PRIOR AUTHORIZATIONS 101

2021 Annual IHCP Works Seminar

Agenda

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

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
- 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

mhs

PROVIDER Quick Reference Guide

Effective August 1, 2020

Applies to all Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) packages.

For an Ambetter Provider Quick Reference Guide, please visit ambetter.mhsindiana.com. Coverage is subject to specific benefit package of member.

Hoosier Healthwise | HIP | Hoosier CARE CONNECT

1-877-647-4848
TTY/TDD: 1-800-743-3333
mhsindiana.com

GENERAL OFFICE HOURS:
8 a.m. to 5 p.m., EST, closed holidays

MEMBER SERVICES AND PROVIDER SERVICES:
8 a.m. to 8 p.m.

REFERRALS AND AUTHORIZATIONS:
8 a.m. to 5 p.m., closed 12 p.m. to 1 p.m.

CASE MANAGEMENT:
8 a.m. to 5 p.m.

AFTER-HOURS:
MHS' 24/7 Nurse Advice Line for members is available to answer calls for emergent authorization needs. Or, you may leave a message on our after-hours recording system. Messages are returned within one business day.

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
68069

BEHAVIORAL HEALTH PAYER ID:
68068

MEDICAL CLAIMS ADDRESS:
Managed Health Services
P.O. Box 3002
Farmington, MO 63640-3802

Claims sent to MHS' Indianapolis address will be returned to the provider.

MEDICAL NECESSITY APPEALS ONLY ADDRESS:
ATTN: APPEALS
P.O. Box 441567
Indianapolis, IN 46244

MEDICAL CLAIMS APPEALS ADDRESS:
Managed Health Services
P.O. Box 3000
Farmington, MO 63640-3800

Providers have 67 calendar days from the date of the Explanation of Payment to file an adjustment, resubmit, or appeal a decision (effective March 1, 2021, 60 days).

Failure to do so within the specified timeframe will waive the right for reconsideration.

MEDICAL CLAIMS REFUNDS:
To refund claims overpayment, please send check and documentation to:

Coordinated Care Corporation
75 Remittance Dr., Suite 6446
Chicago, IL 60675-6446

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993

CASE MANAGEMENT: 1-866-694-3653
Ex. Member Referrals to CM/DM

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers	Latest MHS provider updates and news, as well as online provider enrollment, office and billing address change forms, quality and care gap tools, forms, manuals, guides, online PA tool and tutorials.
mhsindiana.com/health	MHS' Health Library. Click on "KRAMES Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.
mhsindiana.com/login	MHS' Secure Provider Portal lets you submit prior authorization, claims, claim adjustments, and view your panel's medical records and care gaps.
mhsindiana.com/transactions	Information for electronic processing and payment of claims with MHS.

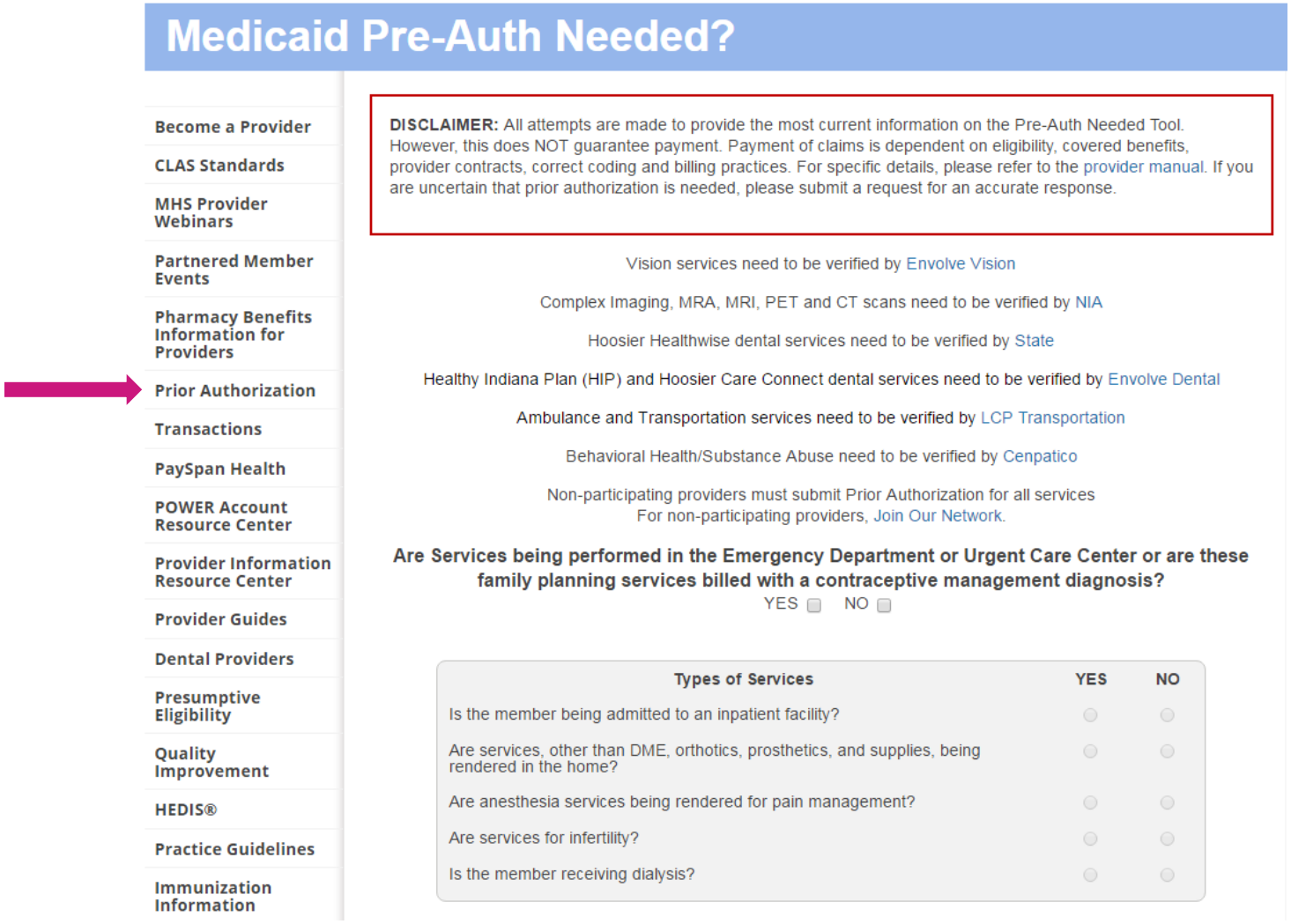
OTHER RESOURCES

payspanhealth.com	MHS is pleased to partner with PaySpan to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment at payspanhealth.com.

You can find out more about the information in this Guide in the MHS Provider Manual, online at mhsindiana.com/providers/resources, or by contacting MHS at 1-877-647-4848.

0720.PR.P.FL.IL 10/20

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 MHS approved training/education materials are posted on the NIA website, RadMD.com. For new users to access these web-based documents, a RadMD account ID and password must be created.

NIA

Outpatient Radiology PA Requests

- MHS partners with NIA for outpatient radiology PA process.
- PA requests must be submitted via:
  - NIA website 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.
- Clinical Policies are available by contacting Turning Point at 1-574-784-1005 for access to digital copies.
- **TRAINING:** Informational webinars are available! Please register at: https://register.gotowebinar.com/rt/7079530369468972290.

Turning Point

Cardiovascular Authorizations

- Managed Health Services has delegated its utilization management function to TurningPoint for cardiac services.
- Services that require prior authorization:
  - Cardiac Surgical Procedures:
    - Automated Implantable Cardioverter Defibrillator
    - Leadless Pacemaker
    - Pacemaker
    - Revision or Replacement of Implanted Cardiac Device
- **Emergent surgeries do not require a prior authorization.**

Web Portal Intake: myturningpoint-healthcare.com Telephone Intake: 1-574-784-1005 | 1-855-415-7482

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

MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in sub-acute 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

Sub-Acute Care cont.

- 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
  - 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.*

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

- 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-no auth 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-no auth required)
- 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: mhsindiana.com/providers/behavioral-health/bhprovider-forms
- 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 Authorization Form
  - Fax Inpatient: 1-844-288-2591; Fax Outpatient: 1-866-694-3649

Behavioral Health Prior Authorization

Limitations on Outpatient Mental Health Services

- As of April 1, 2021 package C Hoosier Healthwise members are eligible for increased benefits.
- MHS follows The Indiana Health Coverage Programs Mental Health and Addiction limitation policy for the following CPT codes that, in combination, are limited to 20 units per provider, per rolling 12-month period.

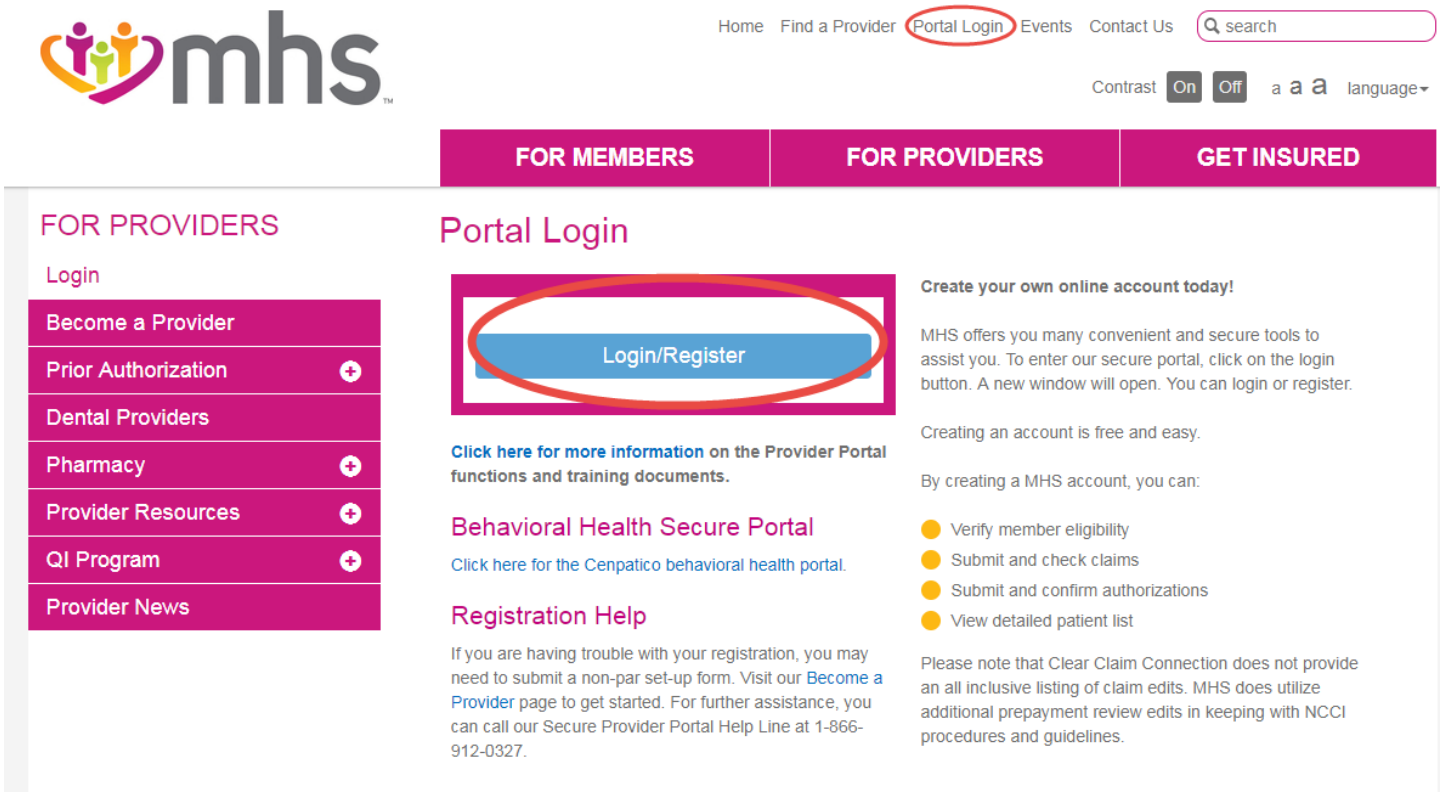
Code	Description
90832 - 90834	Individual Psychotherapy
90837 - 90840	Psychotherapy, with patient and/or family member & Crisis Psychotherapy
90845 - 90847	Psychoanalysis & Family/Group Psychotherapy with or
90849 - 90853	without patient

MHS Secure Provider Portal

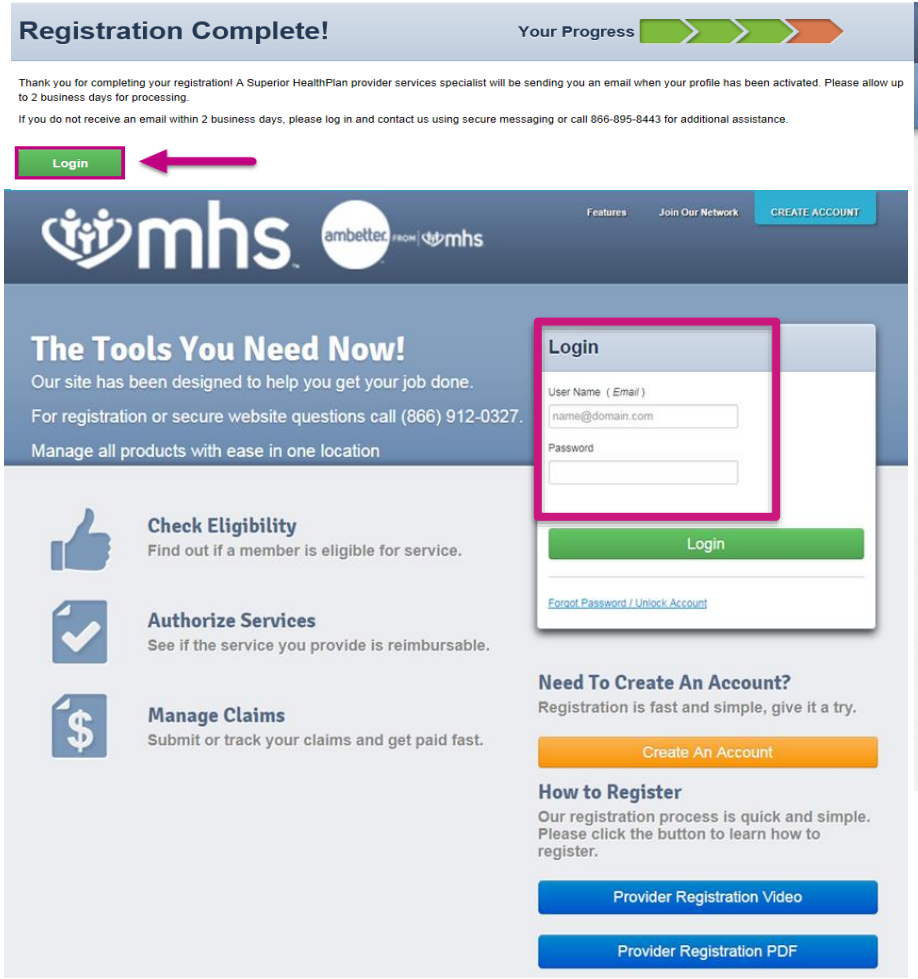
Web Portal Authorizations

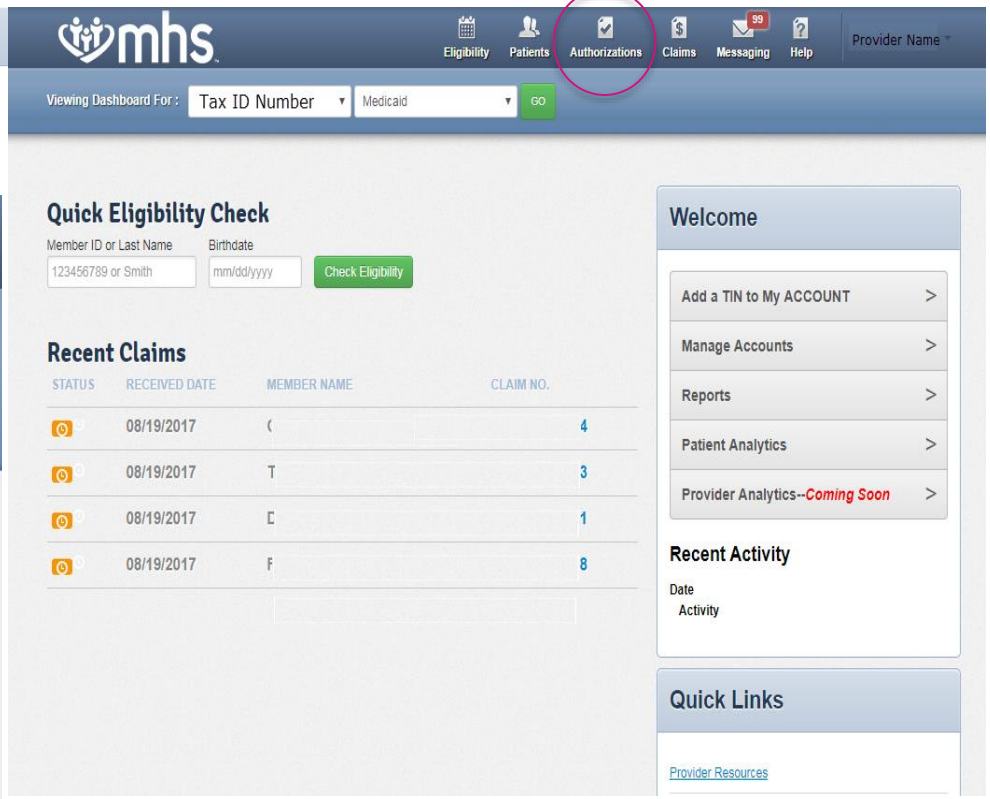
- Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at mhsindiana.com/login.
  - When using the portal, providers can upload supporting documentation directly.
- **Exceptions**: Must submit Inpatient, hospice, home health and biopharmacy PA requests via **fax 1-866-912-4245.**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

Secure Portal Registration and Login



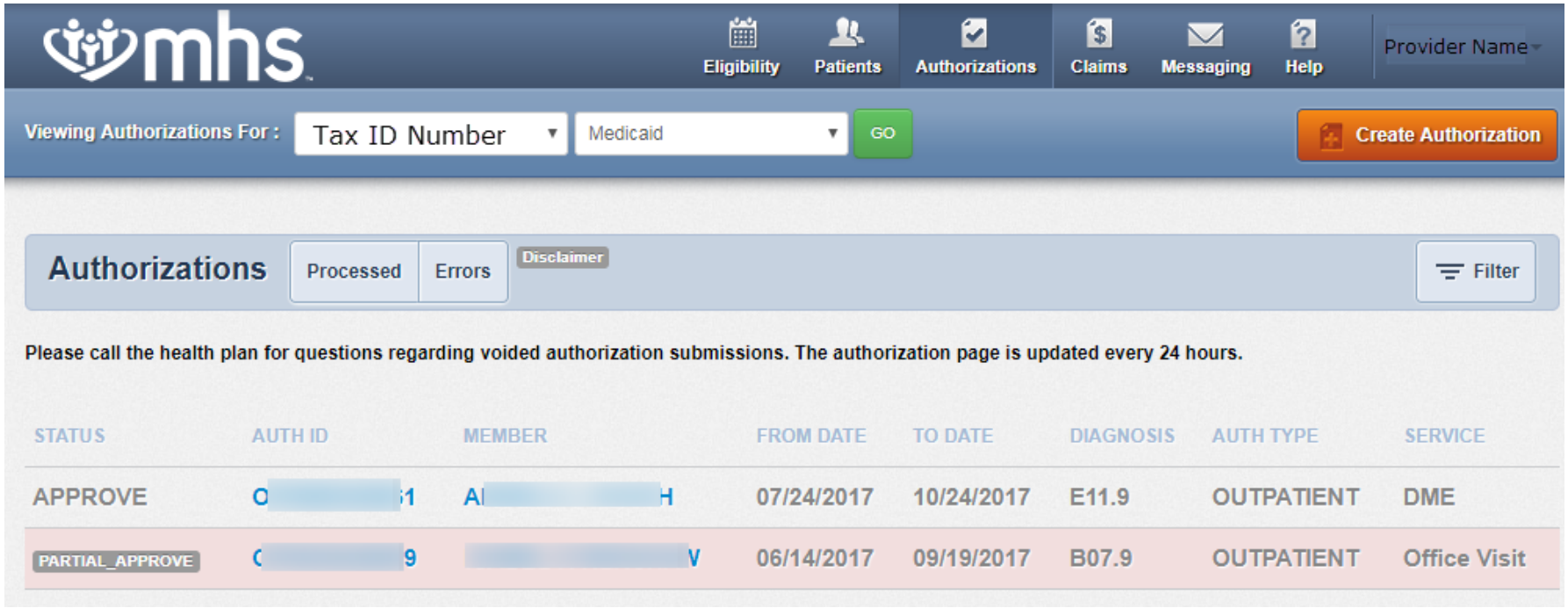
Registration



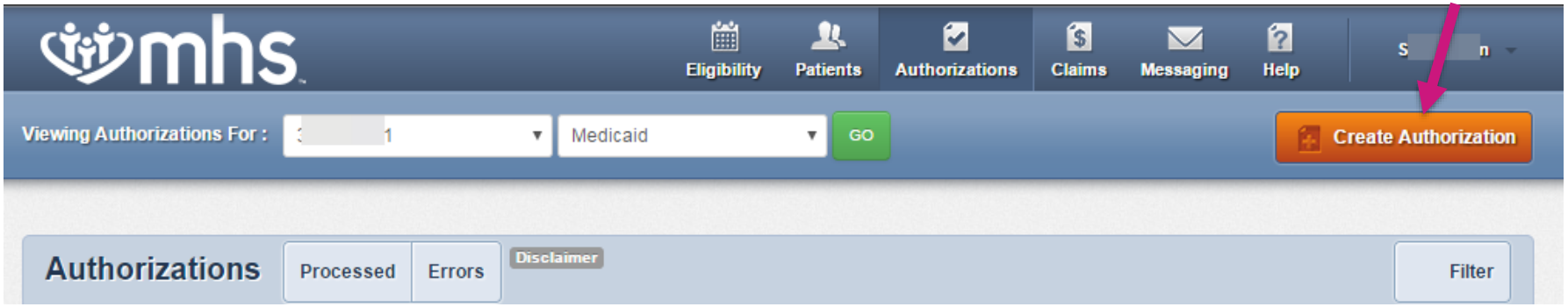


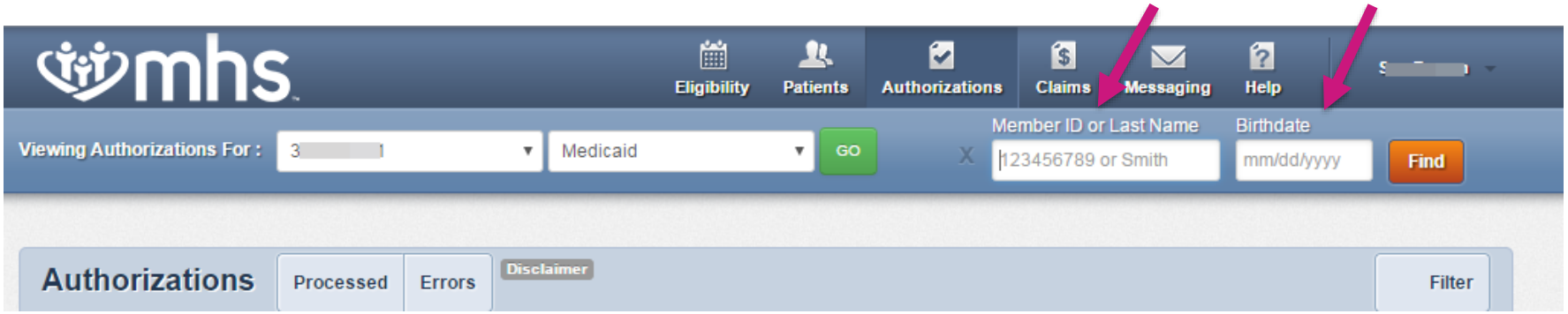
Authorizations:

- View, create and filter group authorizations



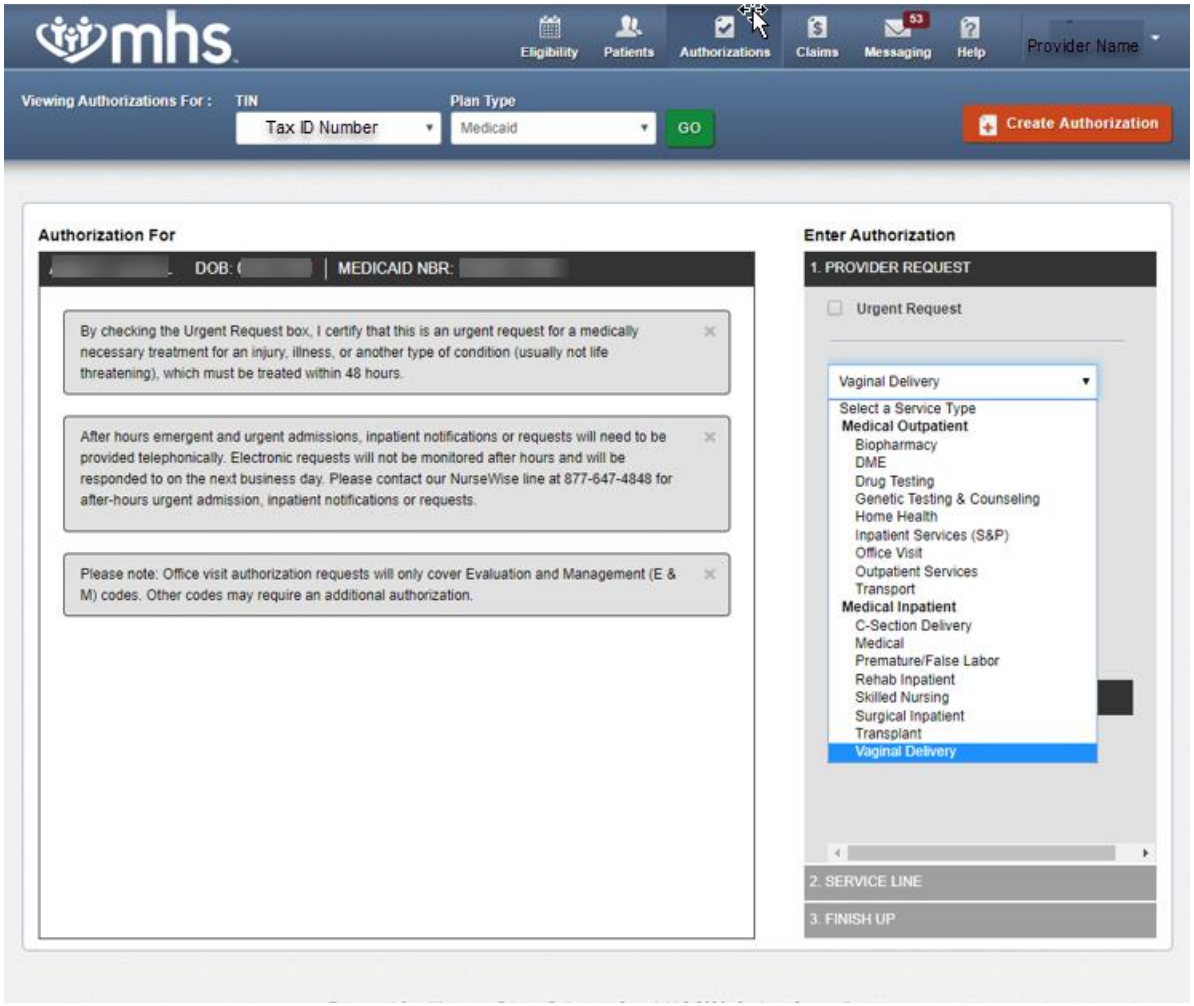
Creating a New Authorization





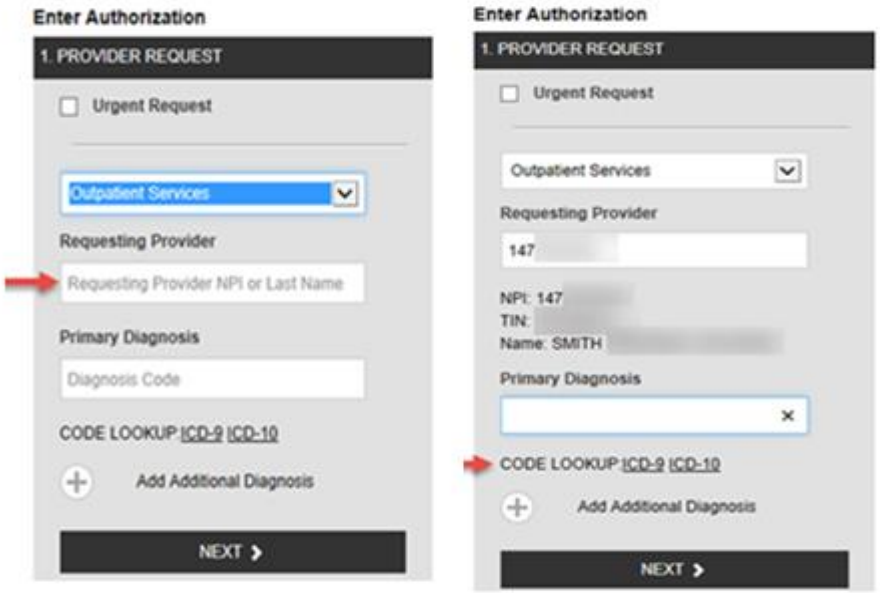
Creating a New Authorization

Select a Service Type



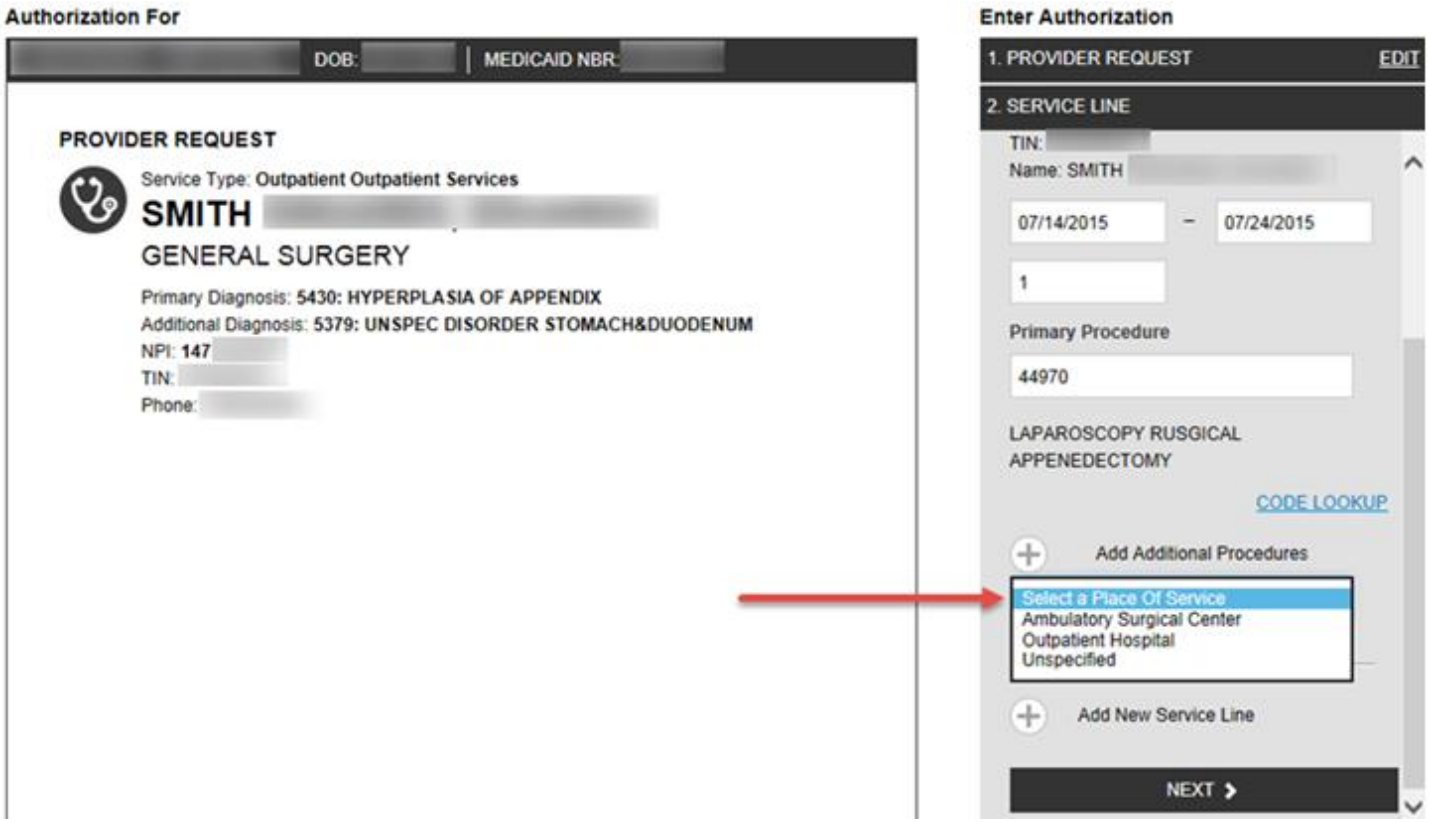
Creating a New Authorization

Select Provider NPI Add Primary Diagnosis



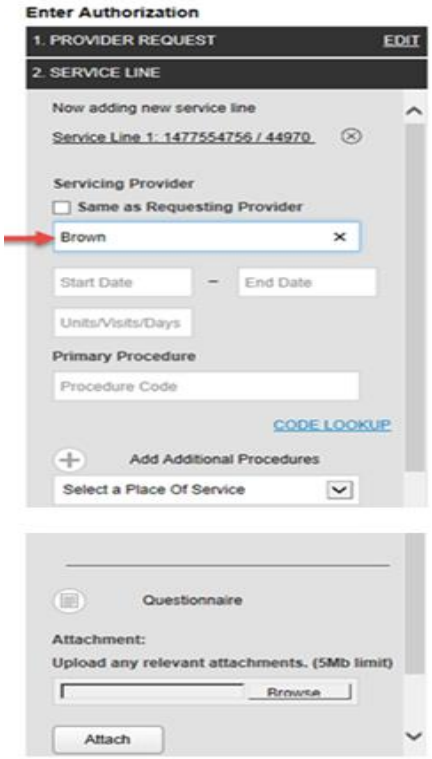
Creating a New Authorization

- If required **Add Additional Procedures**



Creating a New Authorization

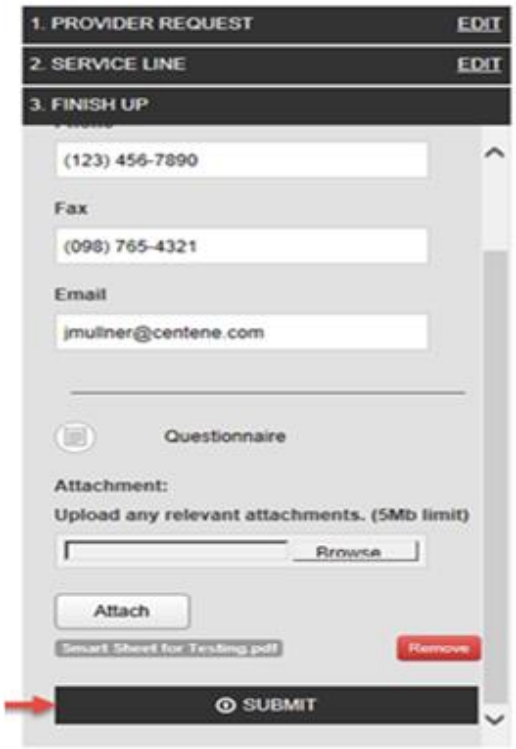
Service Line Details:

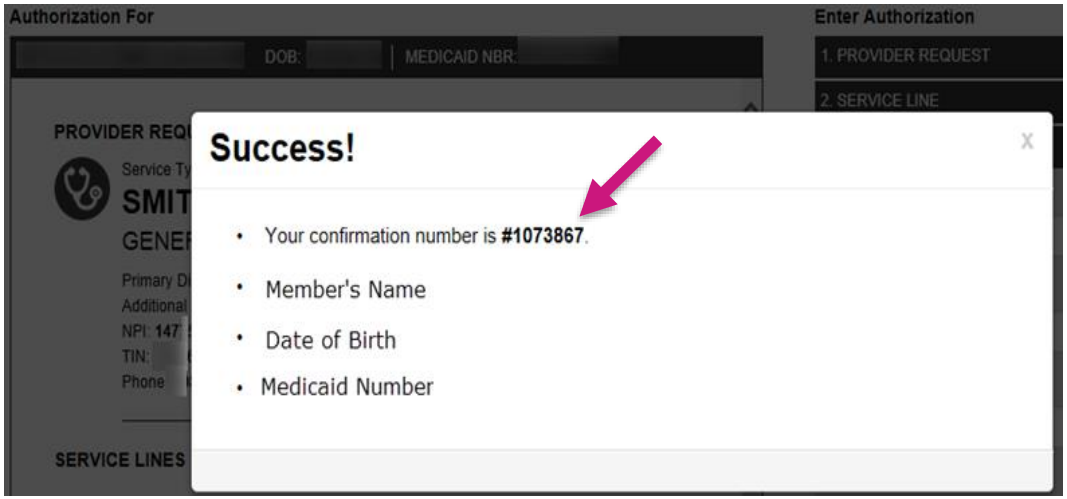


- Provider Request will appear on the left side of the screen.
- Update Servicing Provider:
  - Check box if same as Requesting Provider.
  - Update Servicing Provider information if not the same
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure:
  - Code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

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

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.

Medical PA Denial and Appeal Process

- Send Prior Authorization/Medical Necessity Appeals to:

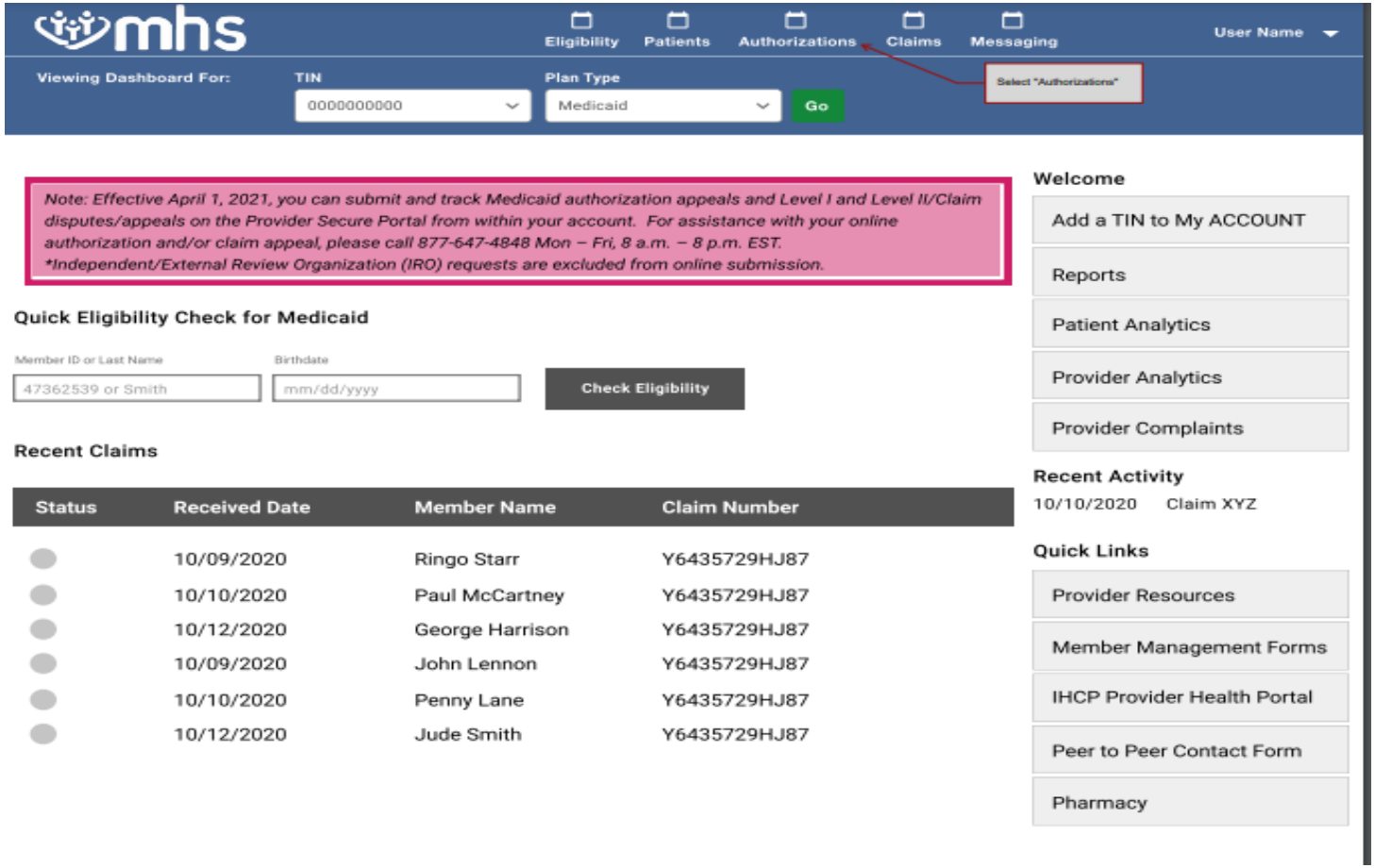
Managed Health Services
Attn: Appeals Coordinator
PO Box 441567
Indianapolis, IN 46244

- 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 **30 calendar days** of receipt.
- ***A prior authorization appeal is different than a claim appeal request.***
- ***This process is applicable to members and non-contracted providers.***

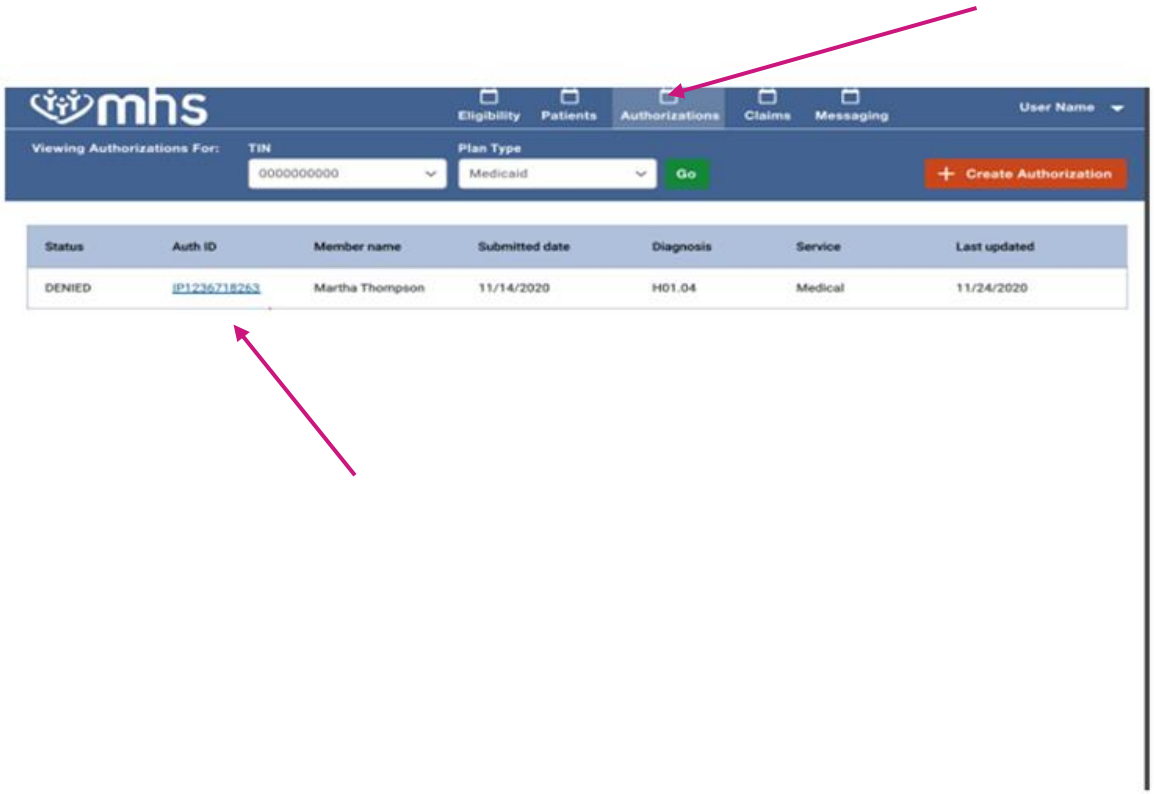
PA/Medical Necessity Appeals on the Provider Secure Portal

- **Effective April 1, 2021**, Medicaid prior authorization/medical necessity denial appeals can be submitted to Managed Health Services (MHS) and will allow tracking of the appeal from submission through decision on the Secure Provider Portal.

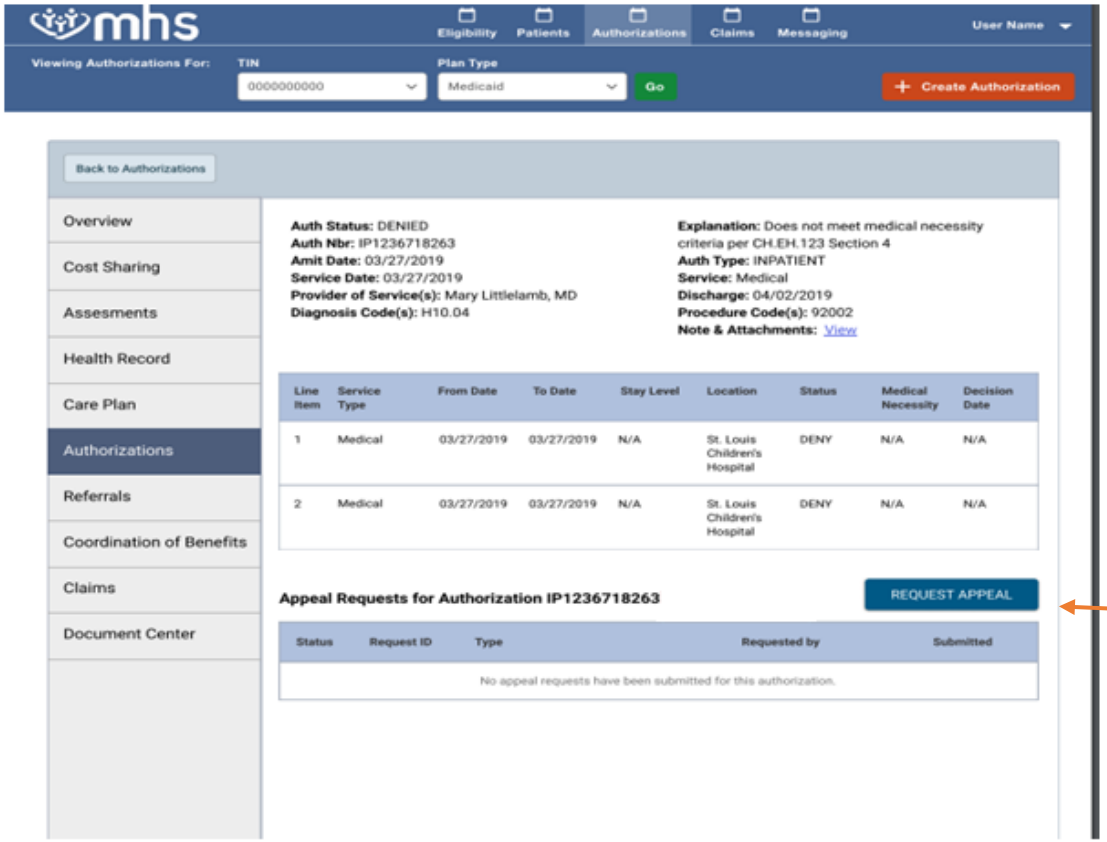
PA/Medical Necessity Appeals on the Provider Secure Portal



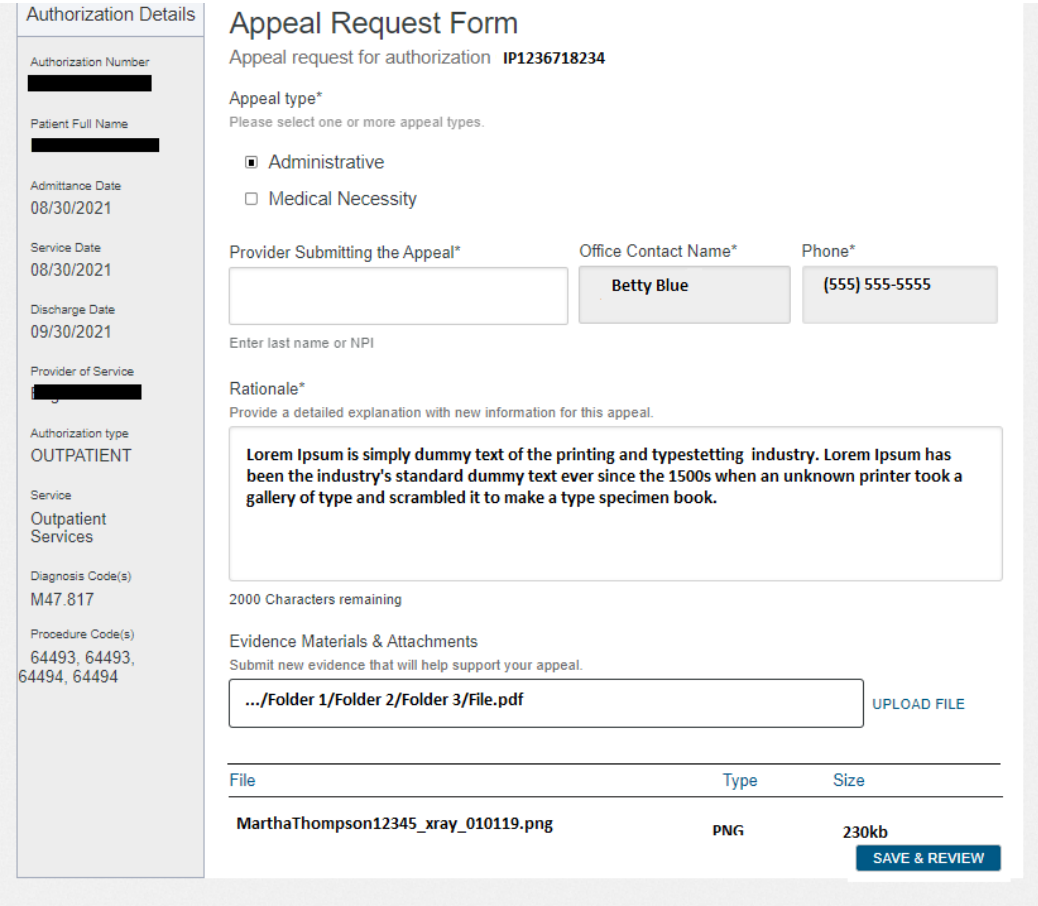
PA/Medical Necessity Appeals on the Provider Secure Portal



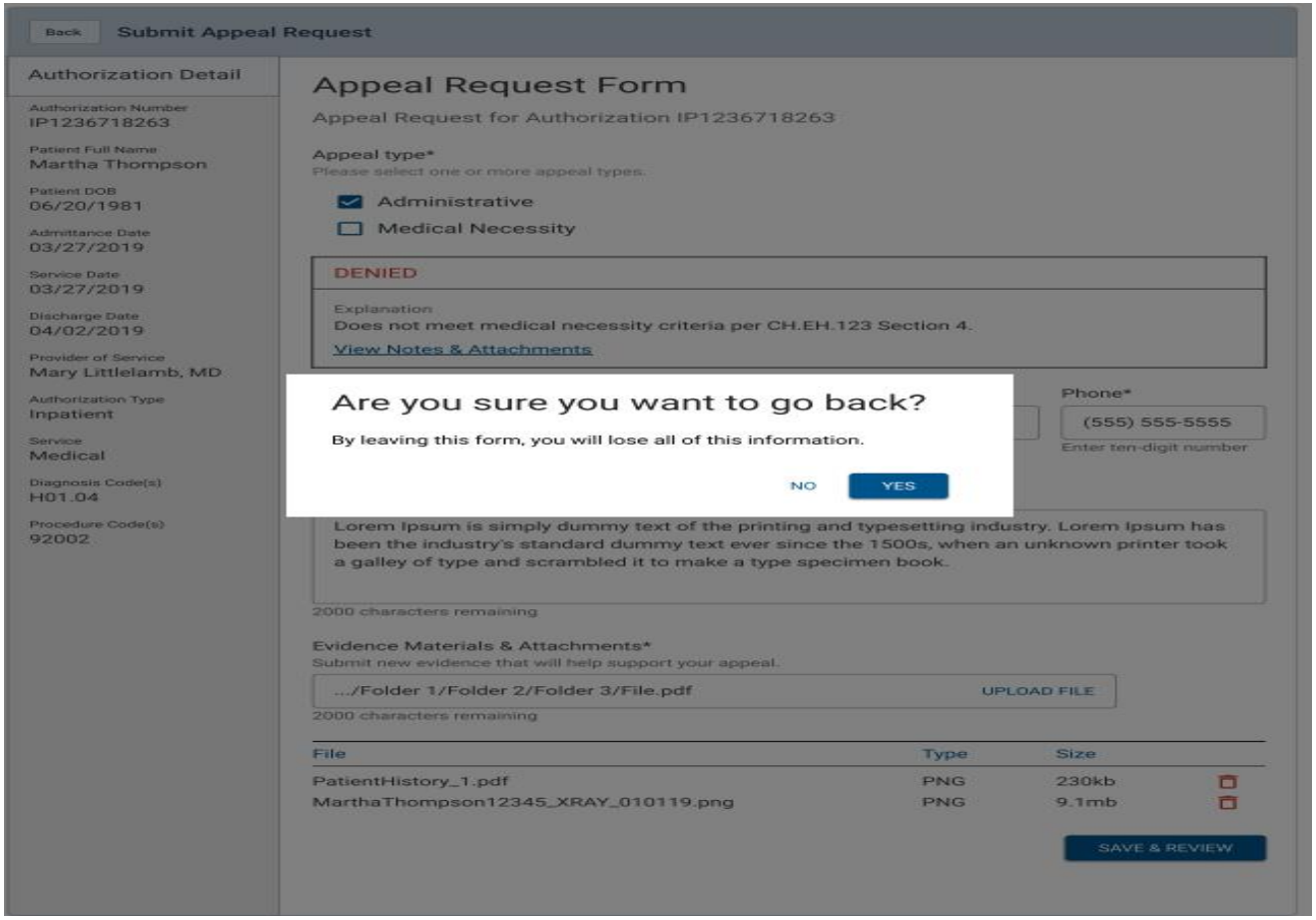
PA/Medical Necessity Appeals on the Provider Secure Portal



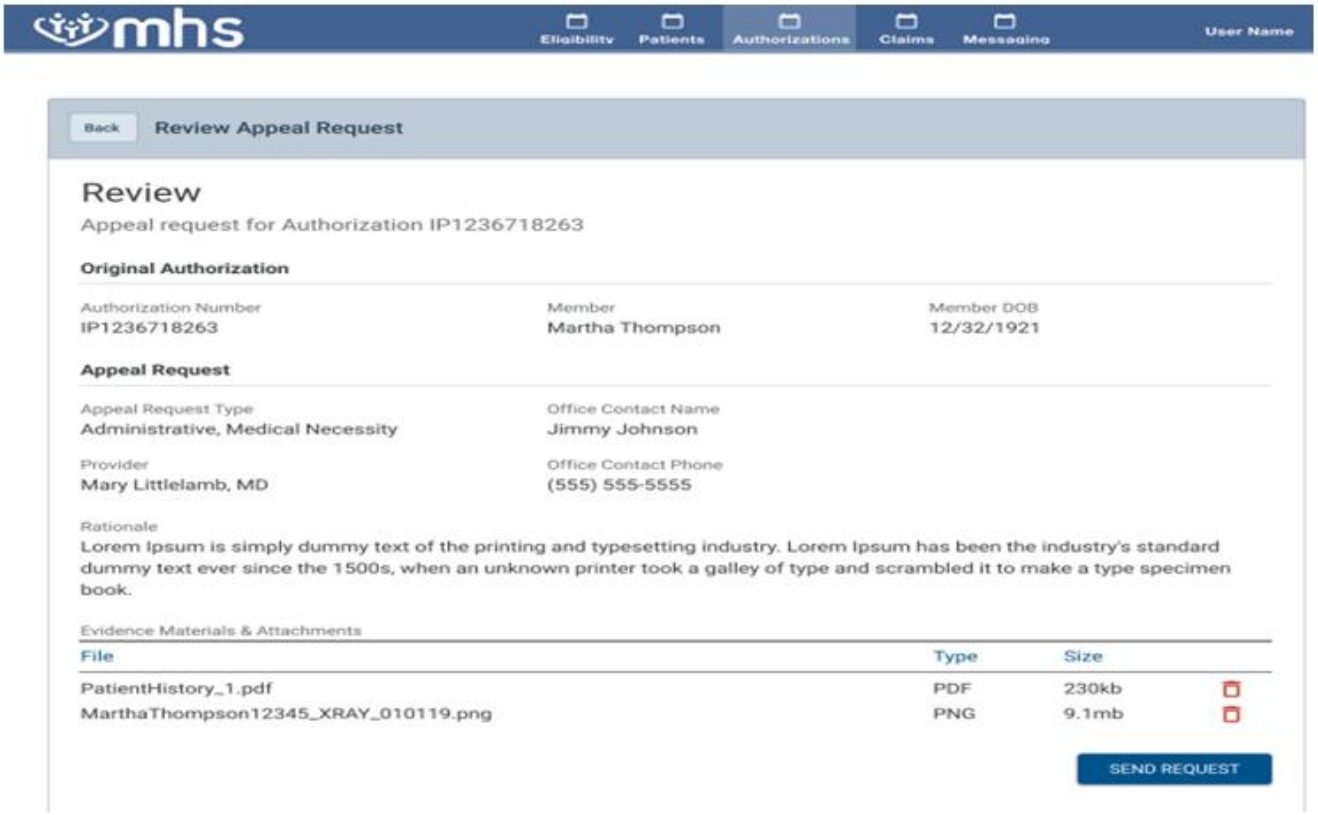
PA/Medical Necessity Appeals on the Provider Secure Portal



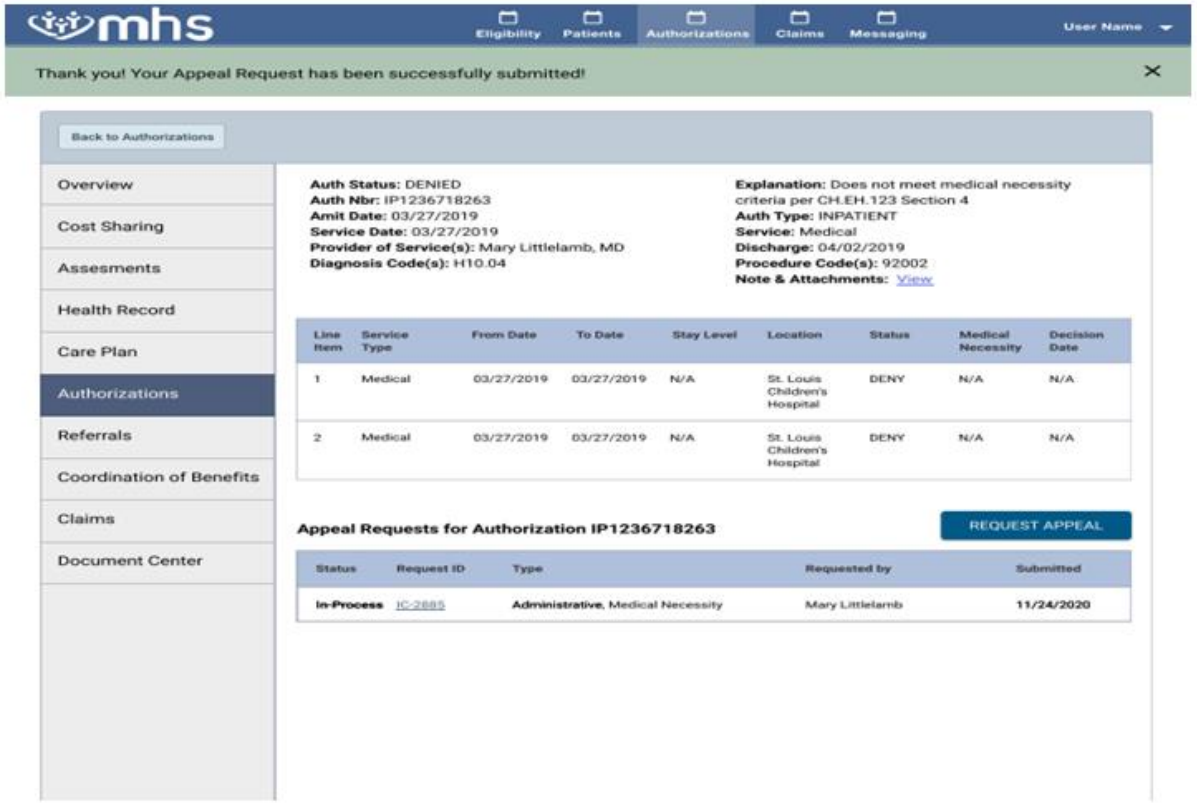
PA/Medical Necessity Appeals on the Provider Secure Portal



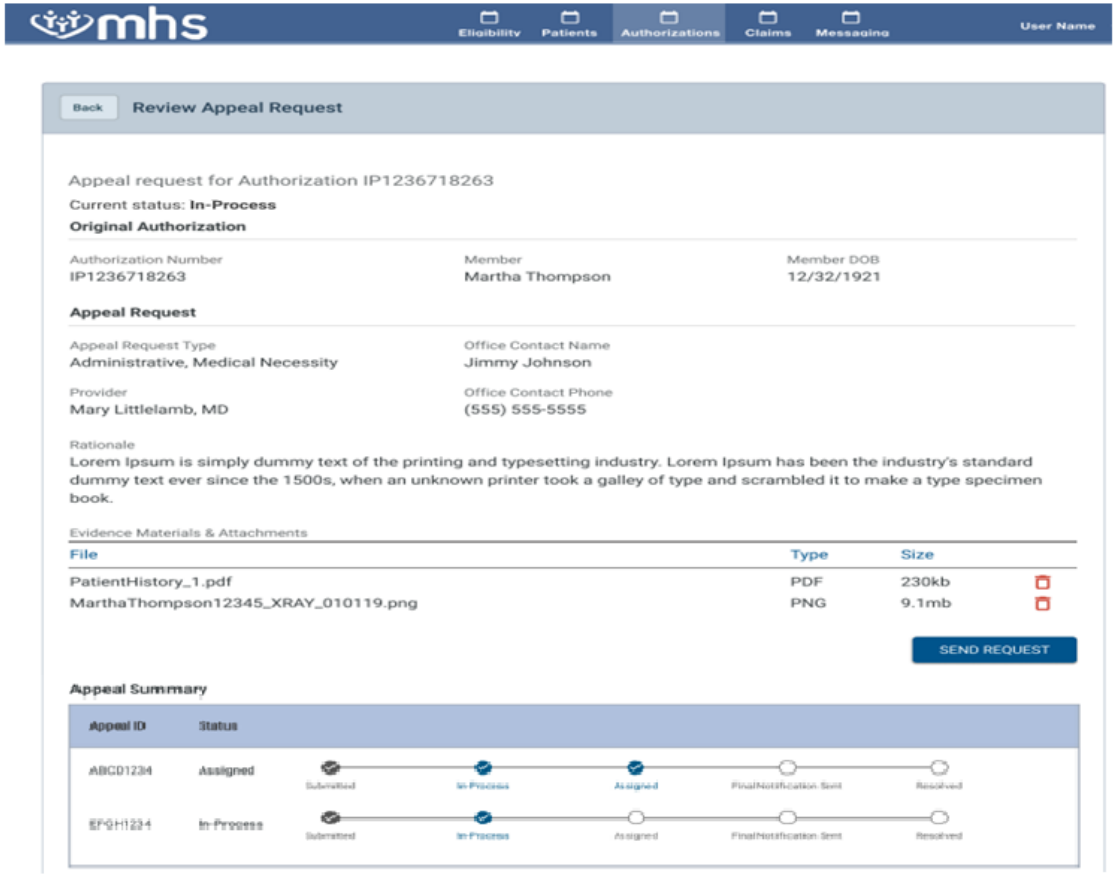
PA/Medical Necessity Appeals on the Provider Secure Portal



PA/Medical Necessity Appeals on the Provider Secure Portal



PA/Medical Necessity Appeals on the Provider Secure Portal



Behavioral Health PA Denial and Appeal Process

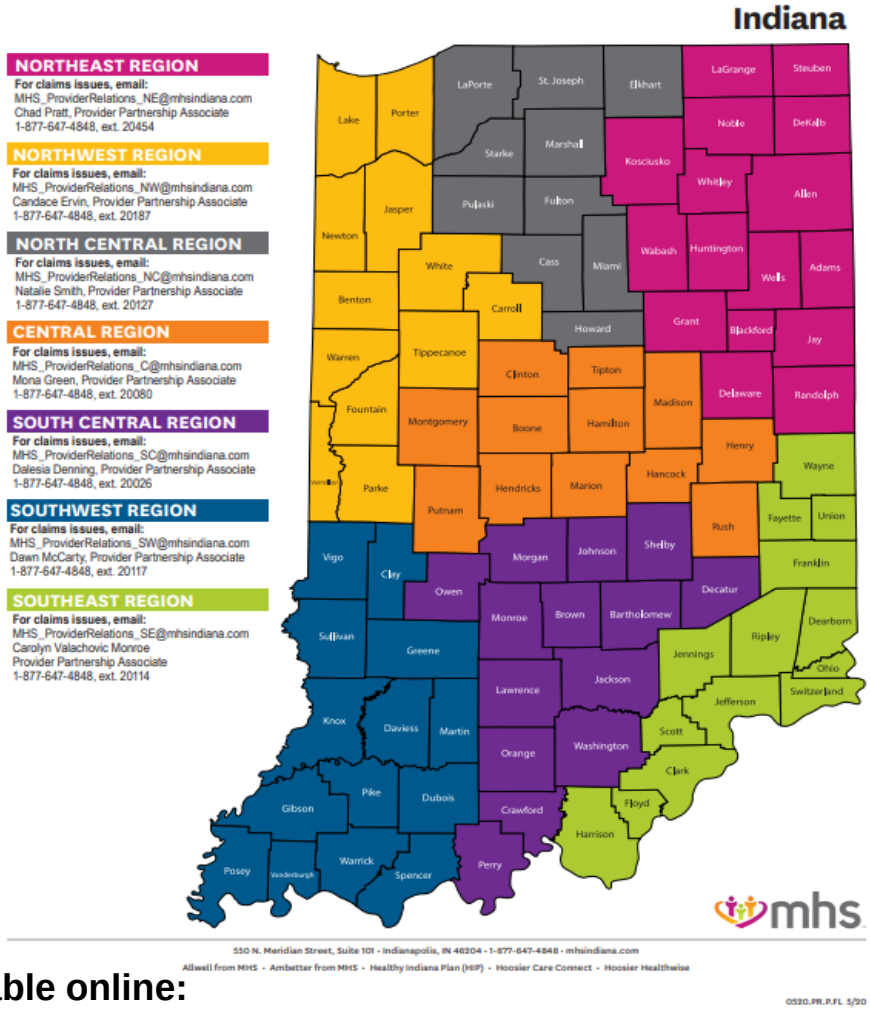
Medical Necessity Appeals

- 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



Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf

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

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
Program Manager,
Provider Engagement
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

ENVOLVE DENTAL, INC.

ANTWAN PEREZ-ALVAREZ
Antwan.Perez-Alvarez@EnvolveHealth.com
Tyneshia James
Tyneshia.James@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

ENVOLVE VISION, INC.

CHANTEL MCKINNEY
Chantel.McKinney@EnvolveHealth.com
Yojani Benitez
Yojani.Benitez@EnvolveHealth.com
Vision Provider Services: 1-844-820-6523
Questions: Envolve_AdvancedCaseUnit@EnvolveHealth.com

Network Leadership

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
1-877-647-4848 ext. 20180
nrobinson@mhsindiana.com

MARK VONDERHEIT
Director, Provider Network
1-877-647-4848 Ext. 20240
mvonderheit@mhsindiana.com

NEW PROVIDER CONTRACTING

TIM BALKO
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

Questions?

Thank you for being our partner in care.