Prior Authorizations - 201

2021 IHCP Works
Annual Seminar

Agenda

- Prior Authorization Services
- Prior Authorization 101 Review
  - Prior Authorization Services
  - Procedure Code Look-Up Tool
  - Submitting Requests
  - Form
  - Timeframes
- Retro Authorizations
- Sterilization/Hysterectomy
- Newborn Process
- Proactive Responses to Issues
- Example of Prior Authorization Issue
- Clinical & Non-Clinical Appeals and Disputes
- Appeal Process
- Important Reminders
- Updates & Announcements
- How to Contact Us

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Prior Authorization 101 Review

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Prior Authorization Services

All Inpatient Services	All Inpatient Rehabilitative Service
Applied Behavior Analysis therapy services (ABA)	All Inpatient Behavioral Health admissions
Transcranial Magnetic Stimulation	Intensive Outpatient Program Services
Genetic Testing	Ambulance Transport – non-emergent
Home Health Care Services	Hearing Aids
Skilled Nursing Facility Services	Prosthetic and Orthotic devices
All powered or customized wheelchairs and supplies	Durable Medical Equipment, rental equipment and specific DME require authorization
	All DME miscellaneous codes (example: E1399)

***This is not an all-inclusive list, please refer to the Procedure Code Look-Up Tool on our website

Prior Authorization Services

Pain Management Services ➢Facets ➢Epidurals ➢Facets Neurotomy ➢SI Joints	Outpatient Services: ➢Cosmetic/Plastic/Reconstructive Procedures ➢Spinal Cord Stimulators ➢Implantable Pain Pumps
Organ Transplants	Partial Hospitalization Program (PHP)
Residential services	Services beyond benefit limits for members 20 years of age and under
Gender Dysphoria Surgeries	Any surgery or procedures that are potentially cosmetic or investigational will require a prior authorization

***This is not an all-inclusive list, please refer to the Procedure Code Look-Up Tool on our website

Procedure Code Look-Up Tool

CareSource announces the Procedure Code Look-Up Tool

CareSource

Procedure Code Lookup

Complete Steps

Choose Line of Business

-- Line of Business --

2 Enter a CPT/HCPCS Code

ABC90 or 92507

Procedure Code Look-Up Tool

DISCLAIMER

- Results are provided “AS IS” and “AS AVAILABLE” and do not guarantee approval or payment for services.
- Approval or payment of services can be dependent upon the following, but not limited to, criteria:
  - Member eligibility
  - Members < 21 years old
  - Medical necessity
  - Covered benefits
  - Modifiers
  - Diagnosis and revenue codes
  - Limits and number of visit variances
  - Provider contracts, Provider types
  - Correct coding and billing practices
- For specific details, please refer to the Health Partner Provider Manual

Procedure Code Look-Up Tool

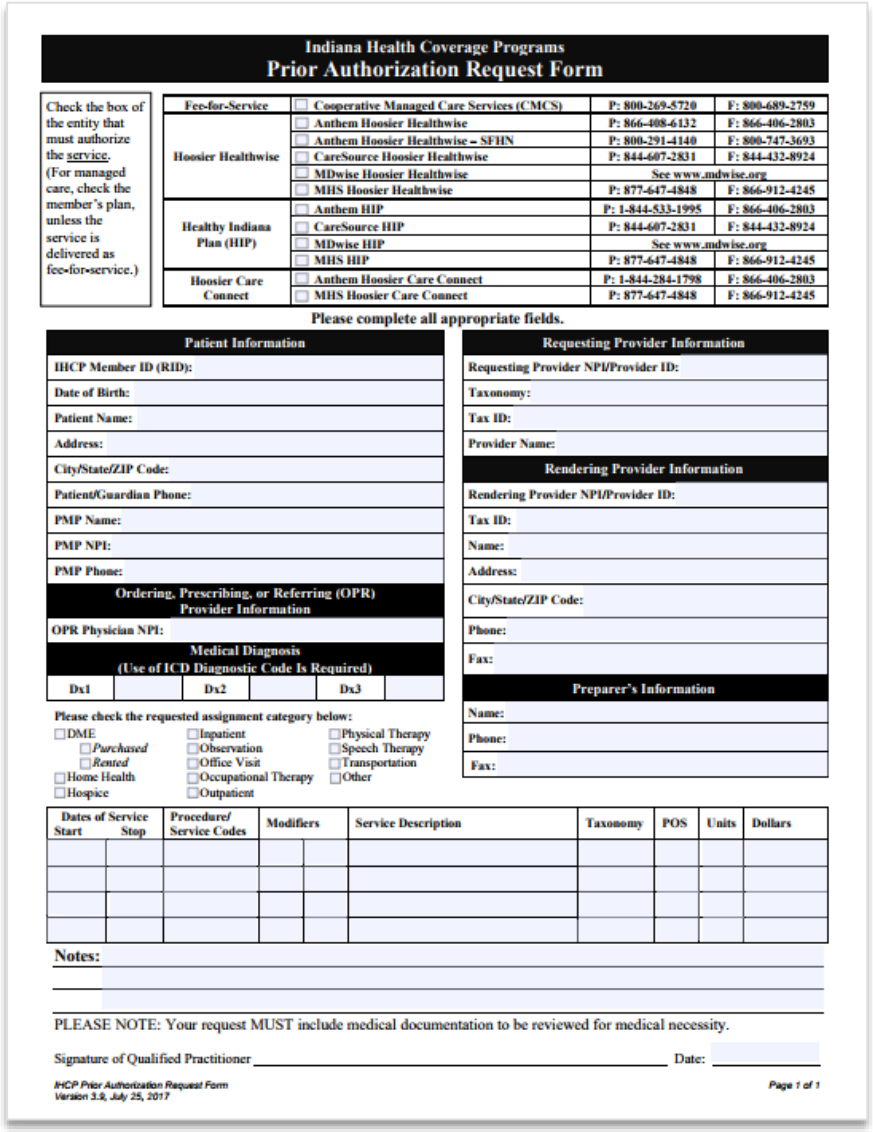
Please Note:

- All non-par providers and all requests for inpatient services require prior authorization.
- For all high tech radiology: CT, CTA, MRI, MRA and PET scans; providers should contact NIA or their web portal at www.radmd.com.
- For more information about drugs that require prior authorization, access our Pharmacy webpage.
- Reference our Dental Provider Manual for dental services that require prior authorization.

How to Submit PA Requests

Provider Portal	Cite Auto Authorization
Phone	1-844-607-2831
Fax	Fax the prior authorization form to 844-432-8924 including supporting clinical documentation. The prior authorization request form can be found on **CareSource.com.**
Mail	CareSource P.O. Box 1307 Dayton, OH 45401-1307

Prior Authorization 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 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: 866-408-6132	F: 866-406-2803
	☐ Anthem Hoosier Healthwise – SFHN	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 3.9, July 25, 2017

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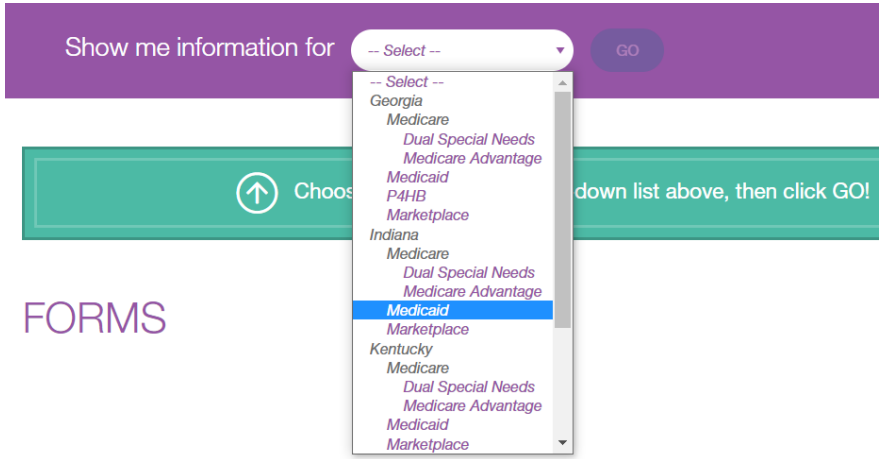
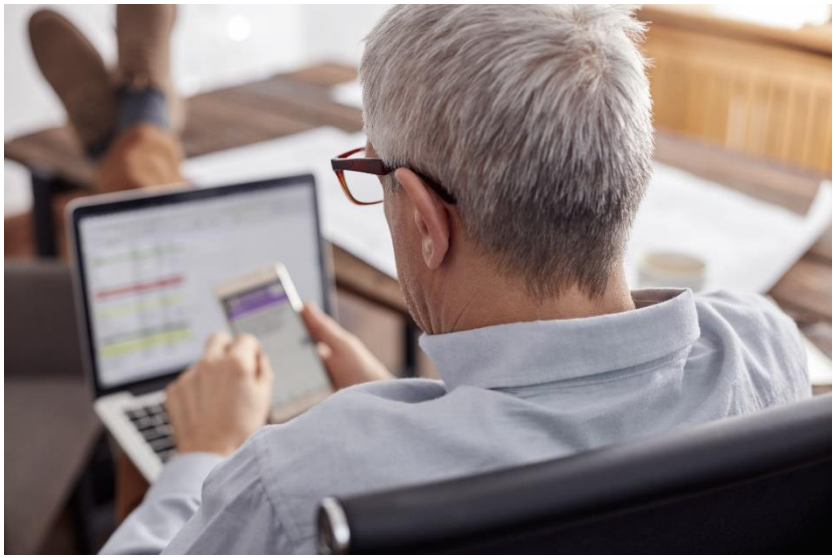
IHCP Prior Authorization Request Form



FORMS

Prior Authorization Timeframes



To check the status of a prior authorization request, call 1-844-607-2831 or to go through the provider portal.

Authorization Type	Decision
Standard pre-service	7 calendar days
Urgent pre-service	3 business days
Urgent concurrent	1 business day (after receiving all information necessary)
Post service (retrospective review)	30 calendar days

Retro-Authorizations

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Retro-Authorizations

Circumstances for a Retrospective/Post-Service Review

- Member eligibility
- Administrative delays
- Services rendered outside of Indiana
- Transportation services
- Provider is unaware of member eligibility
  - Member refusal was documented
  - Member physically unable to provide Medicaid information
  - Provider can substantiate reimbursement was continually pursued

Retro-Authorizations Timeframes

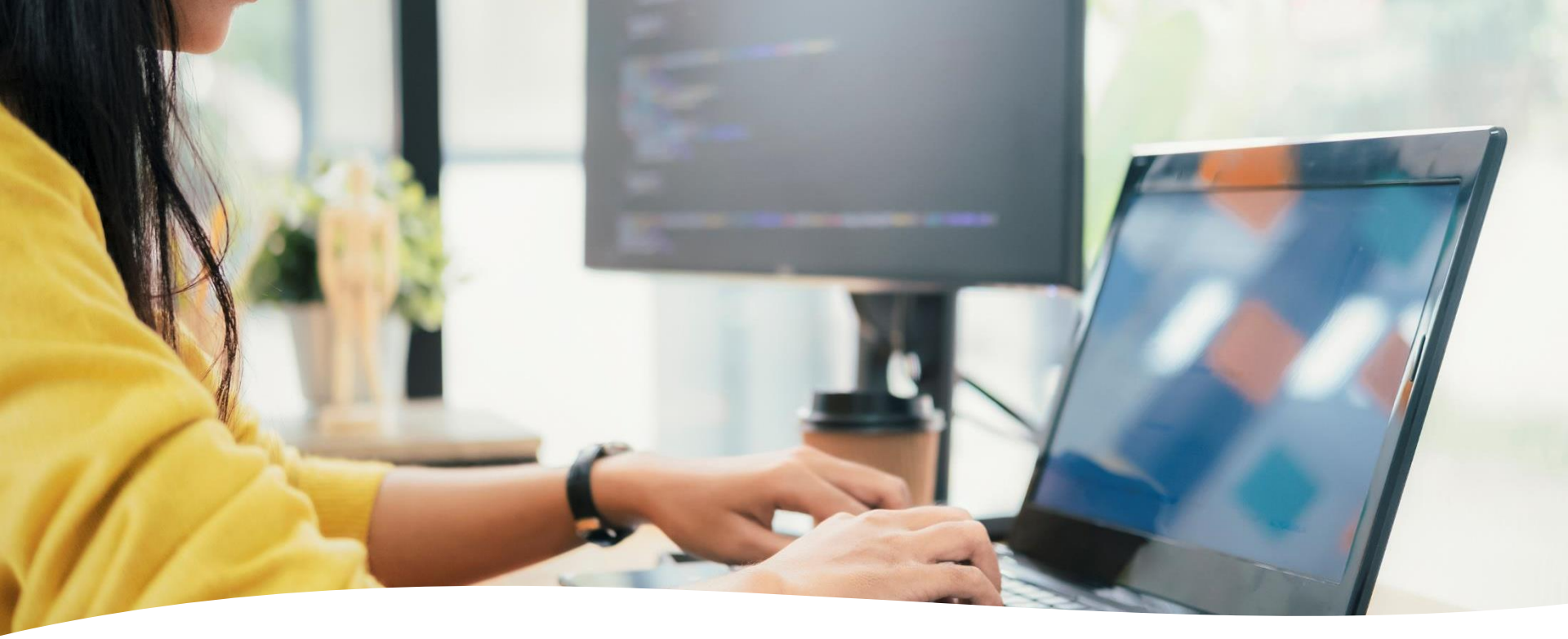
Retrospective (post-service) reviews will be decided upon **30** calendar days from the receipt of the request

Note: Dispute / appeal process may be required for a denied claim

Sterilizations & Hysterectomy

Sterilizations

- Sterilization Definition
- When are sterilizations reimbursable?
- Timeframes
- Sterilizations planned concurrent with delivery timeframes
- Requirements
  - Voluntary Consent given and form signed
  - Is 21 years old or older at time of consent
  - Is neither mentally incompetent nor institutionalized



Sterilization Prior Authorization Checklist

Checklist when submitting the Prior Authorization

- Signed Consent Form
- Clinical Notes
- Member must be over 21 or have a medical reason

Consent for Sterilization Form

Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (Specify Type of Operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (Date)

I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor or Clinic) by a method called _____ (Specify Type of Operation). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (Signature) _____ (Date)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (Interpreter's Signature) _____ (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of Individual) signed the consent form, I explained to him/her the nature of sterilization operation _____ (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (Signature of Person Obtaining Consent) _____ (Date)

_____ (Facility)

_____ (Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of Individual) on _____ (Date of Sterilization)

I explained to him/her the nature of the sterilization operation _____ (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery *(describe circumstances)*: _____

_____ (Physician's Signature) _____ (Date)

HHS-687 (04/22)

Patient Sterilization

- When is a Sterilization Form not necessary?
  - Patient is rendered as sterile due to illness or injury
    - Certification must be attached to the claim
  - Partial Sterilization
    - “Partial Sterilization” **must** be noted on the claim form

Hysterectomy

- IHCP covers hysterectomies when medically necessary
- Member must give consent
- IHCP does not cover to solely render a member permanently incapable of bearing children
- Do **not** use the Consent for Sterilization Form
- Hysterectomy Consent Form must be submitted with the claim
- If performed outside of delivery PA is required

Acknowledgement of Receipt

Acknowledgement of Receipt of Hysterectomy Information

Member Name: _____

IHCP Member ID: _____

Physician Name: _____

NPI or IHCP Provider ID: _____

AMA Education Number: _____

It has been explained orally and in writing to _____ that the hysterectomy to be performed on her will render her permanently incapable of bearing children.

☐ Signed before surgery

☐ Signed after surgery (at the time of the hysterectomy, eligibility was not established).

_____ _____

(Member or Representative Signature) (Date)

Physician Statement

The hysterectomy in the above case is being done for medically necessary reason(s), and the resulting sterilization is incidental and is not, at any time ever, the reason for this surgical operation.

Diagnosis(ses)

_____

_____

(Physician Signature) (Date)

Newborn Process

CareSource™

Newborn Process

CareSource does **NOT** require newborn notification

- Deliveries do not require authorization unless
  - Exceeds **3 days** for vaginal delivery
  - Exceeds **5 days** for C-Section
  - Newborn remains inpatient

Newborn Process

Eligibility Issues

- Providers have **60 days** to request retro-authorization
  - Change of eligibility must accompany request
  - Copy of Retro-Authorization is submitted with claim

Proactive Responses to Providers

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Proactive Responses to Provider Issues

Highest volume of calls are related to:

1) Checking status of auth request
2) Requests for fax approval/denial

Proactive Response to Provider Issues

How has CareSource addressed issues in the past?

We updated our Provider Portal!!!

- Provider Portal
- Checking status
- Instant Authorizations
- Bi-directional communication

How will CareSource address issues in the future?

- Future portal enhancements
- Survey

Example of a Prior Authorization Issue

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Example Prior Authorization Issue

Real life example of a provider authorization issue:

- Substance Use Disorder Related Issue
- The scenario
- The outcome

Clinical & Non-Clinical Appeals and Dispute

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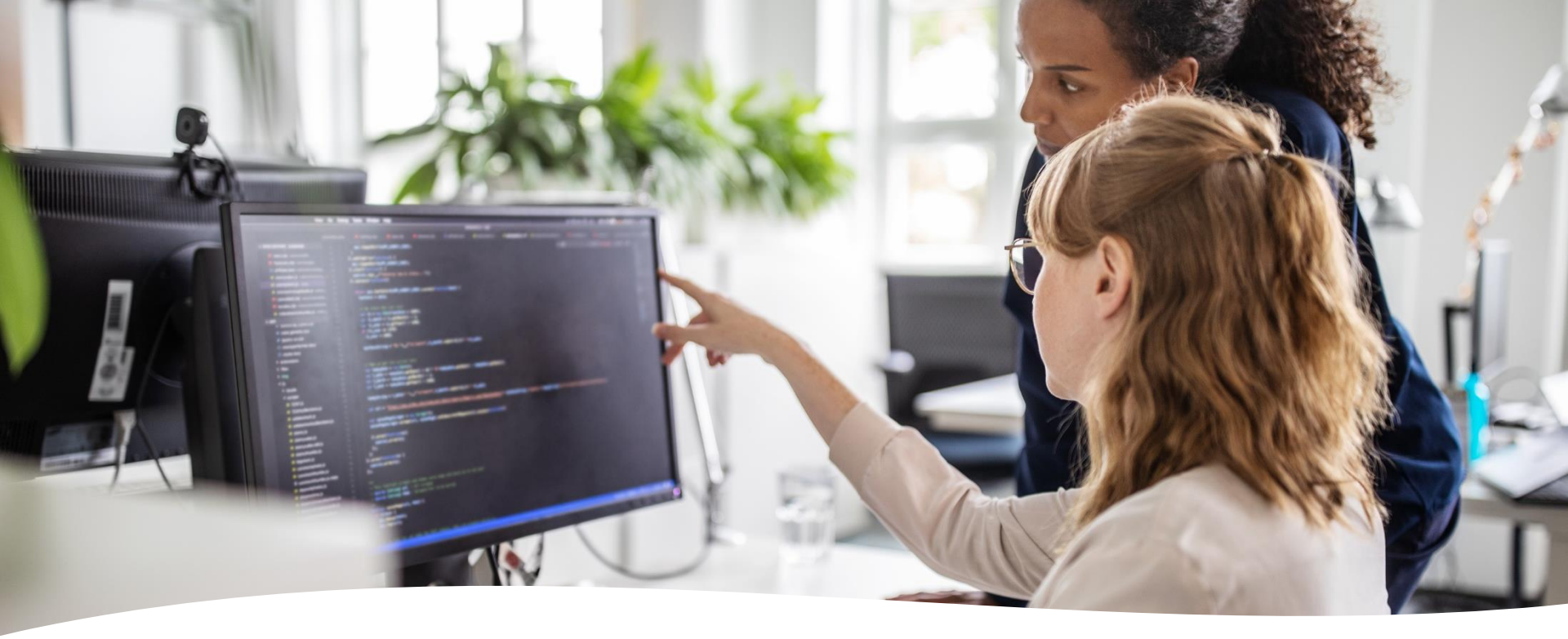


Clinical and Non-Clinical Disputes and Appeals

Top Authorization Drivers

- Claim denials due to lack of obtaining required prior authorization
- Pharmacy
- ABA Therapy
- Newborn Authorizations

Claim Denials Due to Lack of Prior Authorization

- Largest driver
- CareSource upheld 78%
- Only 22% of cases overturned
- See April 2021 Prior Authorization List
- Member written consent is **required**

*****Large volume of requests returned as invalid due to no member written consent**

Pharmacy Authorization Denials

- Lack of clinical information
- CareSource additional efforts

ABA Therapy Authorization Denials

- Reduction in therapy hours
- Meetings with Behavioral Health providers and CareSource and vendors

Newborn Authorizations

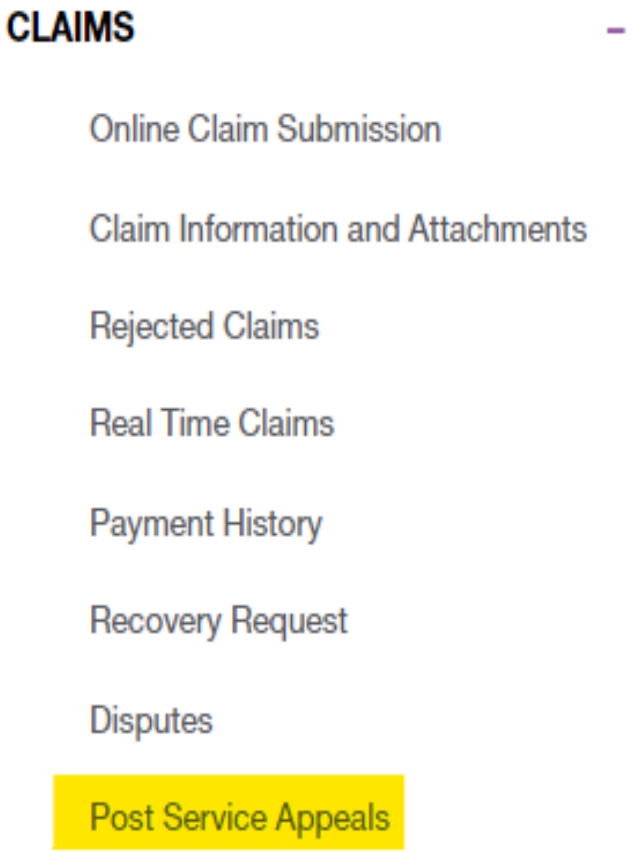
- Configuration Enhancements

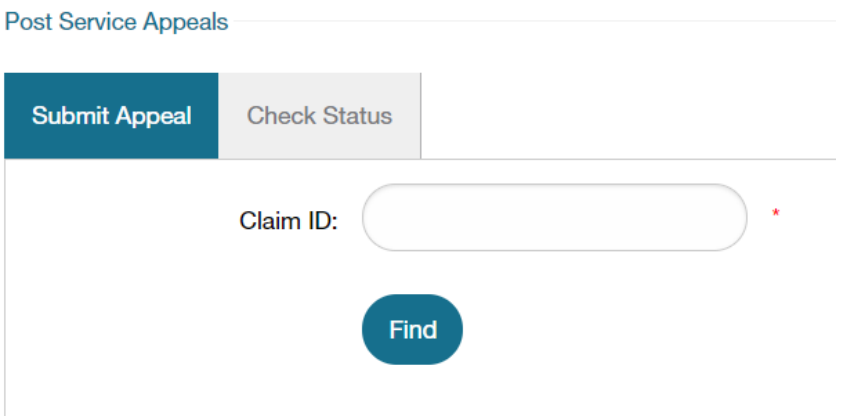
Appeal Process

Expedited Appeals

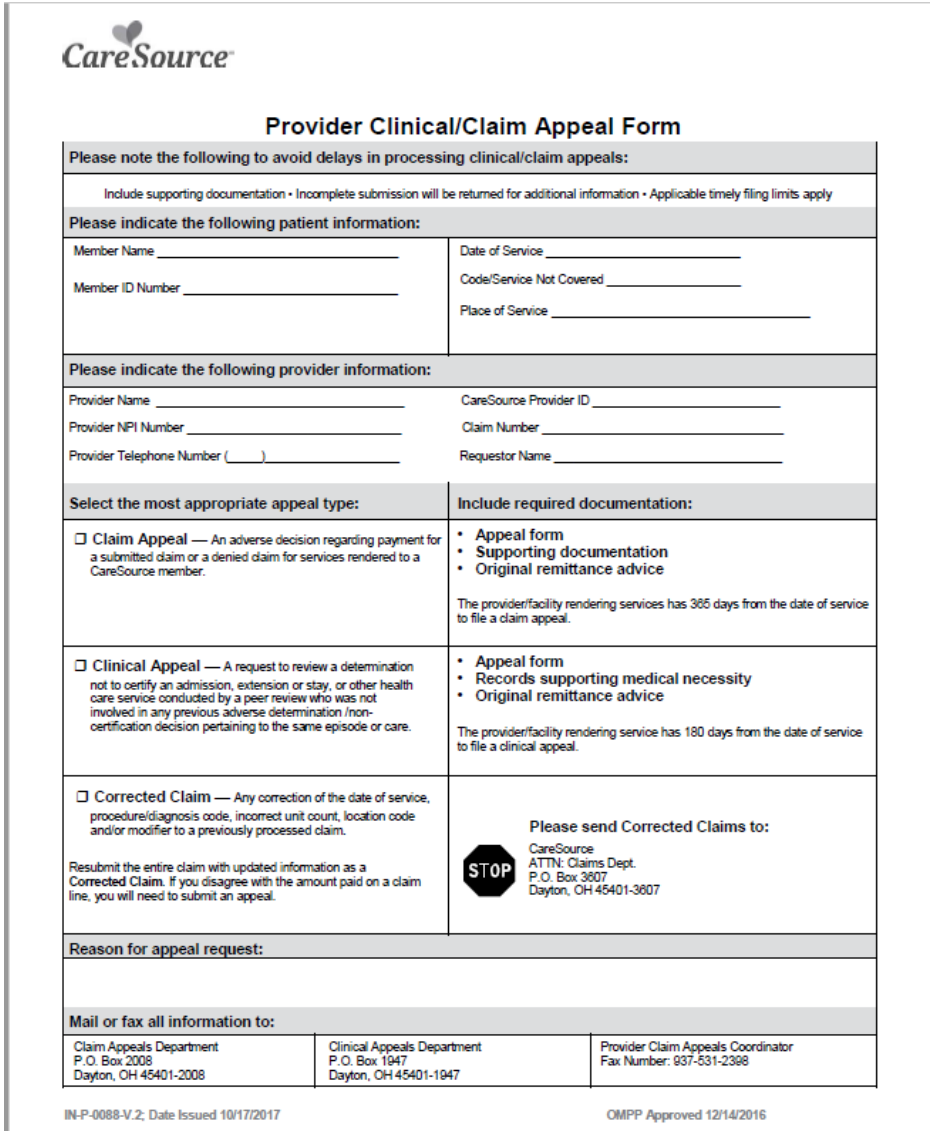
- Call us at **1-844-607-2831** to expedite a clinical appeal.
- Expedited appeals will be resolved and verbal notification will be made within **48 hours.**
- CareSource will decide whether to expedite an appeal within **24 hours.**

Provider Portal: Post-Service Review





Provider Clinical/Claim Appeal Form



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Provider Clinical/Claim Appeal Form

Please note the following to avoid delays in processing clinical/claim appeals:

Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply

Please indicate the following patient information:

Member Name _____
Member ID Number _____
Date of Service _____
Code/Service Not Covered _____
Place of Service _____

Please indicate the following provider information:

Provider Name _____
Provider NPI Number _____
Provider Telephone Number (____)_____
CareSource Provider ID _____
Claim Number _____
Requestor Name _____

Select the most appropriate appeal type:	Include required documentation:
❑ **Claim Appeal** — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	• Appeal form • Supporting documentation • Original remittance advice The provider/facility rendering services has 365 days from the date of service to file a claim appeal.
❑ **Clinical Appeal** — A request to review a determination not to certify an admission, extension or stay, or other health care service conducted by a peer review who was not involved in any previous adverse determination /non-certification decision pertaining to the same episode or care.	• Appeal form • Records supporting medical necessity • Original remittance advice The provider/facility rendering service has 180 days from the date of service to file a clinical appeal.
❑ **Corrected Claim** — Any correction of the date of service, procedure/diagnosis code, incorrect unit count, location code and/or modifier to a previously processed claim. Resubmit the entire claim with updated information as a **Corrected Claim**. If you disagree with the amount paid on a claim line, you will need to submit an appeal.	**Please send Corrected Claims to:** STOP CareSource ATTN: Claims Dept. P.O. Box 3607 Dayton, OH 45401-3607

Reason for appeal request:

Mail or fax all information to:

Claim Appeals Department	Clinical Appeals Department	Provider Claim Appeals Coordinator
P.O. Box 2008 Dayton, OH 45401-2008	P.O. Box 1947 Dayton, OH 45401-1947	Fax Number: 937-531-2398

IN-P-0088-V.2; Date Issued 10/17/2017 OMPP Approved 12/14/2016

https://www.caresource.com/in/providers/provider-portal/appeals/medicaid/

Administrative Denials

- Late notification of inpatient admission
- Member not Eligible at time of request for authorization
- Late Retro Physician Denial
  - Needs to be submitted within 60 days from DOS
- Non-Covered Codes

Peer to Peer Review

- Our members' health is always our number one priority.
- Requesting clinical rationale.
- Discussing an adverse decision with physician reviewer
  - By Phone **1-833-230-2168**
  - Within **five** business days of the determination.

Our new line was created with a special team dedicated to answer live calls.

You will be able to reach a live staff member anytime during normal business hours.

Important Reminders

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Important Information

- Verifying eligibility
- Failure to obtain a prior authorization
- **Authorization is not a guarantee of payment for services.**
- CareSource does not require prior authorization for unlisted CPT codes, however:
  - Signed, clinical record be submitted with your claim
  - Claims submitted without clinical records for unlisted CPT codes will be denied.
  - Denials will be reconsidered through the claim's dispute/appeal process
- **Services beyond applicable benefit limit for members 20 years of age and under require a prior authorization.**

Updates & Announcements

CareSource™

Updates & Announcements

Visit the Updates and Announcements page located on our website for frequent network notifications.

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements

Contact Us

CareSource™

CareSource

PARTNER with Purpose

CareSource Health Partner Engagement Representatives

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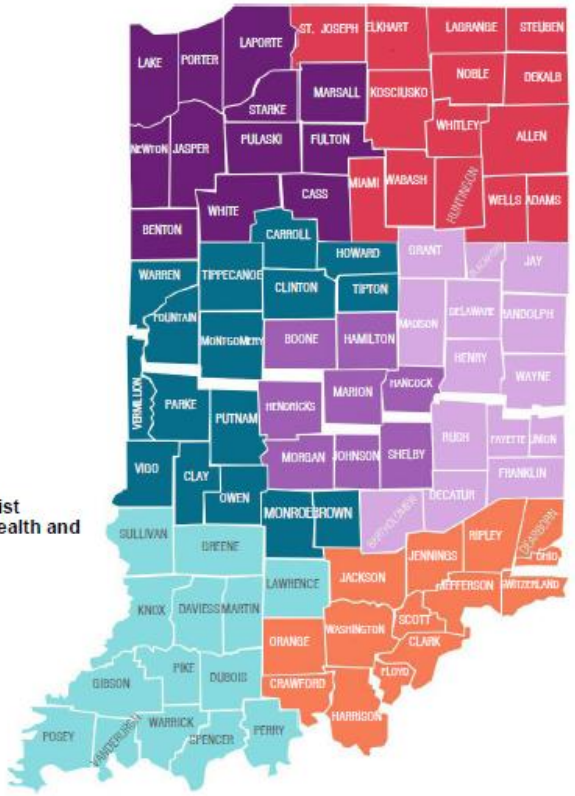

Regional Specialist

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Thank you!
CareSource