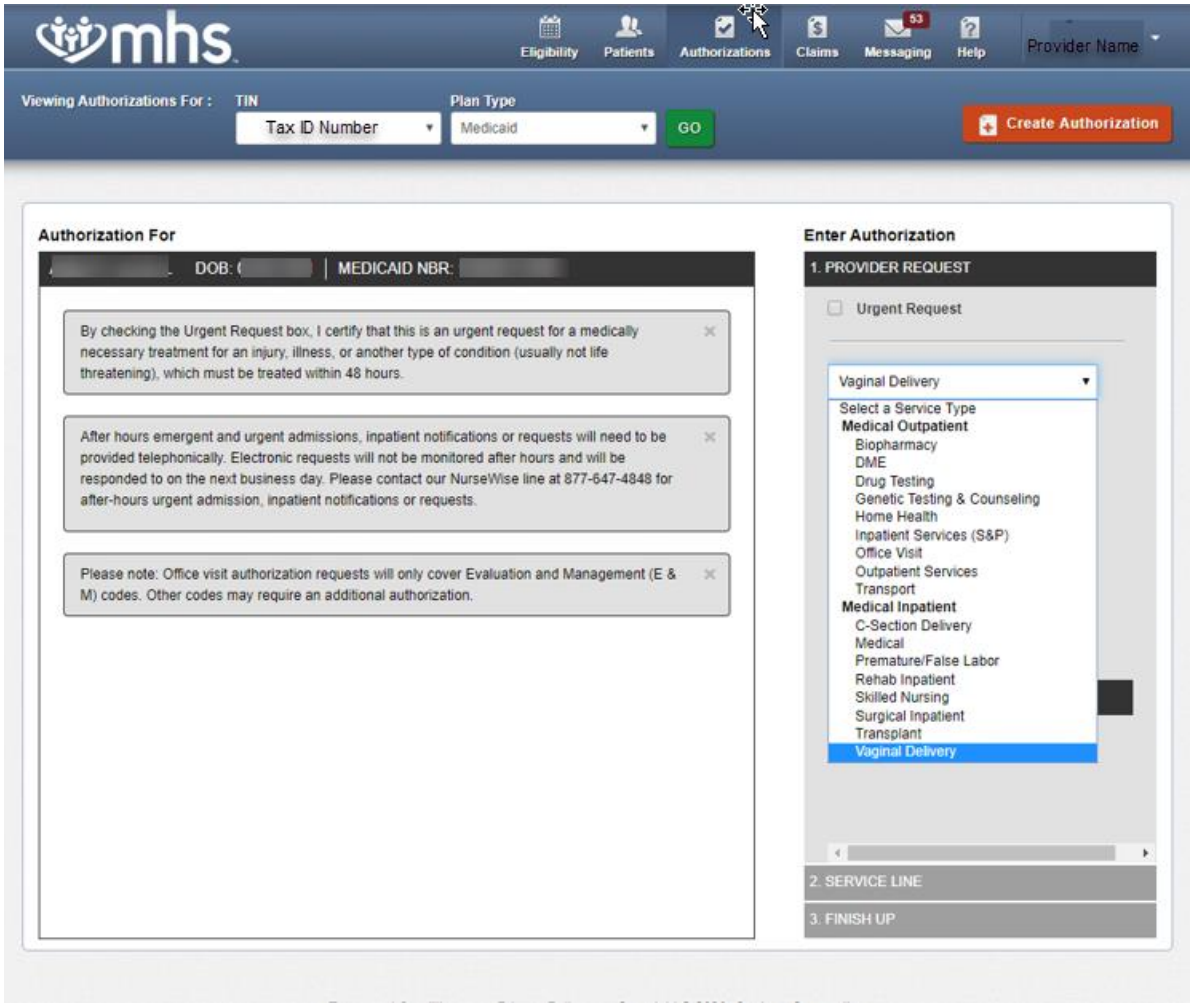
- Click **Create Authorization.**
- Enter **Member ID** or **Last Name** and **Birthdate.**





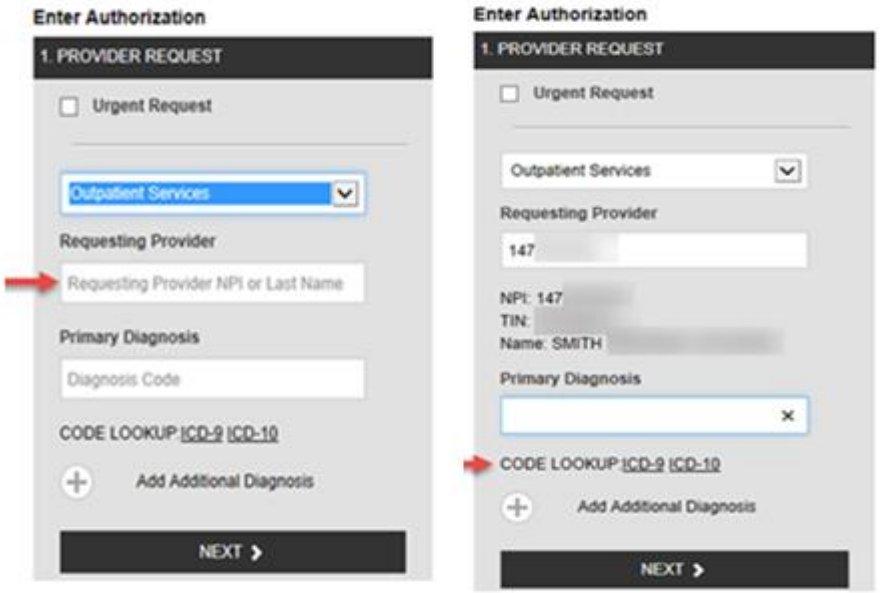
Creating a New Authorization

Select a Service Type



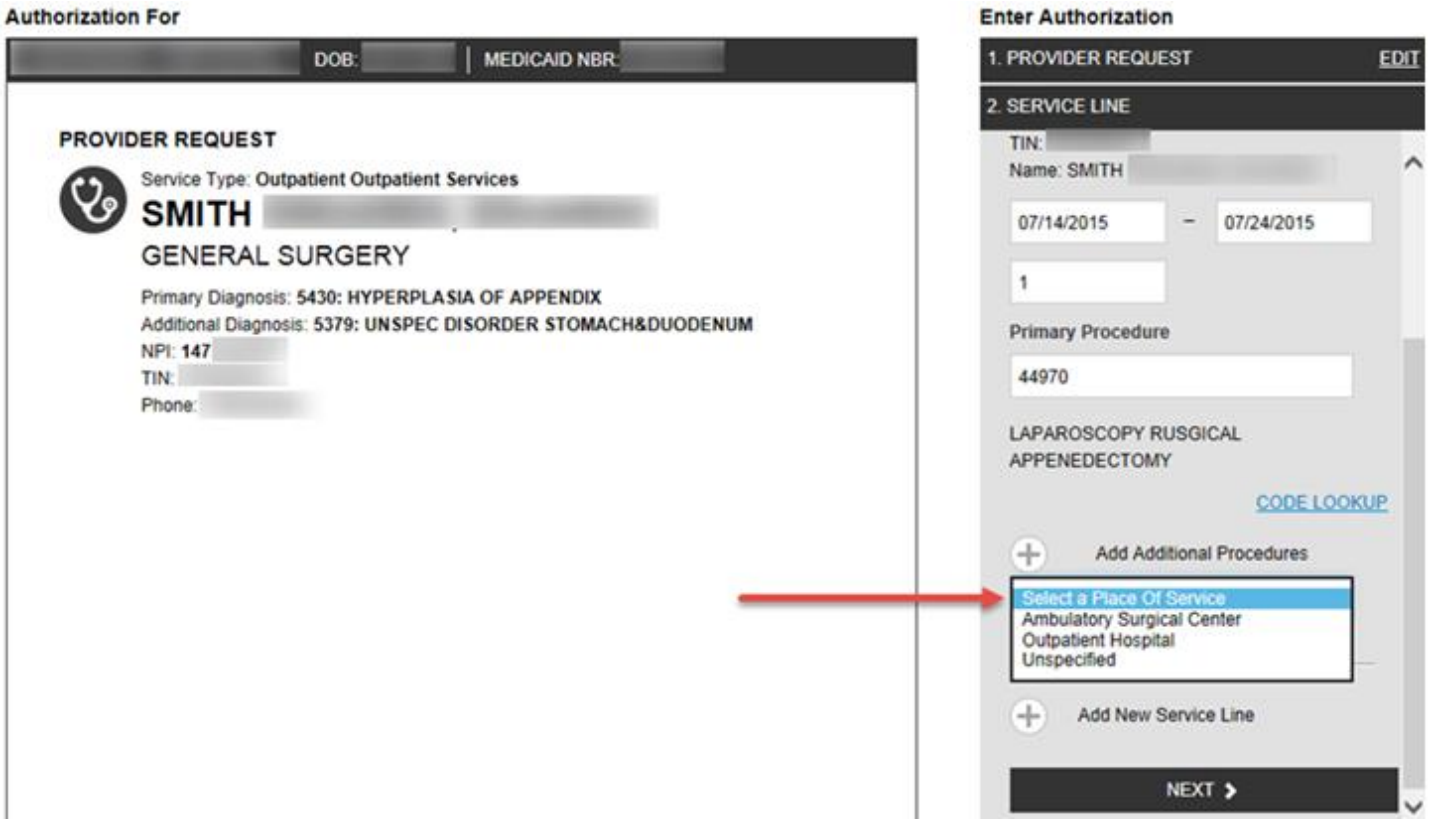
Creating a New Authorization

Select Provider NPI Add Primary Diagnosis



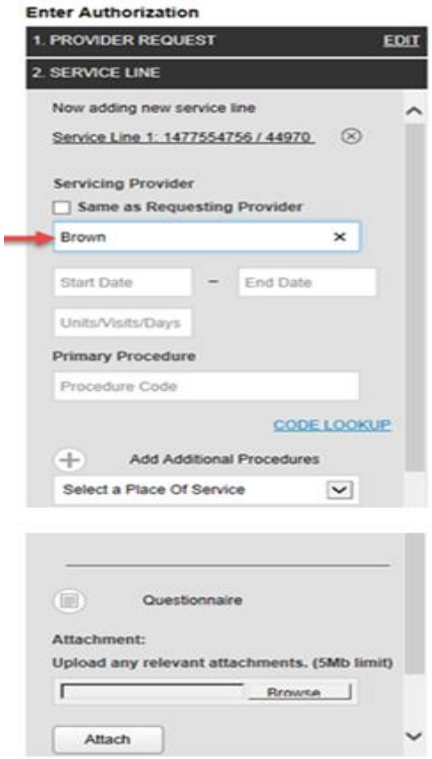
Creating a New Authorization

- If required **Add Additional Procedures**



Creating a New Authorization

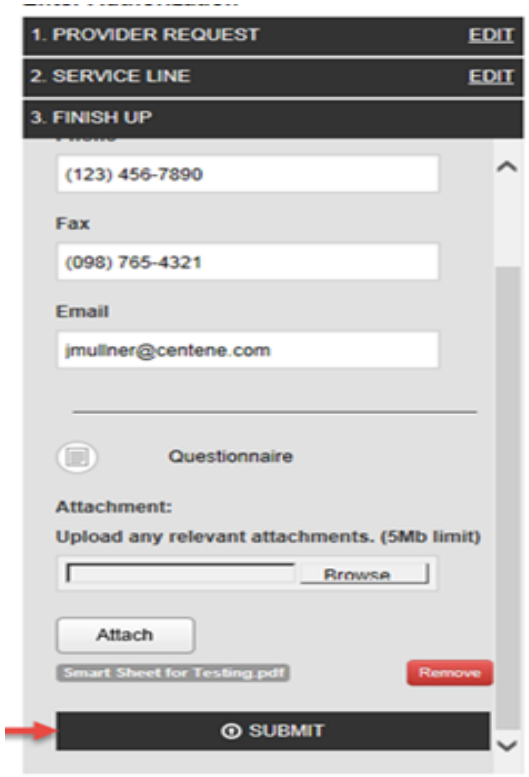
Service Line Details:

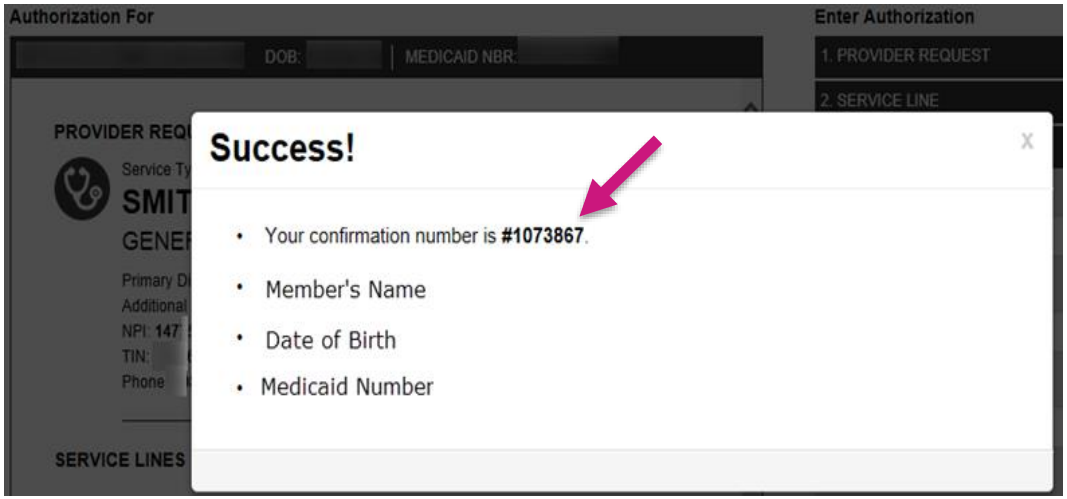


- Provider Request will appear on the left side of the screen.
- Update Servicing Provider:
  - Check box if same as Requesting Provider.
  - Update Servicing Provider information if not the same
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure:
  - Code lookup provided.
- Add any additional procedures.
- Add additional Service Line if applicable:
  - All service lines added will appear on the left side of the screen.

Creating a New Authorization

- Submit a new Authorization:
  - **Confirmation number.**





Telephone and Fax Authorizations

Telephone Authorization

- Providers can initiate Prior Authorization via the MHS referral line by calling 1-877-647-4848:
  - Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
  - After hours, MHS 24-hour nurse line available to take emergent requests.
- The PA process begins at MHS by speaking with the MHS non-clinical referral staff.
- For procedures requiring additional review, we will transfer providers to a “live” nurse line to facilitate the PA process.
- Please have all clinical information ready at time of call.

Fax Authorization

MHS Medical Management Department at 1-866-912-4245:

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	

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

Member ID/RID, DOB
Patient name, **required**

Medical Diagnosis code(s) **required**

Check service category

Fax Authorization

Requesting Provider Information:
NPI#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID#:
Name
Address:
City/State/Zip:
Phone:
Fax:

Enter the **Requesting** provider's information

Enter the **Rendering** provider's individual NPI#

Fax Authorization

Dates of Service Start	Stop	Procedure/ Service Codes	Modifier(s)		Requested Service	Taxonomy	POS	Units	Dollars

Prior Authorization Denial and Appeal Process

Medical PA Denial and Appeal Process

If MHS denies the requested service:

- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request the expedited appeal.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **60 days** of the denial.

The attending physician has the right to a peer-to-peer discussion with an MHS physician:

- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.
- They must request peer-to-peer within **10 days** of the adverse determination.

Prior authorization appeals are also known as medical necessity appeals.

Medical PA Denial and Appeal Process

- Send Prior Authorization/Medical Necessity Appeals to:

Managed Health Services
Attn: Appeals Coordinator
PO Box 441567
Indianapolis, IN 46244

- Providers must initiate appeals within **60 days** of the receipt of the denial letter for MHS to consider.
- We will communicate determination to the provider within **20 business days** of receipt.
- ***A prior authorization appeal is different than a claim appeal request.***
- ***This process is applicable to members and non-contracted providers.***

Behavioral Health PA Denial and Appeal Process

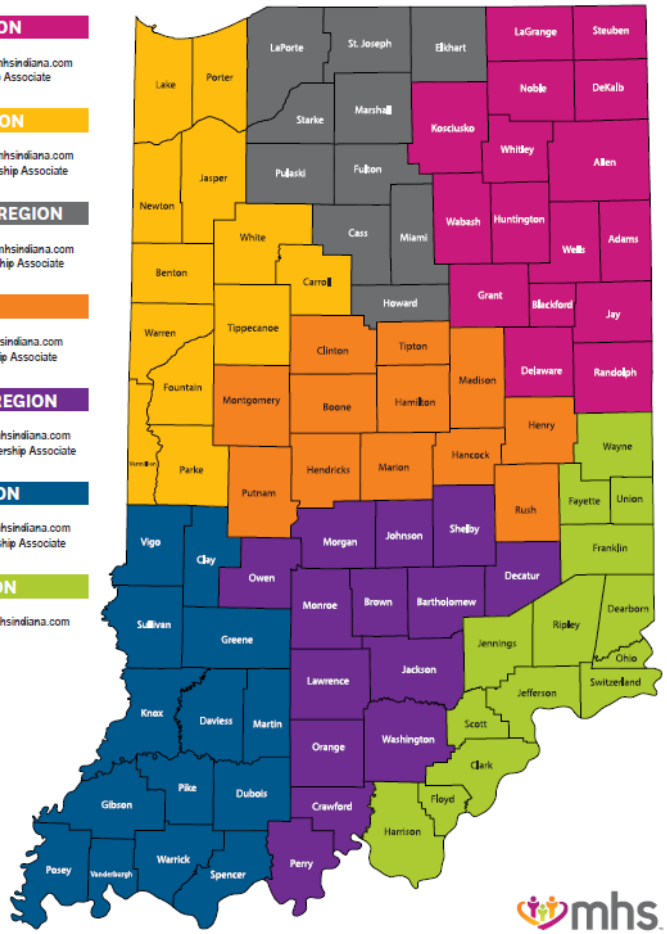
Medical Necessity Appeals

- Medical Necessity appeals must be received by MHS within 60 calendar days of the date listed on the denial determination letter. The monitoring of the appeal timeline will begin the day MHS receives and receipt-stamps the appeal. Medical necessity behavioral health appeals should be mailed or faxed to:

  MHS Behavioral Health
  ATTN: Appeals Coordinator
  12515 Research Blvd, Suite 400
  Austin, TX 78701
  FAX: 1-866-714-7991

MHS Team

MHS Provider Network Territories



NORTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

NORTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848, ext. 20187

NORTH CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
Dalesia Denning, Provider Partnership Associate
1-877-647-4848, ext. 20026

SOUTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848, ext. 20117

SOUTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
Carolyn Valachovic Monroe
Provider Partnership Associate
1-877-647-4848, ext. 20114

Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf

MHS Provider Network Territories

TAWANNA DANZIE
Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS
Beacon Medical Group
Franciscan Alliance
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Parkview Health System
South Bend Clinic

JENNIFER GARNER
Provider Partnership Associate II
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS
American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
HealthNet
Health & Hospital Corporation of Marion County
Indiana University Health
St. Vincent Medical Group

NETWORK LEADERSHIP

JILL CLAYPOOL
Vice President, Network Development & Contracting
1-877-647-4848 ext. 20855
jill.e.claypool@mhsindiana.com

NANCY ROBINSON
Senior Director, Provider Network
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nrobinson@mhsindiana.com

MARK VONDERHEIT
Director, Provider Network
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mvonderheit@mhsindiana.com

NEW PROVIDER CONTRACTING

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Director, Network Development & Contracting
1-877-647-4848 ext. 20120
tbalko@mhsindiana.com

MICHAEL FUNK
Manager, Network Development & Contracting
1-877-647-4848 ext. 20017
michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR
Director, Network Operations
1-877-647-4848 ext. 20049
kelvin.d.orr@mhsindiana.com

ENVOLVE DENTAL, INC.

MICHAEL J. WILLIAMS
Provider Relations Specialist
1-727-437-1832
Dental Provider Services: 1-855-609-5157
Michael.Williams@EnvolveHealth.com

Back of Map

Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf

Thank you for being our partner in care.