A Deep Dive into Prior Authorizations

2025 IHCP Works Annual Seminar

Presented By: Danyelle Pittman

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Agenda

- Who is MDwise?
- Eligibility and Coverage
- Prior Authorization Timelines
- Submitting Prior Authorizations
- myMDwise Provider Portal: Prior Authorization
- Prior Authorization Appeals Process
- Provider Resources

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Who is MDwise?

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MDwise Mission and Vision

Who Are We?

MDwise is your provider-led, local, Indiana-based nonprofit health care company. Our parent organization, McLaren Health Care, is a nonprofit integrated health system that believes all Indiana families should have access to high-quality health care regardless of income.

What Is the MDwise Mission?

MDwise provides high-quality, affordable health care services and improves the well-being of our members by bringing together exceptional employees, community leaders and health care professionals.

What Is the MDwise Vision?

MDwise strives to be the most influential, trusted choice in health plans by doing what is best for the communities we serve.

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MDwise Values

Trust

We trust each other and act with integrity. We are authentic, empowered to act and communicate openly with candor and caring. We make decisions for the greater good. We earn the trust of those we serve through transparency and accountability. We are dependable – a promise made is a promise kept.

Innovation

We continuously improve to be easier to do business with. We challenge the status quo, generate ideas, collaborate, value diversity and demonstrate agility. We are courageous, learn from experience and adjust quickly.

Excellence

We make sound decisions and deliver quality programs with precision. We are subject matter experts and perform at our full potential by working as a team.

Stewardship

We are mission-driven. We are entrusted as stewards of a company that serves members, associates, customers, business partners and our community. We care deeply about each other and all stakeholders. We are privileged to take care of our members and treat every dollar as if it were our own. We are efficient, set priorities and ensure our processes add value to enhance the member experience.

Leadership

We are industry thought leaders and advocates. We take initiative, are accountable for results and empower those around us to be their best. We roll up our sleeves and dig in to help. We lead by example.

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Eligibility and Coverage

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- **Prior to starting the prior authorization (PA):**
  - Ensure member is eligible on the Date of Service (DOS).
  - Ensure the member is assigned to MDwise.
  - Determine the member's plan (Healthy Indiana Plan or Hoosier Healthwise).
  - If the member has a primary insurance, check eligibility and obtain a prior authorization from the member's primary insurance and from MDwise.

- **Determine Coverage:**
  - Based on the member's plan, determine if the service being requested is a covered benefit.
  - Determine if the services or medication require a PA.
    - Services that require PA can be found on the authorization and exclusions list at MDwise.org.

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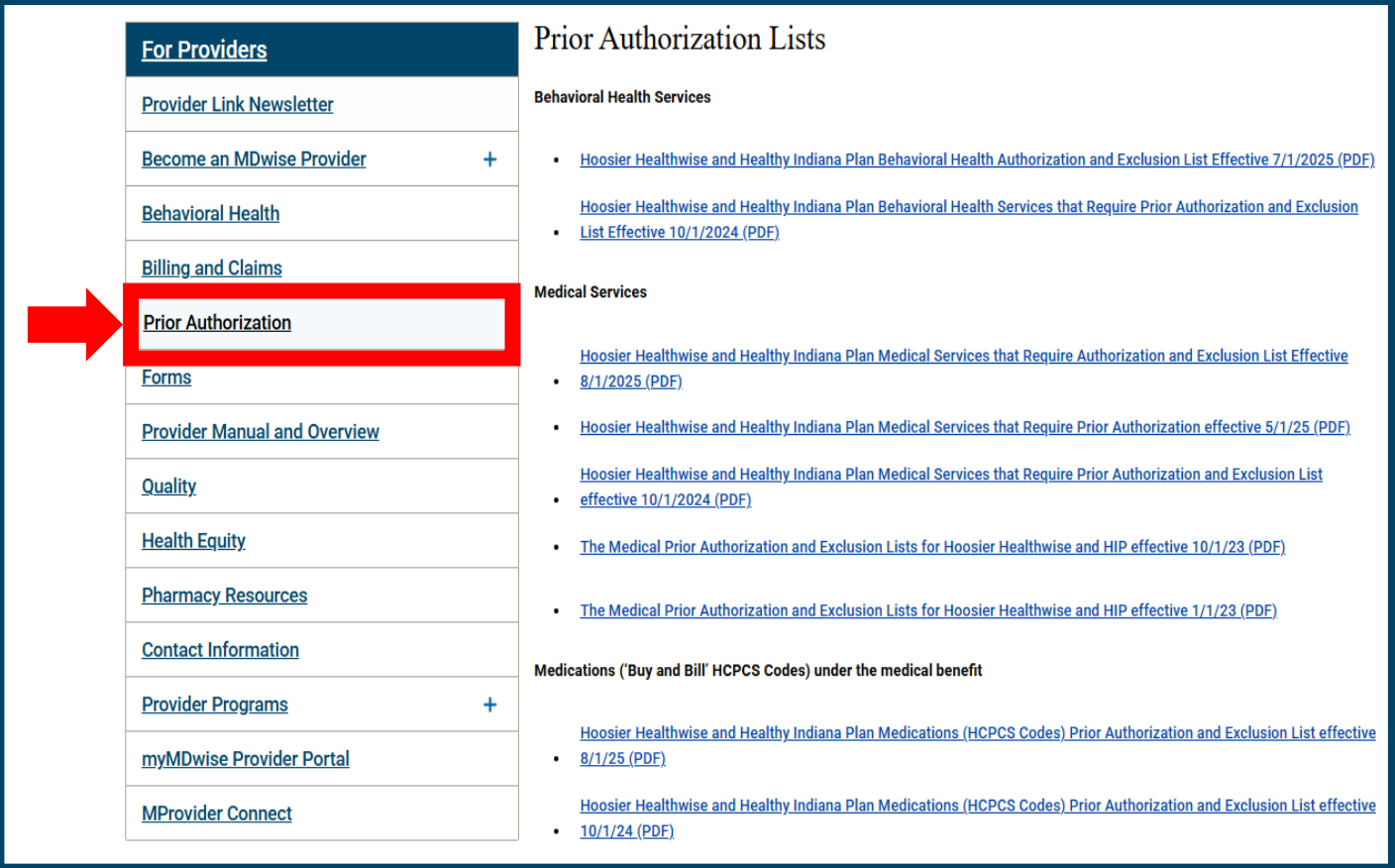
Before You Request a Prior Authorization

Authorization and Exclusion Lists

PRIOR AUTHORIZATION



- MDwise **Behavioral Health** Authorization and Exclusion List
- MDwise **Medical** Authorization and Exclusion List
- MDwise **Pharmacy** Authorization and Exclusion List

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Emergency Services

- Emergency services do not require prior authorization.
  - An emergency service is a service provided to a member following the sudden onset of an emergency medical condition.
- Any resulting inpatient stay **DOES** require prior authorization.

Self-Referral

- MDwise members can seek care from any provider enrolled with Indiana Health Coverage Program (IHCP) **without obtaining authorization or a referral** from their Primary Medical Provider (PMP).
- These self-referral services include but not limited to:
  - Eye Care
  - Foot Care
  - Chiropractic Services
  - Urgent Care
  - Family Planning

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Services That DO NOT Require Authorization

Pharmacy prior authorization requests should be faxed to the MDwise Pharmacy Benefit Manager, MedImpact – FAX: (858) 790-7100.

Statewide Uniform Preferred Drug (SUPDL) list is available on the FFS provider portal website.

- Prior authorization criteria for drugs on the SUPDL may be viewed through the **Prior Authorization Criteria and Administrative Forms** option.
- Prior Authorization Forms can be found under Pharmacy Resources at MDwise.org.
- Medicaid FFS forms should **NOT** be used for SUPDL drugs for MDwise members.

Coverage of certain medications has been carved out from MDwise.

- Any medications marked **Carved Out of Managed Care Coverage** should be submitted to Medicaid FFS.

- Additional information can be found in the IHCP Pharmacy Services Provider Reference Module.

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Prior Authorization Timelines

Request Type	Definition	Decision Turnaround
Urgent Pre-Service	Request for medical care or services with respect to which the application of the time periods for making non-urgent care determinations could result in an adverse effect to the health of the member	24 hours excluding weekends and federal and state holidays
Urgent Concurrent	A review decision for the extension of previously approved ongoing care	24 hours excluding weekends and federal and state holidays
Non-Urgent Pre-Service	Request for medical care or services for which application of the time periods for deciding **does not** jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.	48 hours excluding weekends and federal and state holidays
Retro Authorization	After services have begun or supplies have been delivered, as outlined by IHCP guidelines	Within 30 calendar days of receipt of all necessary information

For additional information, please refer to the Prior Authorization Reference Guide on MDwise.org.

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Provider Prior Authorization Decision Timeline

- Submit new PA requests for ongoing services **at least 30 calendar days before the current authorization period expires** to ensure services are not interrupted.
  - If a provider does not agree with the modification decision, the case is forwarded to a physician for review.
  - If the physician reviews and maintains the modification decision, a peer-to-peer review can be requested.

- Please respond to requests for additional information for **urgent concurrent review within 24 hours of receipt of the request.**

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Timelines To Remember

Submitting Prior Authorizations

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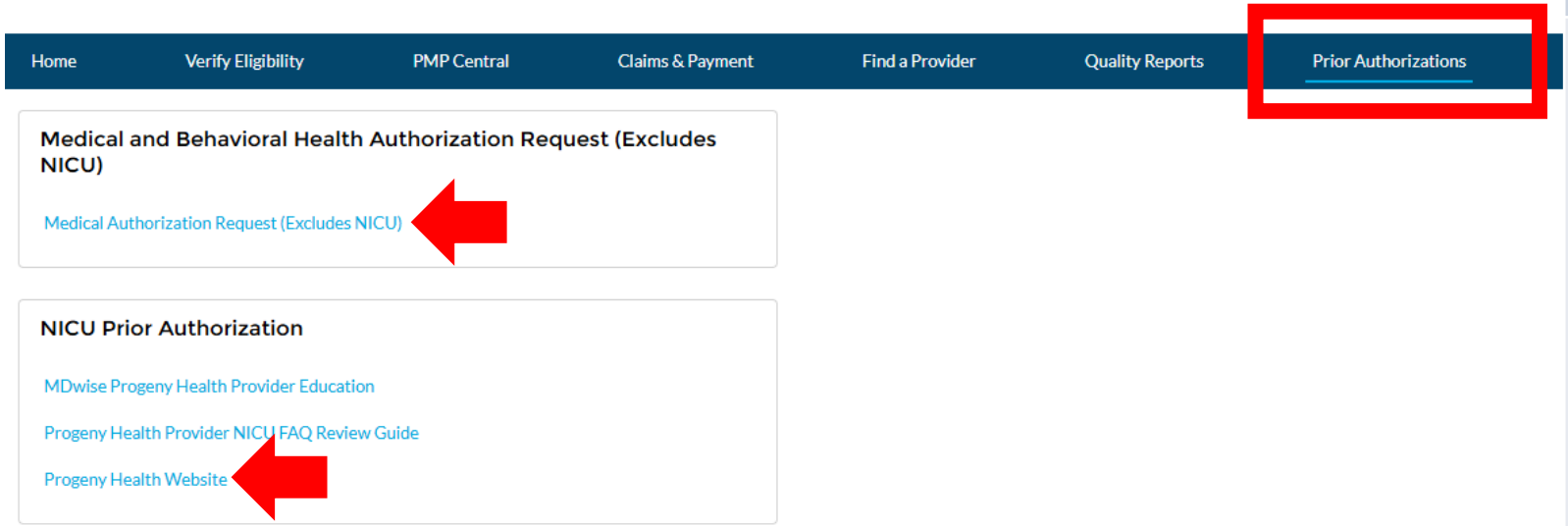
How To Submit a Prior Authorization Request

- The **preferred method** for submitting a Prior Authorization request to MDwise is online through the myMDwise Provider Portal.



MDwise offers the following alternatives, if you are unable to submit online.

Email: PADept@MDwise.org

Fax:

Hoosier Healthwise
(888) 465-5581

Healthy Indiana Plan (HIP)
HIP | Inpatient: **(866) 613-1631**
HIP | All Other: **(866) 613-1642**

NICU Notification of Admission for all infants born on/after April 1, 2025, should be sent directly to ProgenyHealth via fax: (866) 305-6062.

Alternate Methods to Submit Notification of Admission:

- Email: MDwise-UM@ProgenyHealth.com
- Phone: **(888) 832-2006** Monday through Friday, 8:30 a.m. to 5:00 p.m. (Eastern Time Zone)

Please complete a **Universal Prior Authorization Form** and ensure the following items are included:

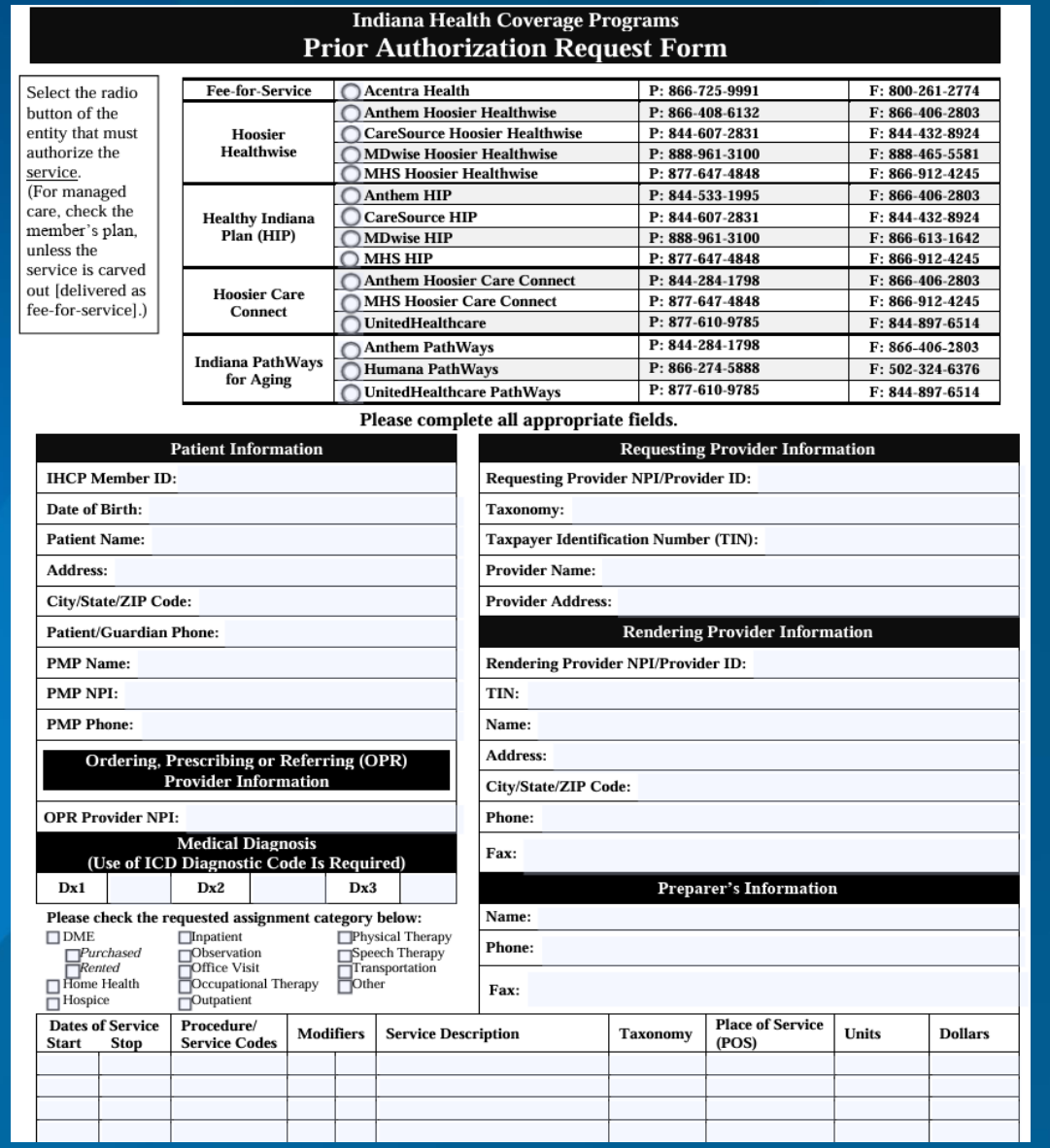
- Mother's Name, Date of Birth (DOB) and Member ID (MID)
- Infant's Name and MID (if known)
- Attending Physician NPI number and Facility NPI number
- Supporting Clinical Documentation (Progress & Treatment notes)

For members managed by ProgenyHealth, **all concurrent reviews, transfer requests and discharge summaries should be sent to ProgenyHealth's secure fax number at (866) 305-6062.**

Prior Authorization Documentation

Complete the **Universal Prior Authorization Form**, found under the **Prior Authorization** section of our website:

- Form must be completed entirely
- Signature and date are required
- Incomplete forms will result in delays
- Include in your request documentation, such as treatment plans and progress notes



Indiana Health Coverage Programs
Prior Authorization Request Form

Select the radio button 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	Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	Anthem Hoosier Healthwise	P: 866-408-6132	F: 866-406-2803
	CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	Anthem HIP	P: 844-533-1995	F: 866-406-2803
	CareSource HIP	P: 844-607-2831	F: 844-432-8924
	MDwise HIP	P: 888-961-3100	F: 866-613-1642
	MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	Anthem Hoosier Care Connect	P: 844-284-1798	F: 866-406-2803
	MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245
	UnitedHealthcare	P: 877-610-9785	F: 844-897-6514
Indiana PathWays for Aging	Anthem PathWays	P: 844-284-1798	F: 866-406-2803
	Humana PathWays	P: 866-274-5888	F: 502-324-6376
	UnitedHealthcare PathWays	P: 877-610-9785	F: 844-897-6514

Please complete all appropriate fields.

Patient Information
IHCP Member ID:
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 Provider NPI:

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

Requesting Provider Information
Requesting Provider NPI/Provider ID:
Taxonomy:
Taxpayer Identification Number (TIN):
Provider Name:
Provider Address:

Rendering Provider Information
Rendering Provider NPI/Provider ID:
TIN:
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

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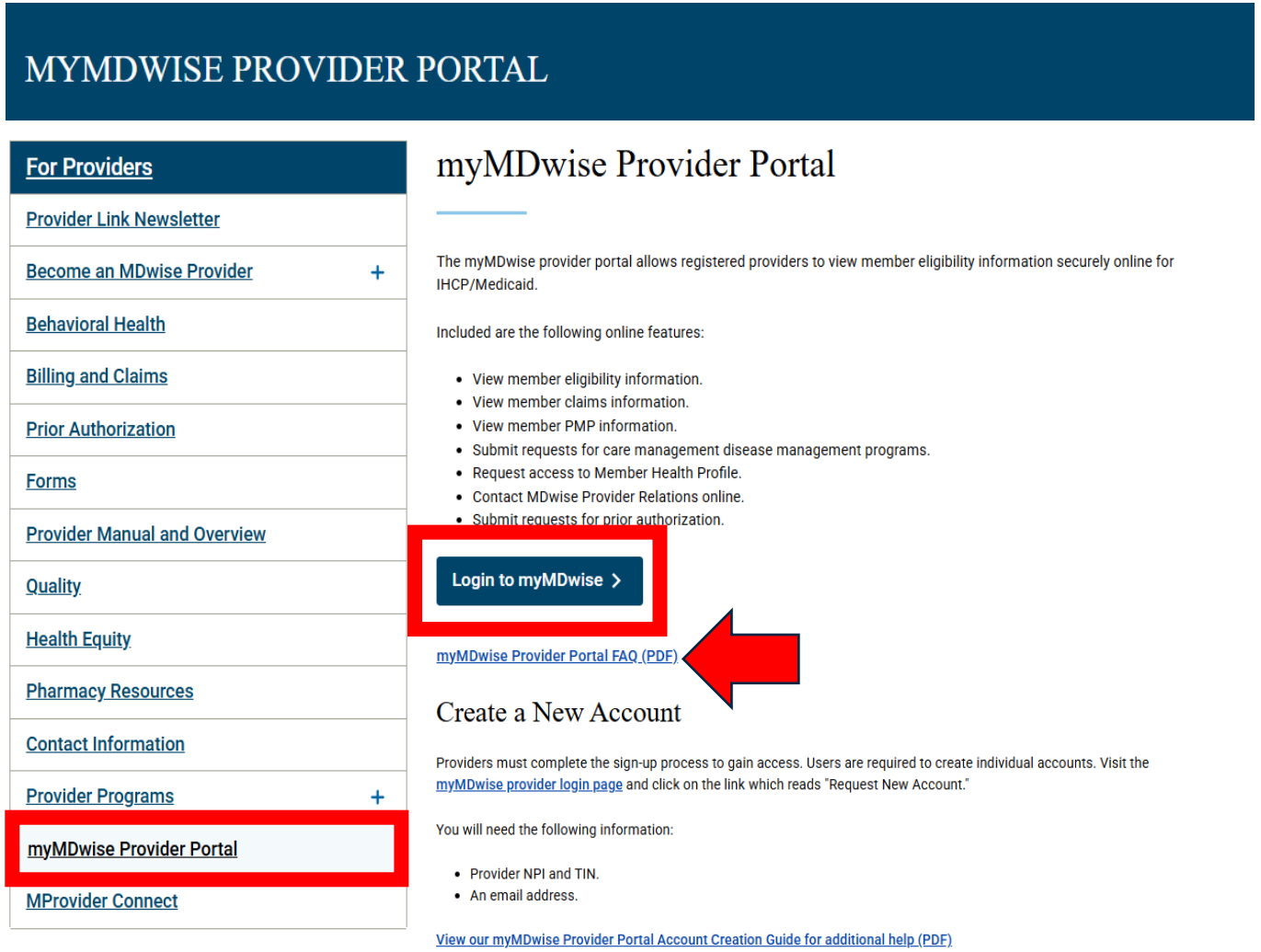
myMDwise Provider Portal: Prior Authorization

- If a login account has not been created on the provider portal, you will need to create a new account using this link: MDwise Provider Portal.

- If you are already registered through MProvider Connect, please use the same username and password.

- Your username is the email you used for registration plus .mdwise at the end (**name@domain.com.mdwise).**



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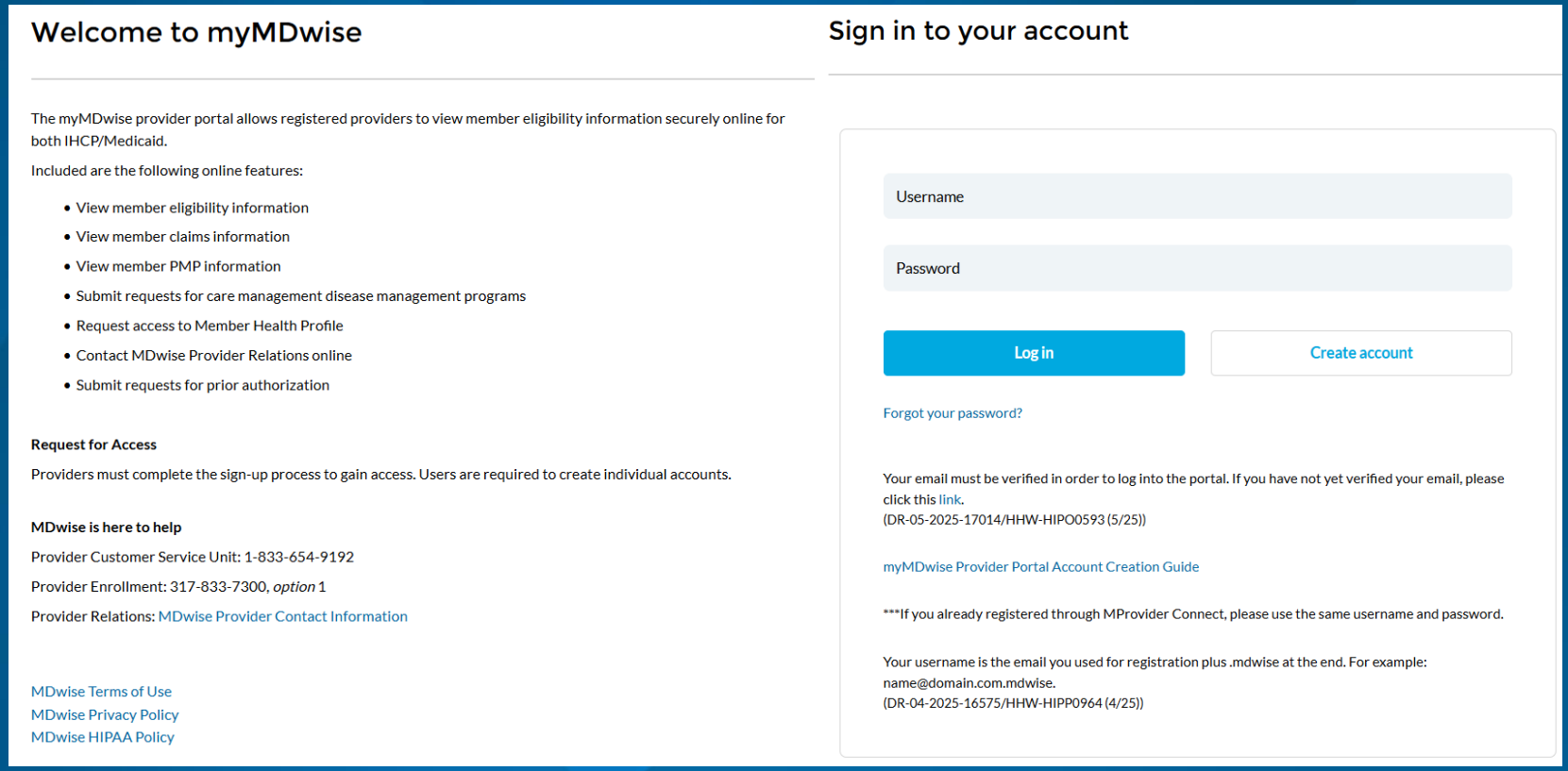
myMDwise Provider Portal

myMDwise Provider Portal Login

- If the tax identification number and IHCP Provider ID combination is incorrect or we are unable to find a valid match, you will receive the following message:

  Unable to find a matching group with the information provided. Please email MDwise directly at PRregistration@mdwise.org to add the Provider Location.



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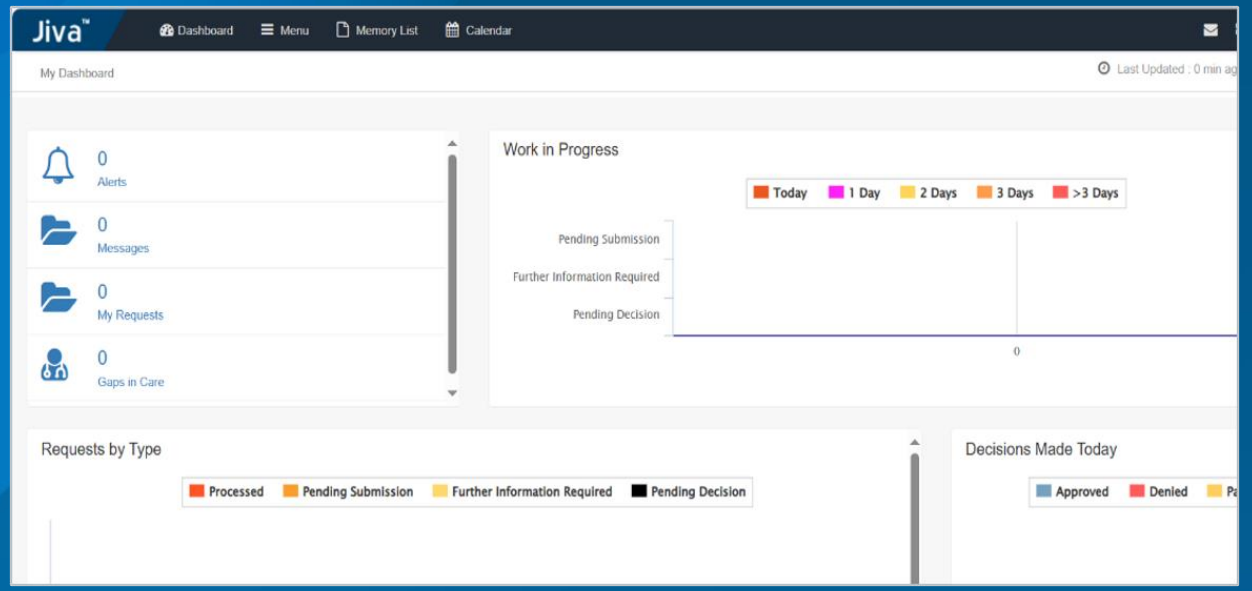
Navigating Your Dashboard

- Once logged in, locate and click on the Prior Authorizations tab in the banner near the top of the page.

- The webpage will automatically redirect to the Prior Authorization Portal (Jiva) to the My Dashboard screen.



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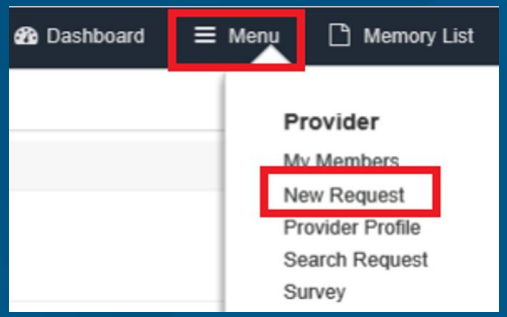
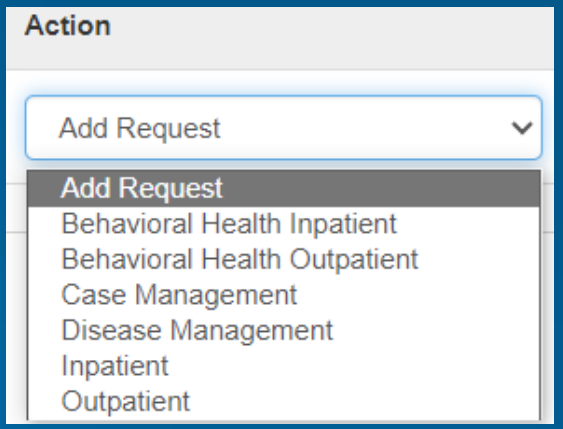
Initiating a Prior Authorization

Select Menu: Choose New Request from dropdown.



Enter Member ID and select the blue Search button. The member will appear.

Locate the Action column on the far right of the screen. Select the Add Request drop-down and choose the appropriate type of request.



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Prior Authorization Request Types

Request Type	Definition	Request Type Examples	Decision Turnaround
Urgent Pre-Service	Request for medical care or services with respect to which the application of the time periods for making non-urgent care determinations could result in an adverse effect on the health of the member	Initial PHP/SUDRT/Urgent Medical OP Preservice and Inpatient stays	24 hours excluding weekends and federal and state holidays
Urgent Concurrent	A review decision for the extension of previously approved ongoing care	Concurrent PHP/SUDRT/Urgent Medical OP Preservice and Inpatient stays	24 hours excluding weekends and federal and state holidays
Non-Urgent Pre-Service	Request for medical care or services for which application of the time periods for deciding **does not** jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain	Initial and Concurrent Medical Preservice, Intensive Outpatient (IOP) applied Behavioral Analysis, and Psych/Neuro testing	48 hours excluding weekends and federal and state holidays
Retrospective	After services have begun or supplies have been delivered, as outlined by IHCP guidelines	Any services that have already begun outside of IP stay as long as submitted timely	Within 30 calendar days of receipt of all necessary information

Portal Request Type

- Click on the Request Type drop-down and choose the appropriate request type.

- Select a Request Priority type.

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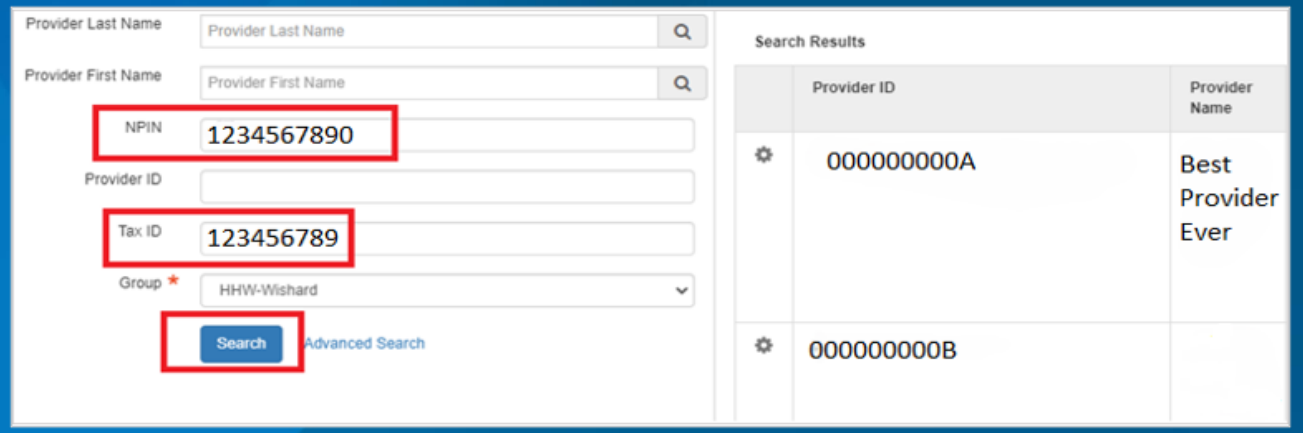
Diagnosis and Providers

- Fill out the Diagnosis section by entering the diagnosis code. Once you have entered the code, wait for Jiva to display its description. Then, select the provided code and description from the list that appears.

- Enter in the NPI and Tax ID for the facility only. Click the blue Search button. Search Results will appear to the right.



- Complete the Providers section. Click the blue Attach Providers button.

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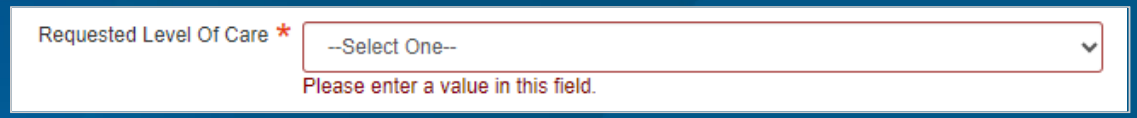
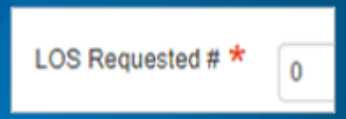
Inpatient PA Submission

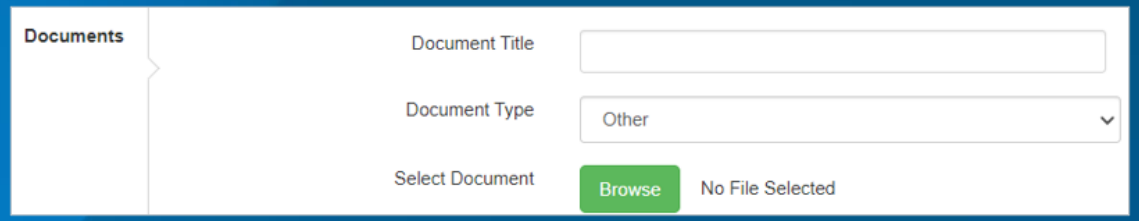
- Select a level of care from the Requested Level of Care dropdown



- Type in LOS (Length of Stay) Requested #.



- Complete the Documents section: Type in Document Title. Click the green Browse button to add documents.



***Please Note:* Documents must include clinicals and a completed PA form.**

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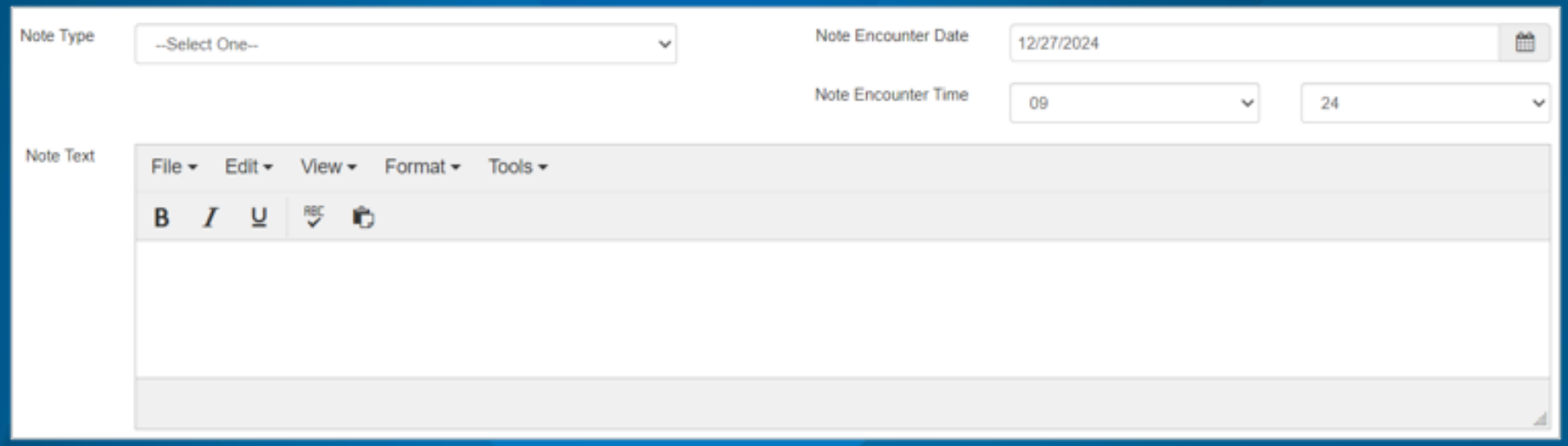
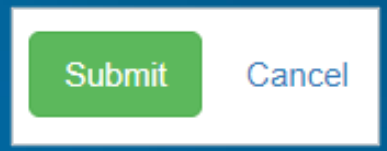
Inpatient Notes

- Complete the Notes section. In the Note text include the following information
  - Requestor Name
  - Requestor Phone Number
  - Requestor Fax Number
  - Additional/Relevant Information needed to process the request (reason for expedited).



- Click the green Submit button to complete the request.



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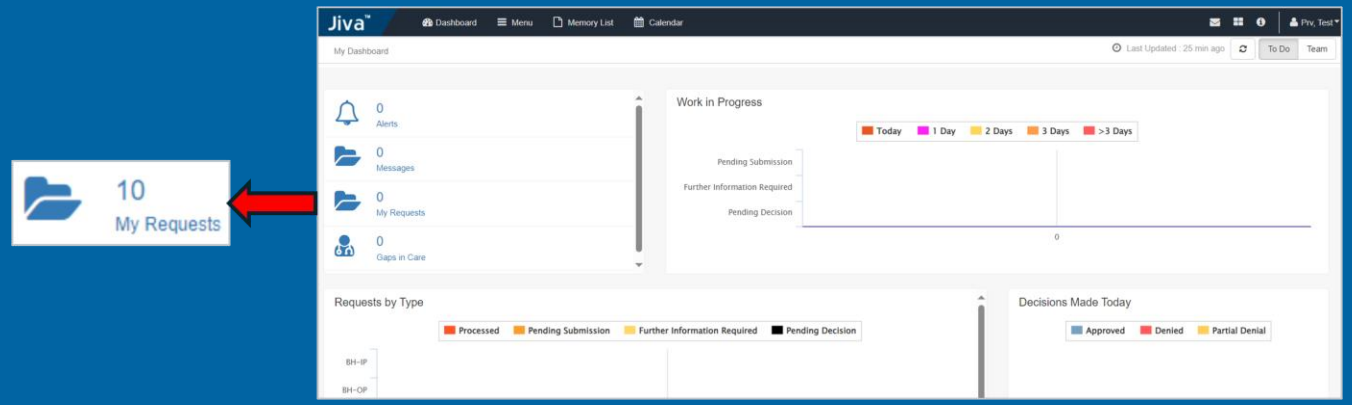
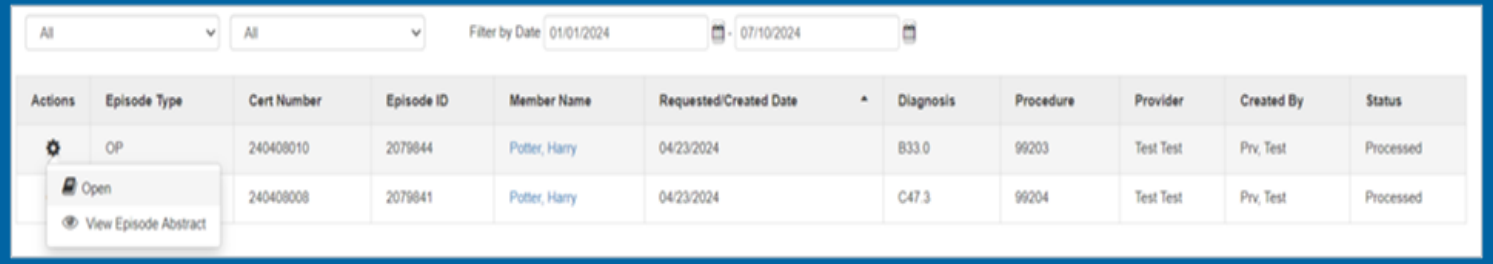
My Requests: Submitting a Concurrent/Extension

- From the Dashboard screen, click on the blue My Requests link that is in the top left widget. You can filter to locate the initial request that needs an extension/concurrent added.



- Once the member is located, click on the cogwheel in the Actions column of the member. Choose Open.



Please Note: *Any outpatient (OP) request over 212 days old, or inpatient (INPT) request over 20 days old will require a new PA submission.*

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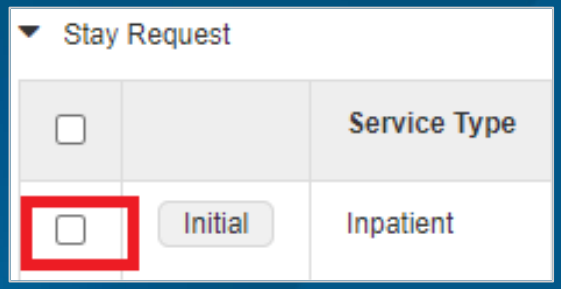
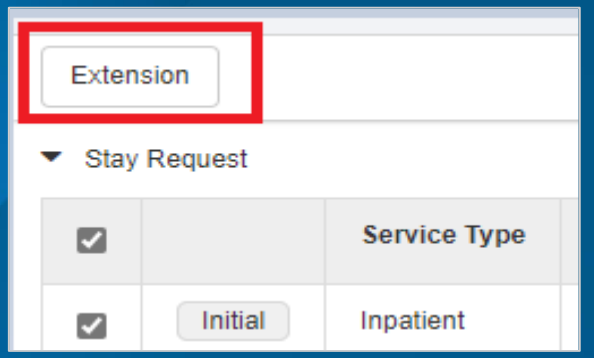
Submitting a Concurrent/Extension Request

- Click the checkbox to the left of the initial or the last extension added for the desired line item(s).



- Click the white extension button that appears above the Stay/Service Request line.



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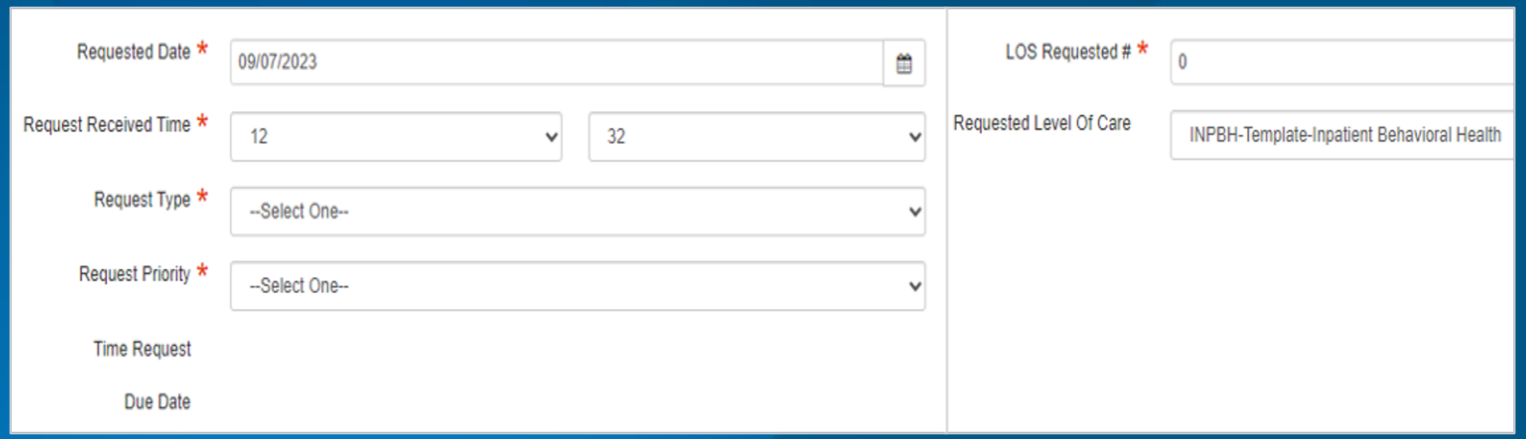
Concurrent/Extension Details

- Enter the required details in the drop-downs with a red asterisk * for the extension request.



- Click the green Save button to complete the request.

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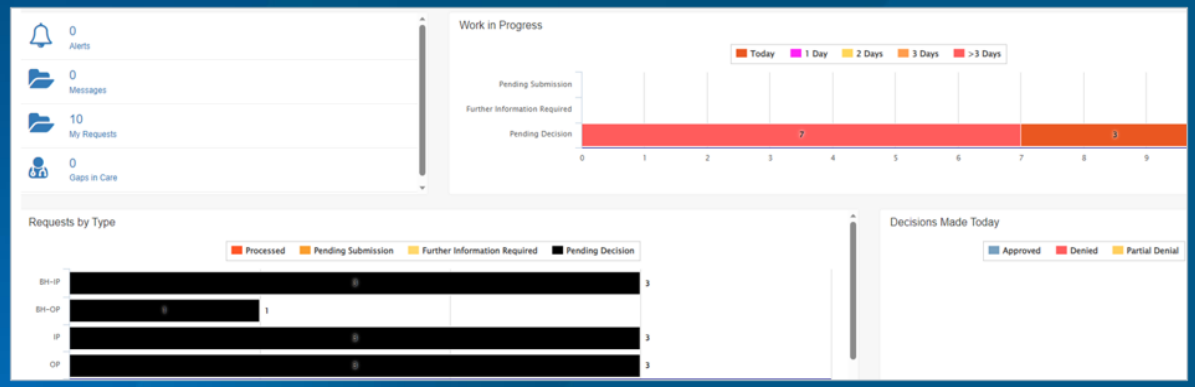
Dashboard Overview

- The dashboard in the Authorization Portal is comprised of several widgets that quickly display data related to the individual assigned provider.



Alerts	Messages
• Alerts are system-generated messages sent to the assigned user that present important information about specific requests. • These messages will only pertain to requests made by the assigned provider.	• Messages are sent via the Jiva application. They are notes that pertain to a request or a member and have been sent to the individual assigned provider. ***Please Note**: Unlike in the Alerts link, messages here may pertain to requests made by anyone other than the assigned provider.*

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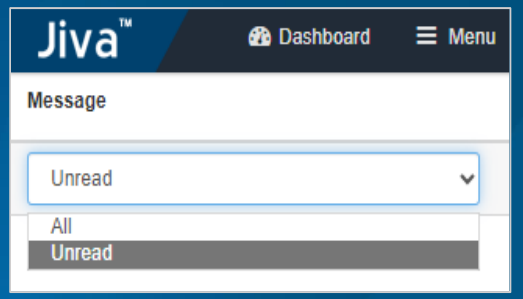
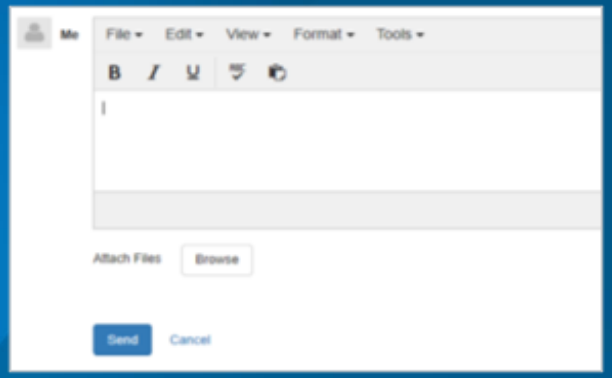
Dashboard Messages

- View message (Choose “All” or “Unread”).



- Choose any message to read. To respond to a message, type the response in the text field box.



- Click the Send button when complete.

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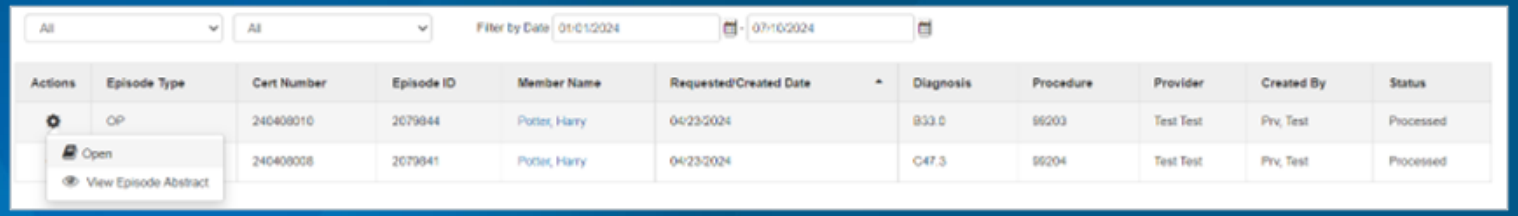
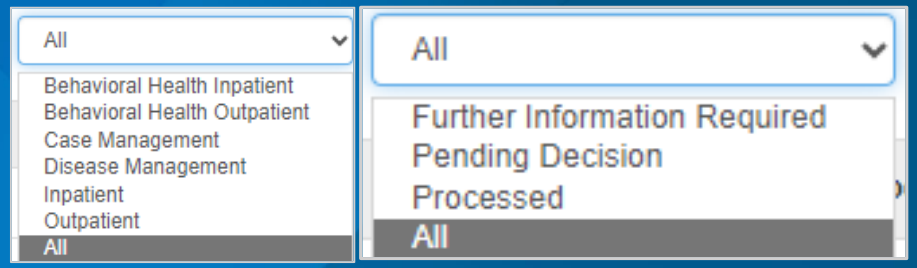
Request Dashboard

- Any new requests created by a provider are grouped and can be accessed using the My Request link.

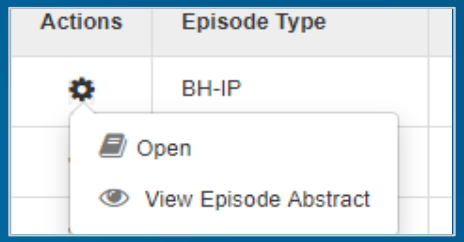
- Locate the different filter options.



- Filter by Episode Type or by Status.



- Click the cogwheel in the Actions column to the left of the Episode Type for the desired request. Select the Open option.



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Prior Authorization Appeals Process

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What Is an Appeal?

Appeal is defined as a request to review an action and/or request to change a previous decision. An action, as defined in 4CFR 438.400(b)(2) 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 by the State, or failure of the MCE to act within the required timeframes.
- For the resident of a rural area where MDwise is the only contractor, the denial of the member's request to exercise the right, under CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable).
- Denial of a member's request to dispute financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.
- A decision adverse to the member regarding a medically frail designation.
- Any decision pertaining to a member not expressly listed above qualifies as an "adverse benefit decision" under 42 CFR 438.400.

Pharmacy and Dental Service Appeal

Providers **must request an appeal in writing** using the Prior Authorization Appeal Form

Pharmacy Service Appeals	Dental Service Appeals
Email: pharmacyappeals@mdwise.org **Mailing Address:** MDwise Pharmacy Department PO Box 441423 Indianapolis, IN 46244-0236	**Email:** dentalappeals@mdwise.org **Mailing Address:** MDwise Dental Appeals PO Box 44236 Indianapolis, IN 46244-0236

If you receive a denial and do not agree with the decision, you can request a Peer-to-Peer Review. Here's how:

- Request a Peer-to-Peer Review within seven **(7) business days** of the denial notice. The denial letter will include the phone number to call for a Peer-to-Peer Review.
- Be ready to provide the following information.
  - Details from the denial letter, including the physician's name and phone number.
  - Times when the physician is available to speak with our physician.
- The Peer-to-Peer Review will be a discussion with the Medical Director or the reviewer who made the decision.
- If the result is still not in your favor, you can request an appeal.
- If documentation was missing, you can include it in your appeal to save your physician time.

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Filing a Medical Service Appeal

Providers must request an appeal **in writing** using the Prior Authorization Appeal Form

Email: PADept@MDwise.org

Fax: (866) 613-1631

Mailing Address:
MDwise Customer Service Department
Attention: Appeals
PO Box 44236
Indianapolis, IN 46244-0236

MDwise
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Member Appeals

- Members have 60 calendar days from the date of denial to submit the of appeal.
- MDwise has 30 calendar days to render a standard appeal and 48 hours for an expedited appeal.
- Members are not eligible to request or receive extensions for appeal submissions.
- If MDwise is unable to decide within 30 business days because additional information is needed (requested previously but not provided from either the provider or member), the time frame can be extended under 42 CFR 438.408(C).

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- Providers have 48 hours to submit an appeal after notice of denial.
- MDwise will render a decision within 30 calendar days for standard request and 48 hours for expedited.
- MDwise resolves provider appeals within 48 hours of receiving the request and the attending physician and member are notified.
- This time frame can be extended under 42 CFR 438.408(C).

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Provider Appeals

Appeals | External Options

- If your standard or expedited appeal is denied, you have more options for review.
- You, your representative, or your provider can request an external review by an **Independent Review Organization (IRO)** and/or a **State Fair Hearing (SFH)**.

Independent Review Organization (IRO):	State Fair Hearing (SFH):
• Request must be filed within 120 calendar days of the appeal decision. • MDwise will confirm receipt within three (3) business days. • A standard IRO review will be completed within 15 business days after your request. • An expedited IRO review will be completed within 72 hours after your request.	• Request must be filed within 120 calendar days of the appeal decision or the IRO determination. • To request a State Fair Hearing, contact: **Office of Administrative Law Proceedings** **100 N Senate Ave, Room N802** **Indianapolis, IN 46204** (Request must be made directly and in writing.) • The Administrative Law Judge will render a decision and notify you of the outcome in writing. • If the decision is in your favor, MDwise will provide the denied services within 72 hours of the decision notice.

Provider Resources

MDwise
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Prior Authorization Resources Page

- http://www.mdwise.org/for-providers/forms/prior-authorization/

MDwise Prior Authorization Inquiry Line (*inquiry only, PAs are not accepted by phone*)

- **(888) 961-3100** | Monday – Friday, 8:00 a.m. to 5:00 p.m. (Eastern Time Zone)

MDwise Provider Manual

- https://www.mdwise.org/mdwise/mdwise-provider-manual

IHCP Provider Reference Modules

- https://www.in.gov/medicaid/providers/provider-references/provider-reference-materials/ihcp-provider-reference-modules/

MDwise Provider Customer Service Unit

- **(833) 654-9192** | Monday – Friday, 8:00 a.m. to 8:00 p.m. (Eastern Time Zone)

MDwise Contact Information

- Quick Contact Guide
- Provider Relations Territory Map

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Helpful Links

MDwise Provider Relations Team

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Region 6

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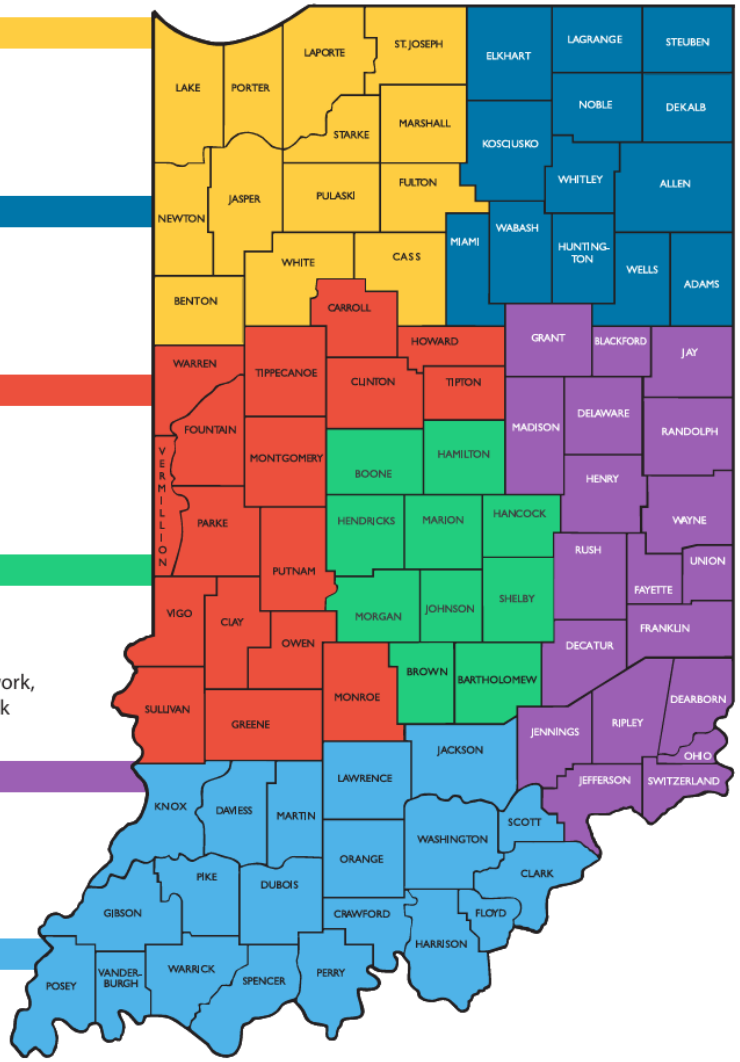
University of Louisville



PROVIDER GROUP REPRESENTATIVES

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317-766-0505

Provider Groups
Ascension St. Vincent
Franciscan Alliance
Home Health and Hospice
Skilled Nursing Facilities (SNFs)

LaToya Robertson
lrobertson@mdwise.org
317-552-8420

Provider Groups
Federally Qualified Health Centers (FQHCs)
Rural Health Center (RHCs)
Community Mental Health Centers (CMHCs)
Eskenazi Health

LeAnne Ramsey
lramsey@mdwise.org
317-460-4697

Provider Groups
DME and HME
Laboratory Services
Dialysis Clinics
ABA Providers
Out of State Providers

PROVIDER RELATIONS LEADERSHIP

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MDwise Provider Relations Territory Map

Questions?

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Thank you!

Please take a few moments to complete the event and session evaluations. We appreciate your feedback!

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