III. PRIOR AUTHORIZATION PROCEDURES

HCE has established workflow procedures to ensure that PA functions are performed in an efficient, accurate, and timely manner. These include procedures for the flow of work from the mail and fax processing area to the PA reviewers, procedures for the performance of all internal PA functions, and procedures for the communication of decisions to members and providers. In addition, procedures have been established for coordination with other departments within HCE, coordination with EDS and OMPP, and communication with providers and members.

There are also mechanisms for modifying procedures when necessary and for establishing new procedures. These mechanisms will ensure that the State and other partners are involved in the policy and procedure development process.

Policies and procedures will be reviewed annually to ensure they remain up to date. This will be the responsibility of the Medical Policy department in collaboration with the Director of Prior Authorization.

The Indiana Administrative Code (IAC 5-3) outlines the provisions under which prior authorization may be provided. Prior to providing any IHCP service that requires prior authorization, the provider must submit a properly completed IHCP prior authorization request (278 transaction or telephone request, for certain services) and receive written notice indicating the approval for provision of the service (approval will be given orally during telephone requests). IHCP will not reimburse any IHCP service requiring prior authorization, which is provided without first receiving prior authorization. The provider is responsible for submitting new requests for prior authorization for ongoing services before the current authorization period expires in order to ensure that payment for service is not interrupted.

Prior Authorization of services is not required under the following circumstances (405 IAC 5-3-12).

- Prior Authorization is not required when a service is provided to an IHCP member as an emergency service. Emergency means a service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:
  - placing the patient's health in serious jeopardy;
  - serious impairment to bodily functions; or
  - serious dysfunction of any bodily organ or part.

Continuation of emergency treatment should be authorized by telephone within 48 hours of the emergency admission.

- Urgent service is defined as the immediate treatment of a medically urgent condition which usually results from complications of a recent illness or injury, marked temperature, prolonged pain, and similar conditions.

- When a member's physician determines that an inpatient hospital setting is no longer necessary, he or she may determine that IHCP covered services (e.g., home health services) should continue after the member has been discharged or transferred from inpatient hospital care. Those services may continue, without prior authorization, for a period not to exceed 120 hours within 30 calendar days of discharge, if the physician has specifically ordered the services in writing upon discharge or transfer from the hospital. This exemption does not apply to durable medical equipment or out-of-state medical services. Prior review and authorization must be obtained for treatment beyond the 120 hours within 30 calendar days of discharge.

  Physical, speech, respiratory, and occupational therapies may continue for a period not to exceed 30 hours, sessions, or visits in 30 calendar days without prior authorization if the physician has specifically ordered such services in writing upon discharge or transfer from the hospital. Prior review and authorization must be obtained for reimbursement beyond the 30 hours, sessions, or visits in the 30 calendar day period for physical, speech, respiratory, and occupational therapies.

  Providers may request authorization for medical services and/or supplies in writing via mail, fax, 278 transactions, or by telephone. All requests for prior authorization are reviewed on a case-by-case basis. Prior authorization requests may be submitted by any of the following: doctors of medicine, doctors of osteopathy, dentists, optometrists, podiatrists, chiropractors, and psychologists endorsed as health service providers in psychology (HSPP), home health agencies, hospitals, or transportation providers.

PA reviewers will rely on established criteria at the first level of review. These criteria are utilized as screening guidelines, and have been approved by the State and formulated through the input of consultants and research of current medical literature. In addition, staff will use the portions of the IAC that delineate guidelines for the approval of services and supplies, and any Bulletins or other directives, written or expressed, approved by the OMPP. Reviewers will be kept informed of any new changes in criteria or rules to enhance the review process.

The review process involves the evaluation of the request utilizing the criteria described above. In the case of procedures, certain services or supplies, the criteria contain indicators that must be present in order for an approval to be made. In the case of ongoing inpatient or outpatient care, the review process involves the evaluation for severity of illness and intensity of service, and for discharge indicators that must be met prior to discharge.

Documentation in the medical records, maintained by the provider, must substantiate the medical necessity for the procedure or service and for the code or description given by the provider. This is subject to post-payment audit and review (405 IAC 5-1-5).

Refer to **Figure III-1** for the Prior Authorization Review Process workflow chart.

FIGURE III-1
PRIOR AUTHORIZATION REVIEW PROCESS

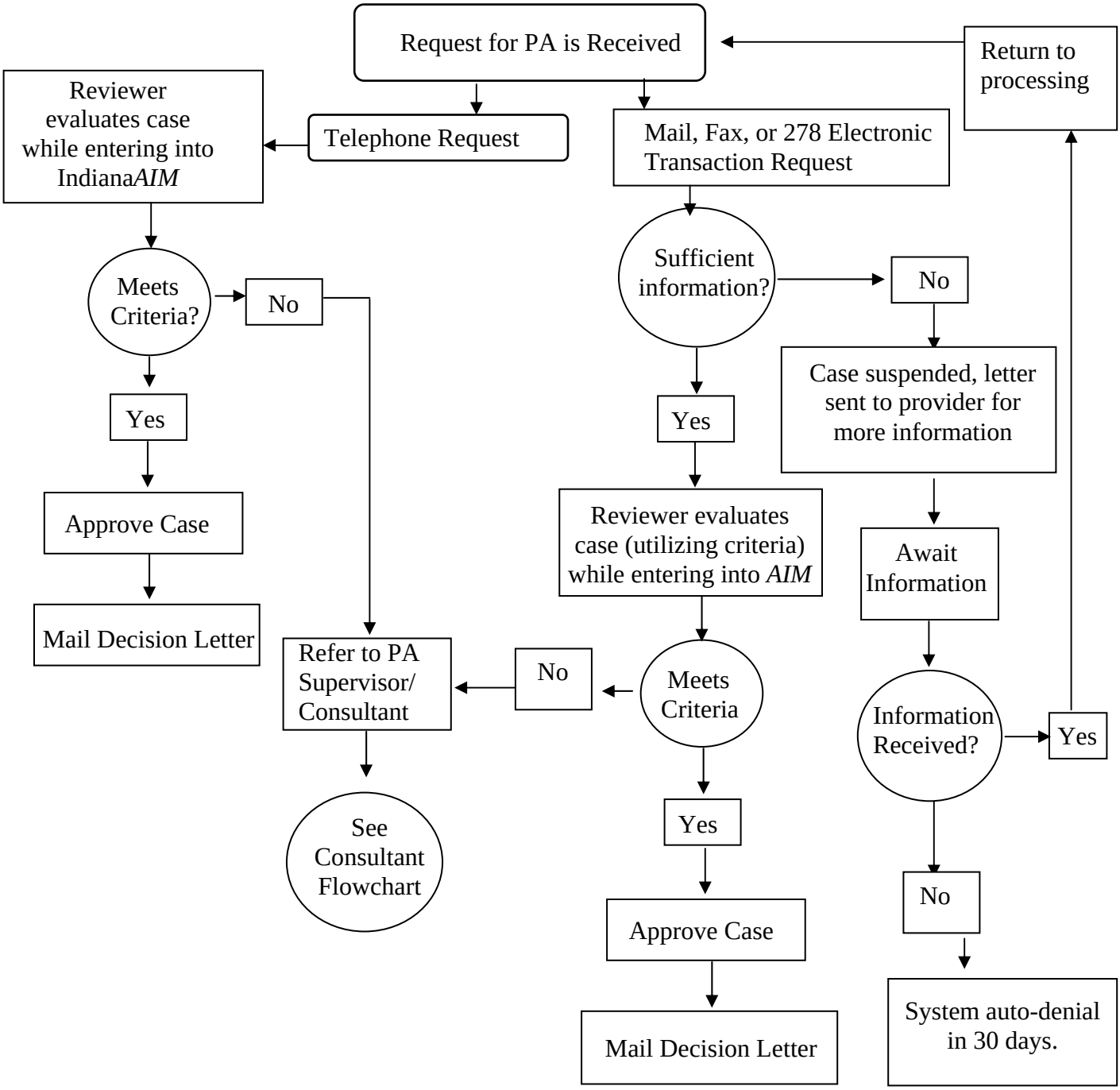
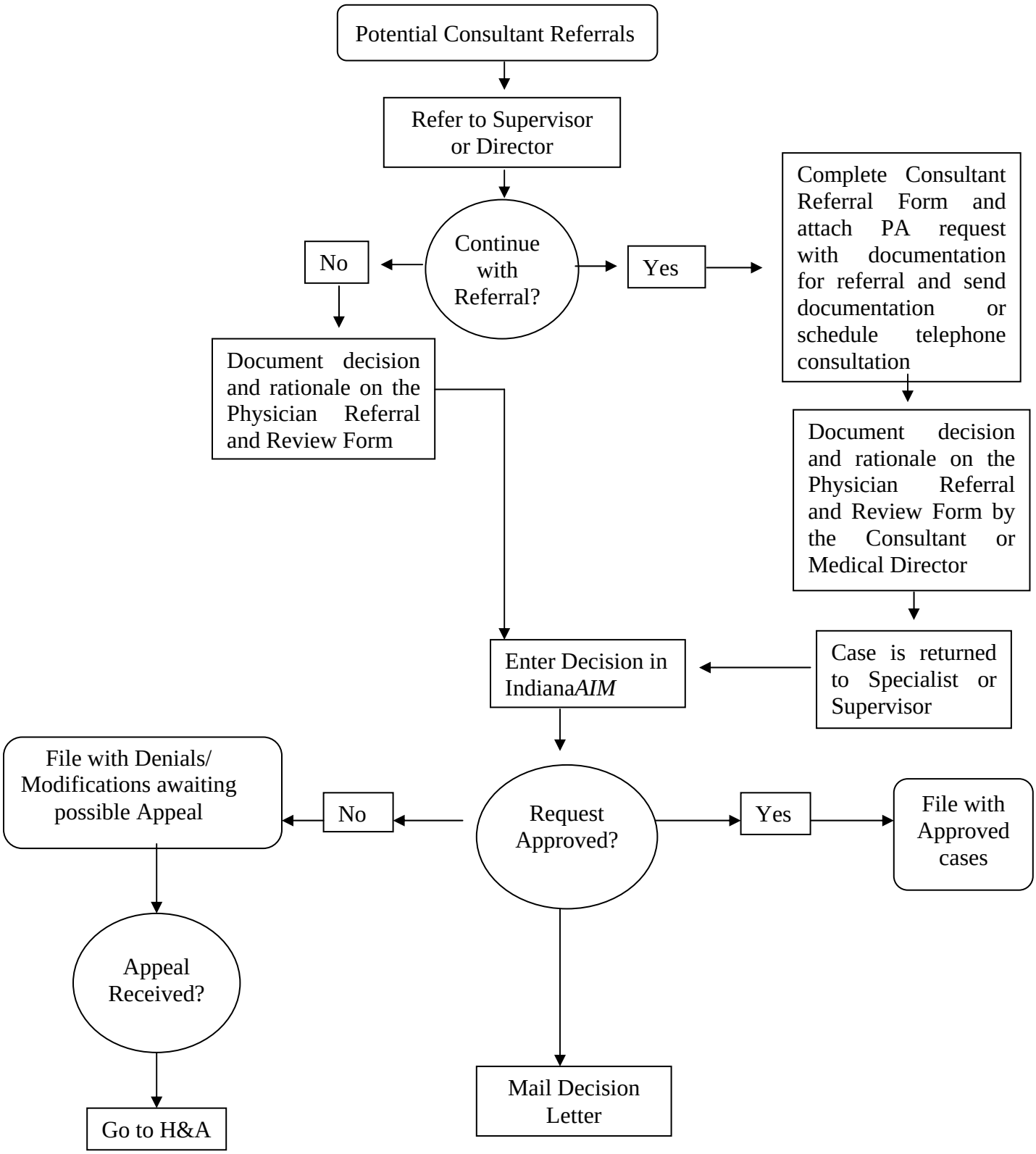


FIGURE III-1 (Continued)
PRIOR AUTHORIZATION REVIEW PROCESS



A. Written Requests

Written requests for prior authorization must meet certain requirements. All requests must be entered into Indiana*AIM* within two business days of the receipt of the request. All requests not adjudicated (completed) within 10 business days are automatically approved.

The requirements include the following (405 IAC 5-3-5).

- Written evidence of physician involvement and personal patient evaluation is required to document the acute medical needs. A current plan of treatment and progress notes as to the necessity, effectiveness, and goals of therapy services, must be submitted with the IHCP prior review and authorization request and/or available for audit purposes.
- All PA requests that are received via the 278 electronic transaction will need to submit by mail all appropriate attachments for that particular request. This will include all medical clearance forms, a plan of care, proof of physicians' signature, and any additional requested information in order for the 278 electronic transaction to be completed.
- For a service requiring a written request for authorization, a properly completed IHCP prior authorization request must be submitted and approved prior to the service being rendered. The following information must be submitted with the written prior authorization request form:
    - name, address, age, and Medicaid number of the member;
    - name, address, telephone number, provider number, and original or stamped signature of the requesting and/or rendering provider;
    - diagnosis and related information (ICD-9-CM code), except for transportation and dental requests;
    - services or supplies requested, with appropriate CPT, HCPCS, or ADA code;
    - name of suggested provider of services or supplies (optional);
    - date of onset of medical problems;
    - plan of treatment with physician's signature;
    - treatment goals

- rehabilitation potential (where indicated);
- prognosis (where indicated);
- description of previous services or supplies provided, length of such services, or when supply or modality was last provided;
- statement of whether durable medical equipment will be purchased, rented, or repaired, and the duration of need;
- statement of any other pertinent clinical information that the provider deems necessary to justify medical necessity;
- additional information that may be required for clarification, including, but not limited to, x-rays or photographs per 405 IAC 5-3-5 (c) (14); and
- results of laboratory tests.

♦ Written requests can include the following optional information or information specific to the type of request:

- diagnoses for transportation and dental providers;
- previous services such as physical therapy, medication regimen, or outpatient rehabilitation treatment; or
- rehabilitation potential for rehabilitation and TBI requests only.

1. Processing of Mailed (Written) Requests for Prior Authorization. (Refer to **Tables III-1** and **III-2**)

   a. Written requests for prior authorization are received via U.S. Mail or may be delivered to HCE by the requesting provider. The HCE mail clerk forwards all written requests to the PA department. The mail clerk is responsible for making sure <u>all</u> mail addressed to the PA department is sorted and delivered to the department at least twice daily.

b. The PA support specialist will open the request and evaluate to ensure that the request contains the necessary information. The support specialist must assess all prior authorization requests for completeness. If required information is missing, the support specialist will return the request to the provider with a letter of explanation. Prior authorization request forms must contain the following information or the request will be returned to the provider.

- Requesting and rendering provider.
- Member number.
- Provider signature.
- Service code.
- Requested dates of service, units or dollars.
- Clinical summary.
- The request must be submitted on the Prior Authorization Request form found in the Indiana Medical Assistance Provider Manual.
- Medical clearance form, if applicable. (Refer to c. below.)

If the requesting provider information is present, the rendering provider information is optional. The provider information listed in the first box on the PA form, whether it is the requesting or rendering provider, will be entered on the initial PA screen and the PA Decision letter will be mailed to this provider.

c. Medical clearance forms must be submitted to justify the medical necessity of designated durable medical equipment (DME) or medical supplies when requesting prior authorization. DME or medical supplies that require medical clearance forms when requesting prior authorization include, but are not limited to:

- audiometric DME (hearing aids);
- non-motorized wheelchairs;
- motorized wheelchairs;

- transelectrical neurostimulator (TENS) units;
- augmentative communication systems;
- Certificate of Medical Necessity (CMN): Parenteral or Enteral Nutrition and/or;
- Certificate of Medical Necessity (CMN) for Home Oxygen Therapy;
- Hospital beds and specialty beds (CMN);
- Standers (CMN);
- Negative Pressure Wound Therapy (CMN).

d. Properly completed requests are sorted by assignment group (e.g., home health, transportation, DME, etc.).

e. The requests are placed in folders of approximately 50 requests per folder. The front cover of the assignment folder is date stamped, labeled with the assignment group code and the quantity of prior authorization requests in that folder. Any system update requests for an assignment group are added to the front of the folder.

f. The assignment folders are moved to the data entry staging shelves and placed in the coinciding assignment bin. This staging area is divided and labeled into day one and day two staging. A designated support specialist is responsible for monitoring the movement of aging day one assignment folders to day two. This allows for the oldest assignment folder to always be completed first.

g. All requests must be entered into the Indiana*AIM* system within two business days of receipt.

h. The data entry support specialist will retrieve assignment folders from the staging area always retrieving from the day two staging first and then day one when day two is complete.

i. Each paper request, and all related attachments, will be manually assigned a sequential prior authorization number by the PA support specialist.

j. All 278 attachment forms will be divided into assignment groups and processed with the regular PA inventory. All attachments without an attachment number will be returned to the provider.

k. Telephone and faxed requests will be manually assigned a 10 digit PA number by the prior authorization reviewer. The PAs received via the 278 electronic transaction will have a PA number automatically assigned to the request. Each support specialist and reviewer will have an assigned range of numbers with which to assign the PA numbers and will maintain a log of each assigned PA number. The logs will be kept for not less than three months. (Refer to **Table III-3**).

l. The PA number is made up of a logical sequence of numbers to identify the year, day of the year and delivery mechanism of the request, using numerically sequential digits to monitor the volume of requests on that particular day.

For example, the number 9-233-1-02-000 would indicate the following:

- 9 = year (1999) (or 8 =1998),
- 233 = August 21 (the 233rd day of 1999 – this is the Julian Date – most desk calendars are labeled with this date),
- 1=Paper request, 2=Telephone request and 3=Faxed request,
- 02 = the PA support specialist or reviewer unique identification number,
- 000 = the first request received for that day, 001 the second request, etc.

This method of number assignment enables the tracking of the exact date and method of transmission of each request, as well as the number of requests processed on a given day.

m. The data entry staff will enter the following information:

- Recipient Identification (RID) Number;
- requesting provider identification number;
- PA number;
- diagnosis code;
- requested procedure code or revenue code;
- dates of service requested; and
- number of units or dollars requested.

Indiana*AIM* will automatically populate the names and mailing addresses for both the member and the provider for mailing purposes. When the provider is a Non-Medicaid Provider, the support specialist must click on the "Non-Medicaid Provider" box and enter the license number of that provider.

Requests received for members enrolled with Risk-Based Managed Care (RBMC) or Primary Care Case Management (PCCM), including Package C (CHIP) will be identified by the program description field on the initial Prior Authorization window in Indiana*AIM* (**Figure III-11**). The program description field will populate with the corresponding initials (RBMC, PCCM, or Package C) indicating the program in which the member is enrolled. All services for members enrolled in the PCCM program, including Package C, will be reviewed for medical necessity by HCE.

When a member switches from RBMC to traditional Medicaid, all services previously authorized by RBMC will be honored by the PA department for 30 days. In addition, HCE will process requests for RBMC members for the following services:

- Dental
- Mental Health Services (excluding inpatient admissions to acute hospital facilities)

All other requests received on behalf of RBMC members will be returned to the requesting provider with instructions to forward the requests to the correct Managed Care Organization (MCO).

n. Those prior authorization requests that exceed the number of line items allowed on the request form will be assigned a second sequential prior authorization number to accommodate the full request

o. The Indiana*AIM* system will allow duplicate services to be entered. Once the reviewer enters a decision of approved or modified in the decision line, the system will then direct the reviewer to the duplicated PA request. The PA reviewer will automatically review all miscellaneous unspecified codes for duplicate services. If the duplicate code is for a specific service, the PA reviewer will refer to the PA history to insure the service is not an actual duplicate of the requested service by comparing the dates and internal text.

p. Upon completion of data entry, each folder is numbered with the range of numbers included in the folder (e.g., 9233100001 – 9233100049). The support specialist will enter the range of numbers onto a personal log sheet (refer to **Table III-3**), for verification of contract compliance, and will place the folder in the reviewer staging area assignment shelves. This staging area is divided by assignment group and day two through 10 aging. This allows for easy visual inventory and assessment of prior authorization aging.

q. Following completion of the review, all written requests for prior authorization are returned to the support specialist for filing numerically for future reference.

r. Decision letters are mailed within 24 hours (one business day) to the member and the requesting <u>or</u> the rendering provider.

TABLE III-1

PROCEDURE/PROCESS: MAILROOM PROCEDURES

No.	Description of Activity	Responsible Party
1.	Mail is received in the HCE mailroom and delivered to the PA department twice daily.	HCE Mailroom Staff
2.	Mail is opened and the request is evaluated to ensure the PA contains the necessary information.	Data Entry Support Specialist
3.	Requests that are incomplete are returned to the provider with a letter of explanation.	Data Entry Support Specialist
4.	Completed requests are sorted by type of service (e.g., home health, transportation, DME, etc.).	Data Entry Support Specialist
5.	The requests are placed in folders of approximately 50 requests per folder.	Data Entry Support Specialist
6.	The folder cover is date stamped and labeled with the assignment group code and quantity of requests in the folder.	Data Entry Support Specialist
7.	Each request will be entered into the Indiana*AIM* system within two days of receipt.	Data Entry Support Specialist
8.	Each paper request and attachment is manually assigned a 10 digit PA number.	Data Entry Support Specialist
9.	Each folder is labeled with: ◆ the range of numbers included in the folder, ◆ the PA assignment group, ◆ quantity of PAs contained in the folder, ◆ date the requests were received, and ◆ date the requests were entered in Indiana*AIM*.	Data Entry Support Specialist
10.	The folder is placed on the shelf in the PA reviewer staging shelves.	Data Entry Support Specialist
11.	Following review of the entire folder, the PA reviewer will label the folders with the review date.	PA Reviewer
12.	Each folder will be labeled with the inventory filing date following completion by the PA reviewer.	Data Entry Support Specialist
13.	All requests are filed numerically for future reference.	Data Entry Support Specialist

TABLE III-2

PROCEDURE/PROCESS: ENTRY OF NEW PRIOR AUTHORIZATION SUBMITTED ON PAPER (MAIL)

No.	Description of Activity	Responsible Party
1.	Mailed requests are entered into Indiana*AIM* within two business days of receipt. The information entered includes: RID number, requesting or rendering provider ID number, PA number, diagnosis code, requested procedure code, dates of service requested, and number of units requested.	Data Entry Support Specialist
2.	The PA request and any attached documentation is reviewed and a determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria. Review previous PA history to determine if requested service has been previously requested and decision for that request.	PA Reviewer
3.	The approved dates of service, approved units, dollars, if applicable, and the decision are entered on the bottom line of the "line item."	PA Reviewer
4.	Repeat step 3 for each line item requested.	PA Reviewer
5.	Update the "Internal Text Screen" and enter all pertinent clinical information including signs, symptoms, precipitating factors, progress, regression, previous PA history for the same service, availability of caregivers for home health requests, or most recent authorization(s) for DME requests.	PA Reviewer
6.	If intensity of service is being reduced from the last PA request, the internal text is updated with the explanation of why and the "suggested" reduction plan is documented.	PA Reviewer
7.	If the requested service is being denied, the internal text is updated with an explanation of why.	PA Reviewer

TABLE III-2 (Continued)

PROCEDURE/PROCESS: ENTRY OF A NEW PRIOR AUTHORIZATION SUBMITTED ON PAPER (MAIL)

No.	Description of Activity	Responsible Party
8.	The initials of the reviewer are entered into internal text.	PA Reviewer
9.	The external text screen is updated including the appropriate IAC and any other additional information that contributed to making the final decision if the request was not approved as requested.	PA Reviewer
10.	"Batch Print" to generate a decision letter to the requesting or rendering provider and member.	PA Reviewer
11.	Mark the PA Request with the appropriate decision such as "A" for approved, "M" for modified, to indicate the request was reviewed and is complete.	PA Reviewer
12.	Save and proceed to the next PA request.	PA Reviewer
13.	Return the folder of completed PA requests to the top shelf of the metal file cart in the center aisle of the PA department for inventory and filing.	PA Reviewer

B. Faxed Requests

Inpatient psychiatric facilities, psychiatric units in acute hospitals or inpatient acute care rehabilitation hospitals, approved by HCE, have the opportunity to submit requests for psychiatric, substance abuse, and acute rehabilitation admissions or concurrent reviews via fax. Typically, these facilities treat a high volume of Indiana IHCP members and the request for prior authorization may be quite lengthy and detailed. The facilities have been provided standardized fax forms, approved by the Office of Medicaid Policy and Planning. The forms must be used to provide the specific information needed to perform a comprehensive review of the request. (Refer to **Table III-5** for a list of facilities that currently fax requests and **Exhibits VI-1 and VI-2,** for samples of forms).

TABLE III-5
FACILITIES WITH PRIOR AUTHORIZATION FAXING PRIVILEGES

HOSPITAL	FAX NUMBER
Ball Memorial	765-747-8406
Bloomington	812-336-9219
Charter Beacon	219-461-5890
Clarian Health Partners	317-929-8448
Columbus Regional	812-376-5443
Community North	317-588-7864
Good Samaritan Hospital, Vincennes	812-885-3928
Lindenview/Parkview	219-480-5017
Memorial South Bend	219-284-7394
Methodist North Lake	219-886-5022
Oaklawn Psychiatric Center	219-534-0157
St. Catherine	219-392-7589
St. Francis	317-782-6929
St. Margaret	219-864-2175
St. Vincent Stress Center	317-243-2789
Wishard Health Services	317-630-8007

Faxed requests may be received at any time during the day or night at the HCE office. Faxed requests are scanned and retained on disk as they are received. Faxed requests must be reviewed, decisions made, and the decisions returned to the requesting provider via fax within 48 hours (two business days) of their receipt. Requests that are received after the close of business (6:00 p.m.) are considered as received on the next business day. For example, a request received at 6:30 p.m. on Friday will be considered as received at 7:30 a.m. on Monday; therefore, the reviewer must render a decision and notify the provider of the decision by 7:30 a.m. on Wednesday.

All requests for prior authorization are reviewed on a case-by-case basis. The decision is rendered based on the submitted documentation and the predetermined rules and criteria approved by the Office of Medicaid Policy and Planning.

Psychiatric facilities have 48 hours (two business days) from the date of an emergency admission to submit the faxed request form. The faxed form should contain all of the information necessary to establish the necessity of the emergency admission.

Days are entered into the Indiana*AIM* system as "pending" for both inpatient psychiatric care and for substance abuse admissions, until such time as the provider submits the completed "Certification of Need for Admission" or 1261A. If the completed 1261A is submitted within the stated time and supports the need for the emergency admission, the "pending" days are changed to approved. If the 1261A does not support the need for the admission or is not timely, the "pending" days are denied following the normal review process. (Refer to **Section III-K** for the procedure for processing the 1261A.)

Rehabilitation hospitals must submit faxed request forms prior to the admission. Admissions most commonly occur when members are transferred from an acute care facility or another rehabilitation facility, thus, are not considered to be "emergency" admissions. The State approved form provides for all information pertinent and necessary to conduct the review and render a decision.

1. Support Staff Processing of Faxed Requests for Prior Authorization

    a. All faxed requests, and any attachments, are collected each morning, and as needed throughout the workday, by a support specialist. Requests are sorted according to the type of service and facility. Faxed requests should be expedited.

    b. Each request is assigned a PA number utilizing the 10 digit numerical assignment procedure described in **Section III-A-1-k.**

    c. All faxes must be placed in a folder labeled with the date the faxes are received. (Currently, only inpatient psychiatric facilities, psychiatric units in acute hospitals, and inpatient rehabilitation facilities have fax privileges.)

d. The folders are placed in the PA fax staging area. The folders are distributed to the appropriate reviewer by the PA Supervisor throughout the day. A decision must be made within 48 hours (2-business days), so it is important that all faxed requests are forwarded to the reviewers promptly.

e. After the PA reviewer evaluates the documentation and enters the decision into Indiana*AIM*, the documents are returned to the support specialist, who faxes the decision form to the requesting facility and then files the faxed requests. These files are kept in close proximity to the Prior Authorization department for at least six months from the date of the original request in the event an appeal is filed, then are moved to remote storage and retained in compliance with the Approved Records Retention and Disposition Schedule.

Refer to **Table III-6** for a step-by-step process of Entry of New Prior Authorization Submitted on Paper (Fax) and **Exhibit VI-16,** for PA Fax Communication form.

TABLE III-6

PROCEDURE/PROCESS: ENTRY OF NEW PRIOR AUTHORIZATION SUBMITTED ON PAPER (FAX)

No.	Description of Activity	Responsible Party
1.	Faxed requests and any attachments are collected each morning and as needed throughout the workday.	Support Specialist
2.	Requests are sorted by type of service and facility.	Support Specialist
3.	Each request is assigned a 10 digit PA number.	PA Reviewer
4.	Requests are placed in folders labeled with the date the fax was received and placed in the fax staging area.	Support Specialist
5.	The folders are distributed to the appropriate reviewer(s) by a supervisor. A decision must be made within 48 hours.	PA Supervisor
6.	The rendering provider ID number is entered in the provider ID box.	PA Reviewer
7.	The Recipient Identification (RID) number is entered in the RID No. box.	PA Reviewer
8.	The PA number is entered in the PA number box.	PA Reviewer
9.	The requested type of service is entered in the PA assignment box.	PA Reviewer
10.	The numeric diagnosis code(s) is entered in the diagnosis box.	PA Reviewer
11.	Enter each line item requested including the procedure code(s), dates of service and the number of units requested.	PA Reviewer
12.	The PA request and any attached documentation is reviewed and a determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria.	PA Reviewer
13.	Review previous PA history to determine if requested service has been previously requested and decision for that request.	PA Reviewer

TABLE III-6 (Continued)

PROCEDURE/PROCESS: ENTRY OF NEW PRIOR AUTHORIZATION SUBMITTED ON PAPER (FAX)

No.	Description of Activity	Responsible Party
14.	The approved dates of service, approved units or dollars, and the decision are entered on the bottom line of the line item.	PA Reviewer
15.	Repeat step 14 for each line item requested.	PA Reviewer
16.	Update the "Internal Text Screen" and enter all pertinent clinical information including signs, symptoms, precipitating factors, progress, regression, and previous PA history for the same service.	PA Reviewer
17.	If intensity of service is being reduced from the last PA request, the internal text is updated with the explanation of why and the "suggested" reduction plan is documented.	PA Reviewer
18.	If the requested service is being denied, internal text is updated with an explanation of why.	PA Reviewer
19.	The PA decision is entered into the internal text including the number of units and dates of service that are approved or denied.	PA Reviewer
20.	The initials of the reviewer are entered into internal text.	PA Reviewer
21.	The external text screen is updated including the appropriate IAC and any other additional information that contributed to making the final decision if the request was not approved as requested.	PA Reviewer
22.	"Batch Print" to generate a decision letter to the rendering provider and member.	PA Reviewer
23.	Save and proceed to the next PA request.	PA Reviewer
24.	Return the folder of completed PA requests to a support specialist for faxing back to the requested provider within the allowed 48 hours. The support specialist files the request by provider and date received.	PA Reviewer

C. Telephone Requests

Telephone requests for PA may be accepted for selected services if the initiating provider is a Doctor of Medicine, Doctor of Osteopathy, Dentist, Optometrist, Podiatrist, Chiropractor, Psychologist endorsed as a Health Care Provider in Psychology (HSPP), home health agency, or hospital (405 IAC 5-3-2 and IAC 5-3-10).

Notification of approval or denial will be given at the time the call is made for the following services (405 IAC 5-3).

- Inpatient hospital admissions and concurrent review for services requiring prior authorization (405 IAC 5-3-13).
- Continuation of emergency treatment for those conditions listed in IAC 5-3-13 on an inpatient basis originally without prior authorization, subject to retrospective medical necessity review.

Some services prior authorized by telephone require a properly completed Prior Authorization Request Form to be submitted subsequent to the authorization. These services include:

- medically necessary services or supplies needed to facilitate discharge from, or prevent admission to, a general hospital;
- equipment repairs necessary for life support or safe mobility of the patient; and
- services, when a delay of beginning the services could reasonably be expected to result in a serious deterioration of the patient's medical condition.

All requests for Prior Authorization are reviewed on a case-by-case basis. The decision is rendered based on the submitted documentation and the predetermined rules and criteria approved by the Office of Medicaid Policy and Planning.

1. All requests for services which are determined to be urgent, emergency, or immediate may be requested by telephone. Telephone authorizations may be granted for a shorter period of time than may normally be given.

    a. The reviewer will request all information necessary in order to render a decision and simultaneously enter the information into the Indiana*AIM* system.

b. The reviewer will use the Prior Authorization Telephone Script as a guideline for the telephone authorization. (Refer to **Exhibit III-1**.)

c. The reviewer will be courteous and helpful at all times.

d. Each reviewer will maintain records of all reviews and retain daily log sheets for future reference.

e. A telephone review should include the following (IAC 5-3-6):

- initiation of the telephone request by a provider authorized to request PA (see Section C. above);
- the requesting provider number;
- the name, address, age, and Recipient Identification number (RID);
- diagnosis and related information (ICD-9-CM code);
- services or supplies requested (CPT, HCPCS code, or NDC);
- name of the suggested provider of the services or supplies;
- member-specific clinical information required to establish medical necessity, including the following: prior history, results of diagnostic studies; prior treatment; comorbid conditions; treatment plan and rationale; progress; and date of onset of medical conditions;
- additional information when needed for clarification, including, but not limited to, x-rays, lab test results, and photographs [per 405 IAC 5-3-5 (c) (14)] when appropriate; and
- for emergency admissions, type of accident and accident date, if applicable.

f. A decision is rendered, using the IAC, IHCP bulletins, written directives from OMPP, and internal criteria as guidelines. Clinical information, decision, and rationale for the decision are entered into the internal text, for internal use only. The appropriate IAC citation, and any comments necessary, are entered into the external text, for provider and member notification.

g. Providers receive the prior authorization number and decision immediately via telephone, if approved or modified. Each reviewer keeps an ongoing log tracking the PA numbers assigned to each telephone and faxed request.

h. All telephone requests that cannot be approved or modified (partially approved) are referred to the PA supervisory staff for review. Cases that still cannot be approved or modified are then referred to a physician consultant before the determination may be given to the provider requesting the service(s) or supply(s). Decisions will be entered as "suspended" until the physician review is completed. These referrals must be expedited in order to ensure rapid turnaround and optimal customer service. Documentation of this review, including the name of the physician and the rationale for the denial, is entered into the internal text by the reviewer, and onto the Physician Reviewer Referral and Review Form.

i. Once the decision has been made, the Prior Authorization Decision Form is mailed, within 24 hours of the decision, to the provider and the member. A Notice of Appeal Rights is included in the mailing.

j. Refer to **Table III-7,** for a step-by-step procedure for Entry of New Prior Authorization Requested via Telephone.

TABLE III-7

PROCEDURE/PROCESS: ENTRY OF NEW PRIOR AUTHORIZATION REQUESTED VIA TELEPHONE

No.	Description of Activity	Responsible Party
1.	The phone will be answered on or before the fourth ring.	PA Reviewer
2.	The provider number or license number of the requesting provider must be entered.	PA Reviewer
3.	The Member Identification (RID) number will be entered. The provider must identify member's name.	PA Reviewer
4.	The numeric diagnosis (ICD-9 CM) code(s) will be entered.	PA Reviewer
5.	The services or supplies (CPT or HCPCS code) will be entered.	PA Reviewer
6.	The name of the rendering provider will be entered, if applicable.	PA Reviewer
7.	Member-specific clinical information is requested to establish medical necessity, including prior history, results of diagnostic studies, prior treatment, co morbid conditions, treatment plan and rationale, progress, and date of onset of medical conditions.	PA Reviewer
8.	If the request is for an emergency admission, the type of accident and date of accident will be requested.	PA Reviewer
9.	A determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, approved medical criteria and directives from OMPP.	PA Reviewer
10.	Clinical information, decision, and rationale for the decision are entered into the internal text.	PA Reviewer
11.	The appropriate IAC ruling, and any comments necessary, are entered into the external text for member and provider notification.	PA Reviewer
12.	The requesting provider will receive a prior authorization number and decision immediately via telephone if approved or modified.	PA Reviewer
13.	The approved dates of service, approved units or dollars, and the decision are entered on the bottom line of the "line item."	PA Reviewer
14.	Repeat step 13 for each line item requested.	PA Reviewer
15.	Generate a "batch print" to automatically send a decision letter to the provider and member.	PA Reviewer

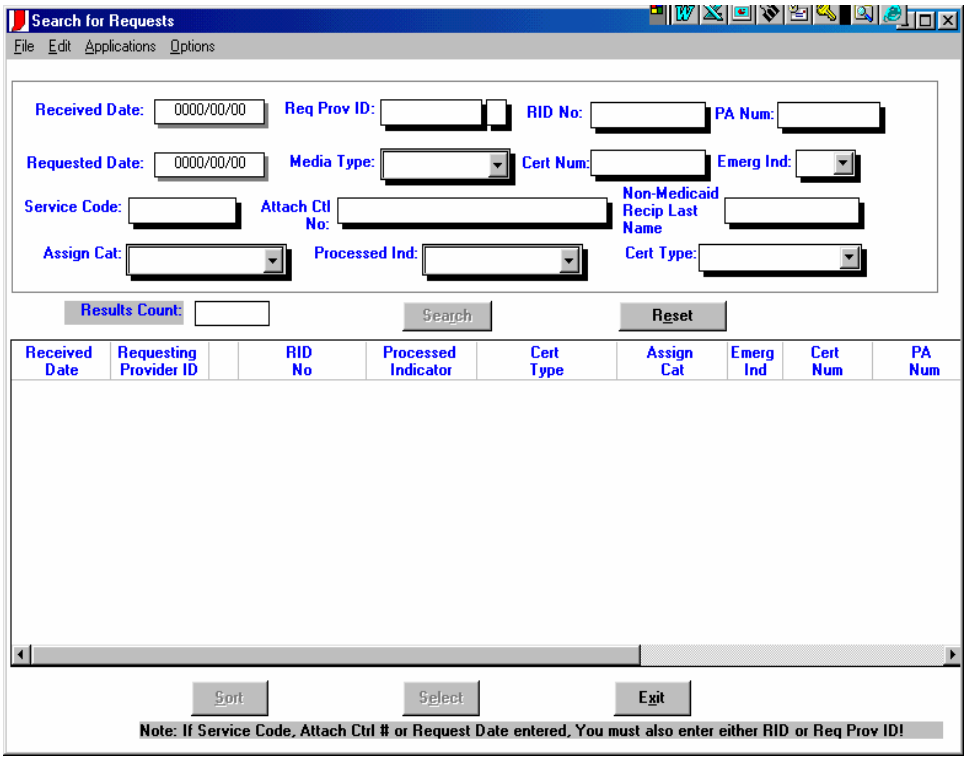
D. 278 TRANSACTION PROCESS: REVIEW PROCESS FOR ELECTRONIC PRIOR AUTHORIZATION REQUESTS

PA requests can be received electronically via the 278 transaction. This business function has been implemented due to HIPAA requirements. This electronic transmission is an elective process for the provider community and is not considered mandatory.

Electronic requests for PA may be accepted for all service types if the initiating provider is a Doctor of Medicine, Doctor of Osteopathy, Dentist, Optometrist, Podiatrist, Chiropractor, Psychologist endorsed as a Health Care Provider in Psychology (HSPP), home health agency, hospital, or transportation provider (405 IAC 5-3-2 and IAC 5-3-10).

All requests will be processed in the Indiana*AIM* system. Notification of approval, denial, suspension, and pending status will be issued in the normal PA business function process. Services that currently require a paper attachment will be followed with a paper attachment submitted by mail. This paper attachment must include the attachment control number, so the attachment can be matched with the original 278 transaction, once received. If the submitting provider is not a provider who is able to submit a PA request independently, that provider will need to mail in proof of the appropriate requesting provider signature. The attachments can include a plan of care, medical clearance form, proof of the requested item by an authorized provider agent, and any other additional documentation that may be requested by the PA reviewer. The PA business function for reviewing PA requests, current medical policies and criteria, apply to the 278 transaction process.

1. The Search for Requests window will be selected for the 278 electronic request transactions.



2. The PA reviewers will select media type “Electronic” and the assignment category of “Non-processed’, then select the search button. This will display all electronic requests that have not been processed.

3. All electronic requests will include the following information on the Search for Request screen:

   a. Received Date
   b. Requesting Provider ID
   c. Member Identification Description (RID) Number
   d. Processed Indicator
   e. Certification Type
   f. Assign Category
   g. Emergency Indicator
   h. Certification Number
   i. PA Number
   j. Media Type
   k. User ID

4. The electronic transaction automatically assigns the new request a PA number unless it is a duplicate or appeal request.
5. If the request is a duplicate, the system will ask for the duplicate PA number.
6. The reviewer will highlight a request and press the select button.
7. The PA request is then displayed on the Request for Review Window.
8. The Request for Review Window will display all medical information submitted by the requesting provider.
9. Clicking on the service detail line item will open the Indiana*AIM* production screens.
10. The normal review process for prior authorization will be followed as described in Section III-1.
11. Once the PA request has been given a decision status, the 278 transaction is automatically completed. An electronic response is transmitted back to the submitting provider indicating the decision status and any additional information necessary for that particular request.
12. A PA decision letter is processed as normal by the Indiana*AIM* system to the requesting provider and member.

E. Support Staff Processing of Medical Records Received from Providers

Entire medical records may be submitted if the provider is requesting a retroactive review for authorization or wishes to appeal a modification or denial of a prior authorization request for hospitalization.

1. The PA support specialist will date-stamp each medical record and any attachments, and will evaluate to determine if the record needs to have a PA number assigned. Retroactive requests for authorization must have a PA number assigned. The provider should include the original PA number when requesting an appeal. If the PA number is not included but the RID and Date of Service (DOS) is provided, the support specialist can find the case in Indiana*AIM* and the request will be processed.

2. The records are then forwarded to the Prior Authorization reviewer, or to the hearings and appeals staff.

3. Any cover letter or attachments remain with the record.

4. The envelope is attached to any records being forwarded to hearings and appeals.

5. If there are any questions as to the disposition of a record, they are discussed with a supervisor.

F. Review of Retroactive Prior Authorization Requests

1. 405 IAC 5-3-9 provides the conditions under which services or supplies requiring prior authorization may be authorized after the services have been rendered or the supplies provided.

   - Retroactive prior authorization may be given for pending or retroactive member eligibility. The prior authorization request must be submitted within 12 months of the date eligibility was established and entered into Indiana*AIM*.
   - Retroactive prior authorization may be given in the case of mechanical or administrative delays or errors by HCE or the County Office of Family and Children.
   - A provider who has not yet received a provider manual may receive retroactive prior authorization for services rendered outside Indiana.

- Retroactive prior authorization may be given for transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within 12 months of the date of service.
- Services for 590 members may be authorized retroactively.
- Retroactive prior authorization may be given when the provider was unaware the member was eligible for services at the time services were rendered. PA will be granted in this situation only if the following conditions have been met.
  - The provider's records document that the member refused or was physically unable to provide the Member Identification (RID or Medicaid) number.
  - The provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered.
  - The provider submitted the request for prior authorization within 60 days of the date IHCP eligibility was discovered.
  - Situations where the physician cannot determine the exact procedure to be done until after the service has been performed.

a. These requests can be received either written or via 278 electronic transaction, and are reviewed as if they had been submitted prior to the provision of services or supplies, following the normal review process.

b. Retroactive requests for members whose eligibility was pending on the date of service will be verified by completing an eligibility audit in Indiana*AIM*.

c. Appropriate criteria will be utilized, and if the request cannot be approved or modified, the request will be referred to the PA supervisory staff that will refer the request to a physician consultant for a determination of medical necessity.

2. A member, having purchased an item or service, and later learning of IHCP eligibility made retroactive to cover the date the item or service was purchased, may request that the provider submit a claim to IHCP and reimburse the member the IHCP reimbursed amount of the item(s). The provider may wait to receive reimbursement from IHCP prior to refunding the total paid amount to the member.

   - The reviewer will evaluate the PA request to determine whether it is a covered IHCP service or supply.
   - If the service or supply is not a covered service by IHCP, the request is denied, and the provider is under no obligation to reimburse the member any portion of the payment.
   - If the request is approved and the provider is reimbursed, the provider should reimburse the member an amount equal to that paid by the member.

TABLE III-8

PROCEDURE/PROCESS: APPROVAL OF A PRIOR AUTHORIZATION

No.	Description of Activity	Responsible Party
1.	A prior authorization request and any attached documentation is reviewed and a determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria.	PA Reviewer
2.	Review previous PA history to determine if requested service had been previously requested and decision for that request.	PA Reviewer
3.	The approved dates of service, approved units or dollars, and the decision are entered on the bottom line of the "line item."	PA Reviewer
4.	Repeat step 3 for each line item requested.	PA Reviewer
5.	Update the "Internal Text Screen" and enter all pertinent clinical information including signs, symptoms, precipitating factors, progress, regression, previous PA history for the same service, availability of caregivers for home health requests, or most recent authorization for DME requests.	PA Reviewer
6.	The initials of the reviewer will be entered into internal text.	PA Reviewer
7.	"Batch Print" to generate an approval decision letter to the requesting provider and member.	PA Reviewer
8.	Save and proceed to the next PA request.	PA Reviewer
9.	Return completed PA requests to the top shelf of the metal file cart in the center aisle of the PA department for inventory and filing.	PA Reviewer

TABLE III-9

PROCEDURE/PROCESS: DENIAL OF A PRIOR AUTHORIZATION

No.	Description of Activity	Responsible Party
1.	A prior authorization request and any attached documentation is reviewed and a determination is made regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria.	PA Reviewer
2.	Any request that is denied for noncompliance or procedural reasons (e.g., retroactive coverage, non-covered service or supply, etc.) will be documented in the internal text. The external text will cite the appropriate IAC on the decision form that is mailed to the requesting provider and member.	PA Reviewer
3.	If the request is unable to be approved or modified based on medical necessity, the request will be suspended and forwarded to the PA supervisory staff.	PA Reviewer
4.	The request will be evaluated to ensure that all available documentation and criteria have been assessed.	PA Supervisory Staff
5.	Any request that cannot be approved or modified will be referred to a Physician Consultant.	PA Director
6.	The consultant will be contacted to ensure availability and willingness to evaluate the case.	Support Specialist
7.	If the service or supply is elective in nature, the case documentation will be mailed or faxed to the consultant for a decision.	Support Specialist
8.	If the service or supply is considered to be urgent or emergent, the case will be described in detail, via telephone conference with the consultant.	PA Supervisory Staff
9.	A decision will be made regarding the medical necessity based upon current standards of practice and professional judgement. The physician consultant is constrained by the State of Indiana rules and regulations regarding coverage issues.	Consultant
10.	The decision is recorded on the Physician Reviewer Referral & Review Form, citing the rationale and mailed back to HCE within 5 business days.	Consultant
11.	Urgent and emergent cases that are decided by phone will be documented on the Physician Reviewer Referral & Review Form, including the rationale cited by the consultant.	PA Supervisory Staff
12.	The consultant decision is entered into the Indiana*AIM* system and a decision letter is mailed out within 24 hours.	PA Supervisory Staff
13.	Requests that do not contain adequate and/or necessary information are entered as suspended.	PA Reviewer
14.	The external text is documented with the reason for suspension, requesting the provider resubmit the request with the information listed on the Prior Authorization Decision Form. (If the provider does not respond within 30 days with the necessary information to approve the request, the system will automatically deny the request.)	PA Reviewer

G. Review Process for Initial Prior Authorization of Services and Supplies

PA reviewers will perform the initial review utilizing approved criteria, the IAC, IHCP bulletins and other directives of the OMPP. Cases that cannot be approved or modified based upon criteria will be referred to PA supervisory staff for further review.

If the PA supervisory staff determines there is a question of medical necessity, the case will be referred to an appropriate consultant for further review. A decision is rendered based on the submitted documentation and the decision is then entered into the Indiana*AIM* system.

There are four basic decisions for prior authorization requests. These are approved, modified, denied, or suspended. Any of the additional 20 decisions available in Indiana*AIM* are variations of these four types. Refer to **Tables III-10** and **III-11,** for a brief explanation of each decision code.

TABLE III-10

PRIOR AUTHORIZATION DECISION CODES

Approved	This decision status is used when the requested service is approved exactly as requested, including service code, the number of units or dollars, and the dates of service.
Modified	This decision status is used when either the number of units or dollars, or the dates of service, is approved at a lesser level than was requested. A Notice of Appeal Rights must be attached to all modified decisions. The service code cannot be changed in any way from what was requested.
Denied	This decision is used when the entire request is denied, or in any situation when a member is refused a requested service. For requests submitted after the services have begun or the supplies provided, the dates of service prior to the receipt of the prior authorization request may be denied, while the remainder of the request may be approved, modified, pended, or denied based on documented medical necessity or lack thereof. Non-covered services are denied, as are services that have met the benefit limit, e.g., 20 trips under the transportation services coverage guidelines, without prior authorization. Based on the submitted documentation, medical necessity must be present for any additional trips. All requests lacking documentation supporting medical necessity must be reviewed and signed by a physician designee. A Notice of Appeal Rights must accompany all notifications of decisions to deny.
Suspended	A request for prior authorization may only be suspended when the submitted documentation is insufficient to make a decision. The requesting provider and member are notified of the necessary documentation on the PA Decision Form. If the requested documentation is not received within thirty (30) days, the PA request is automatically denied.

TABLE III-11

DECISION STATUS CODES

A (Approved)	All details are approved as requested.
B (Non-covered code, PA authorized)	Even though the procedure or supply is not covered by the Indiana Health Coverage Programs, medical necessity is present and the procedure or supply is approved by the OMPP. (May or may not be the result of an appeal decision.)
C (Decision overturned by ALJ)	Previously denied or modified decision has been approved by the Administrative Law Judge.
D (Denied)	All details of the request are denied.
E (Evaluation)	All requests remain in "evaluation" status until reviewed by the PA reviewer. (No decision has yet been made.)
F (Approved Continuation of Service)	Request has been approved exactly as approved on previous PA request.
G (Modified Continuation of Service)	The request was approved at exactly the same level as was previously approved, not necessarily as requested on this prior authorization request.
H (Denied Continuation of Service)	Even though exact services have been previously approved, there is not documentation to warrant approval of this request for prior authorization.
I (Non-Covered Code Denied)	The code is not a covered service, therefore, the request is denied.
K (Suspended, Awaiting additional information)	Effective 01/1/99 a suspended decision will automatically deny after 30 days if the additional information was not received and the decision was not changed in the system (replaced "rejected").
L (PA restored to previous level pending appeal decision)	Previously approved services, that are modified or denied, may be appealed by the member. When this occurs, the services are reinstated at the level previously approved, until the decision is received from the Administrative Law Judge.
M (Modified)	Units/dollars or dates of service are approved at a level less than requested.
N (No PA required)	The requested service is exempt from prior authorization requirements.

TABLE III-11 (Continued)

DECISION STATUS CODES

O (No PA required when requested by a PMP)	Many services do not need PA when the member is enrolled in a Managed Care Organization and the MCO Primary Medical Physician (PMP) authorizes the service.
P (Pending, pays the same as denied)	Requests needing written documentation supporting medical necessity will remain "pending" in the Indiana*AIM* system until such documentation is received and the need for service(s) is verified. For example, inpatient psychiatric services require the Certification of Need document (1261A) be completed and approved before the days can be changed to "approved" status.
Q (Incorrect PMP)	The provider number indicated on the request is not that of the member's PMP.
R (Rejected, PA denied for administrative reason)	Effective 01/01/99, this is no longer a valid decision.
S (Dismiss/No hearing/Approved)	A request for an Administrative Hearing has been filed. Additional review, or submission of additional documentation, confirms medical necessity. The request is approved and the hearing dismissed.
T (Dismiss/No hearing/ Modified)	A request for an Administrative Hearing has been filed. Additional review, or submission of additional documentation, confirms medical necessity for a portion of the services or supplies requested. The appellant is agreeable to the modification. The request is modified and the hearing dismissed.
U (Dismiss/No hearing/ Denied)	A request for an Administrative Hearing has been filed. Medical necessity for the services or supplies is not present or the request was denied because of an error on the part of the provider. For example, the Certification of Need was not submitted within the allowed time limit, causing the requested days to be denied. The appellant is in agreement with the error and will withdraw the appeal.
V (Modified through court)	Following the Administrative Hearing, the Administrative Law Judge awards the appellant a portion of the services or supplies previously denied. Both the provider and the member are provided with instructions regarding further appeals of this decision issued by the State.

TABLE III-11 (Continued)

DECISION STATUS CODES

W (Decision upheld by ALJ)	The Administrative Law Judge is in agreement with the previous modification or denial of services. No additional services or supplies are awarded. Both the provider and the member are provided with instructions regarding further appeals of this decision.
X (Modified through Administrative Review)	A request for Administrative Review has been filed. Additional review or documentation verifies a portion of the requested services or supplies is medically necessary. Both the provider and the member may request an Administrative Hearing, of this modification.
Y (Approved through Administrative Review)	A request for Administrative Review has been filed. Additional review or documentation verifies medical necessity and the services are approved as requested.
Z (Automatic approval after 10 working days)	In compliance with 405 IAC 5-3-14, any request for prior authorization that is not adjudicated within ten (10) business days of the receipt of all documentation specified in sections 5 and 9 (1) of 405 IAC 5-3, is granted within the coverage and limitations specified.

The decision approves only the number of days or units determined to be necessary to reach the initial goals and/or stabilize the patient. Prior to the end of the approved or pending days, the provider must submit another request if additional days and/or services are believed to be necessary.

Requests not containing adequate and/or necessary information are "suspended" and the provider is advised to resubmit the request with the information listed on the Prior Authorization Decision Form. A suspension is not a denial, and the provider does not need to "appeal" a suspension (405 IAC 5-7-1). The Indiana*AIM* system automatically denies suspended decisions after 30 days.

Timely adjudication of the request is the responsibility of the PA reviewer. If the reviewer encounters difficulties that will slow the processing of the request, the PA supervisor will be notified.

Review Process

1. For written requests, the reviewer removes the "oldest" folder from the shelf for the type(s) of service for which he or she is responsible. The reviewer will record in a log sheet the date, type of service, and PA number range for that folder. The reviewer will initial each entry on the log sheet. This creates a tracking system for paper PA requests in process.

2. Faxed requests are distributed to the reviewers. Faxed requests must be processed within 48 hours (2 business days).

3. PA requests received via 278 electronic transaction will be processed from oldest date received. All requests received marked emergency, will be reviewed within 48 hours (two business days).

4. Telephone calls are routed to the PA department by the Automated Call Distribution system. Callers are asked to choose between mental health (1), hospice-home health (2), other medical surgical/DME (3), "other" services (4) or hearings and appeals (8). Reviewers will be cross-trained in all areas, but will specialize in a specific area to facilitate review. Calls will be distributed to the first available reviewer within the queue, but may overflow into other queues to prevent callers from remaining on hold. (See **Section III-I,** Internal Grievance Procedure, for the handling of complaints.)

   The reviewer answers the telephone on or before the fourth ring. (Refer to **Exhibit III-1,** for the sample Telephone Scripts for telephone reviews.) The information is entered into the Indiana*AIM* system as the review is conducted.

   - Request the provider number or provider license number if the provider calling is not a Medicaid-enrolled provider.
   - Inform the caller that the PA decision forms will be mailed to the Provider "A" address showing in Indiana*AIM* until the provider files are corrected. If corrections are needed, the provider will be directed to notify EDS Provider Enrollment in writing, by mail or fax, of the desired changes.

5. The reviewer enters the case into the Indiana*AIM* system in accordance with the following procedure.

   a. Enter the identification number of the requesting or rendering provider (upper left corner of the PA request form) in the "Provider ID" box.

   b. Enter the Recipient Identification (RID) number in the RID No. box.

   c. Enter the PA number in the "PA Number" box. For written or faxed requests, use the PA number assigned by the support specialist. For phone requests, assign a PA number using the following procedure.

      - Y = 9 (Year-1999)
      - JJJ = Julian date (247th day of 1999)
      - M = Media type (1=Paper/written, 2=Phone, 3=Fax)
      - 02 = Unique reviewer identification number
      - 000 = Numeric sequence assigned to the individual reviewer (s)

      The result is PA number 9247202000

   d. Click on "PA Assignment" to produce the "pull down box" listing all the types of service. Click on the appropriate type.

   e. Enter the primary diagnosis code into the "Diagnosis" box.

   f. Click on "Enter" at the bottom of the window. This will automatically populate the remaining information on the window.

NOTE: For telephone reviews, click on "Applications" at the top of the PA screen, and pull up "Member" information. Verify the mailing address with the caller and advise that the decision letter will be mailed to the member address on file.

g. Click on "Applications" at the top of the PA screen.

- Click on "LOC" to verify the level of care. If the LOC screen is blank, there is no record of this member having been in a long-term care (LTC) facility during the period of IHCP eligibility; proceed with the review.

- If the LOC screen indicates the member is in a LTC facility, DO NOT approve services that are covered as a part of the per diem of a LTC facility.

h. Pull up the "Line item" and enter the first requested procedure code, the dates of service requested, and the requested number of units on the top line.

6. After reviewing the PA request and any attached documentation, make a determination regarding the appropriateness and medical necessity of the service or supplies being requested based on the IAC, IHCP bulletins, and approved medical criteria.

7. If approved, or modified due to procedural error, continue with this procedure. If unable to approve or modify, refer the case to the PA Supervisor for consultation with the PA Director as necessary, following the referral procedure.

a. Enter the approved dates of service, the approved units or dollars, and the decision on the bottom line of the "line item." Repeat the same procedure for each line item requested.

b. Click on "Internal Text" and enter the following information:

- time of call, if applicable;
- agency or provider requesting the PA;

- age and gender of member;
- place of member residence (private residence, LTC, ICF/MR, group home, etc.); and
- service codes being requested. (If the member is living in a LTC facility, document whether the requested service is included as a part of the per diem.)

c. Click on "Applications" & "PA history" to determine if the requested service has previously been requested, and the decision for that request.

- If the previous request was denied, check the internal text of the other PA(s) to see why it was not approved.
- If this request is a duplicate of a service already approved, deny the request as a duplicate of services already approved.
- Was the service previously appealed? If so, what was the outcome? This information may provide insight regarding previous modifications or denials.

d. Return to the "Internal Text" screen and continue to enter all pertinent clinical information, including, but not limited to the following.

- What were the signs, symptoms, and precipitating factors?
- Tell about any progress or regression since the last request for PA, if member has been previously approved for the same service(s), (e.g., therapies or home health).
- Describe the availability of caregivers in the home, if request is for home health services.
- Describe the most recent authorization(s) of DME, and types of DME previously authorized, if request is for DME.
- What is the medical status of the member? Is the member capable of participating in the requested regime?

- Is the intensity of the requested service being reduced from the level of the last PA request? Explain why, and give the "suggested" reduction plan.
- Is the service to be denied? Explain why. Are similar services being provided by any other entity?
- Include the decision, including number of units, and clearly state the first and last days approved, or denied.
- Include the initials of the reviewer.

e. Pull up "New IAC/Text" and enter the following information that will print on the PA decision form mailed to the provider and the member.

- The appropriate IAC, if the request was not approved as requested. To find the IAC, click on the arrow beside the "IAC Codes" box, then on the appropriate code; the system will generate the verbiage of the code.
- A listing of any additional information needed to make the final decision if the request was suspended due to lack of information.
- An explanation of the reason(s) the request was modified or denied.

f. Proofread the external text and correct any errors. This text is sent to members and providers; it should be clear, concise, accurate, and free of any misspellings or typographical errors. Consult an appropriate dictionary and/or your supervisor for any questions.

g. Click on "batch print" to automatically generate copies for automated mailing to the provider and the member the following day.

h. Decision letters are mailed within twenty-four (24) hours to the member and the requesting provider. A notice of appeal rights is included with the decision letter.

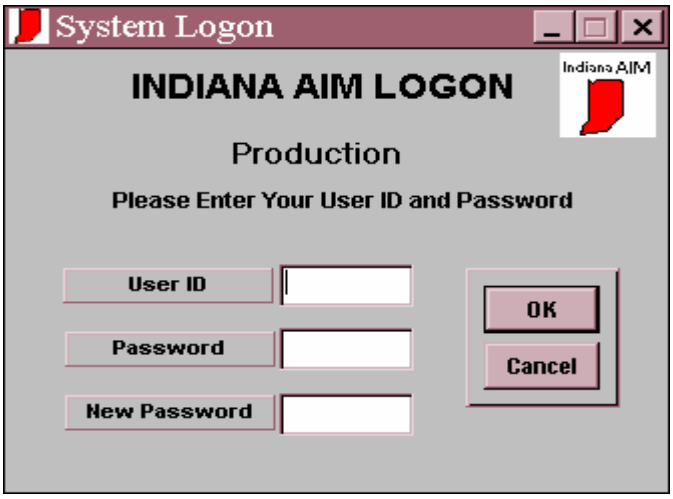
i. Click on “save” and proceed to the next PA request.

NOTE: Units/days for inpatient hospitalizations are counted as follows. The day of admission is day one. No units are given for the day of discharge or the last day authorized. For example, a member is hospitalized on 1/1/99 and the hospital stay is approved until 1/5/99. Four days/units would be entered into the computer system for January 1, 2, 3 and 4. No days/units will be given for January 5.

Refer to **Figures III-2** through **III-14,** for a detailed illustration of entry of Prior Authorization requests into the Indiana*AIM* system.

FIGURE III-2

WINDOW: SYSTEM LOGON



The system logon window is the first window that will be encountered when accessing the Indiana*AIM* Medicaid database.

1. Type in the User ID that was issued on the approved security forms.

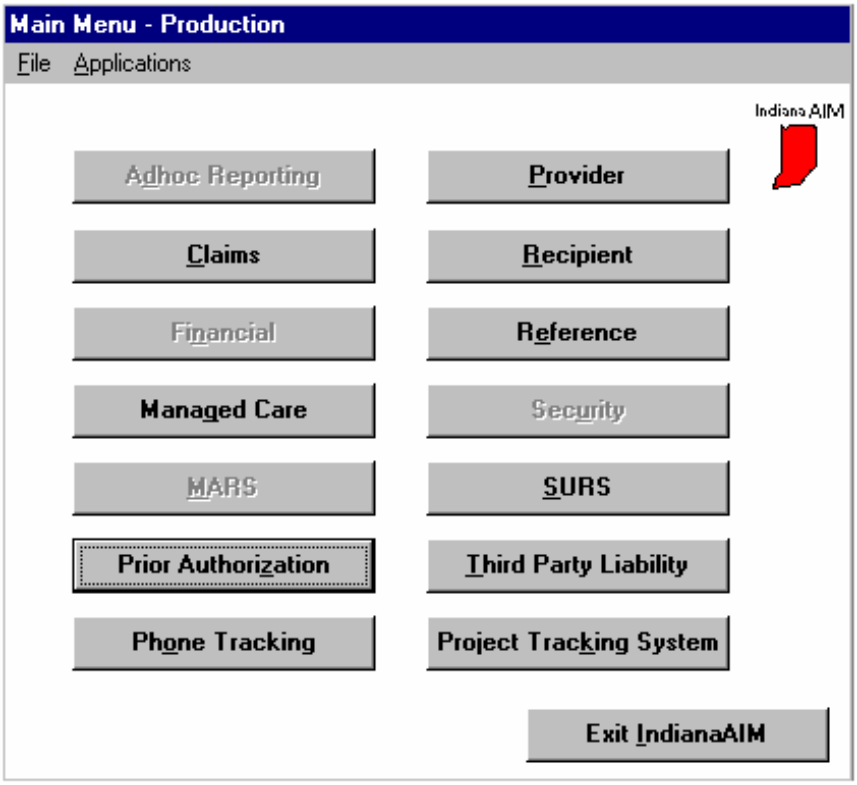
2. Type in the Password that was issued on the approved security forms.

3. Type in a new password. This is the confidential password that will need to be changed in order to maintain security within the Indiana*AIM* system. The screen will prompt the user to enter the New Password a second time. This is a cross check to verify the users password. (This password must be kept confidential to ensure the integrity of the user and the Indiana*AIM* system.)

4. Click on "OK" with the mouse or press the enter key to advance to the next window.

FIGURE III-3

WINDOW: MAIN MENU

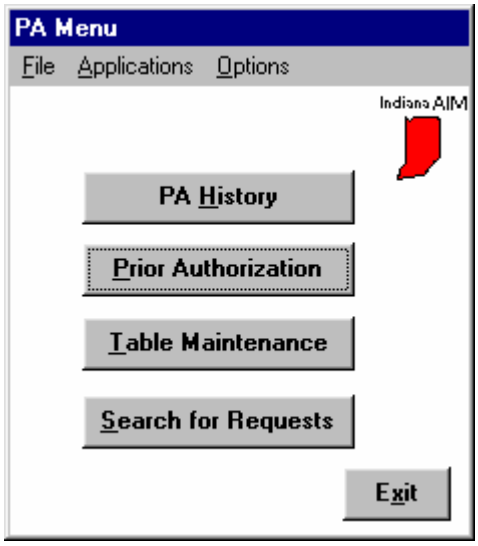


The main menu is the initial window viewed upon entry into the Indiana*AIM* application. This window is used to gain access to the following windows:

Adhoc Reporting
Claims
Financial
Managed Care
MARS
Prior Authorization
Provider
Member
Reference
Security
SURS
Third Party Liability
Phone Tracking/Project Tracking System

FIGURE III-4

WINDOW: PA MAIN MENU



The PA main menu window is used to gain entry to the entire PA database.

1. **PA History:** This window allows the user access to line item detail of all PA requests for a Member. Claims information related to the PA can also be accessed from this area.

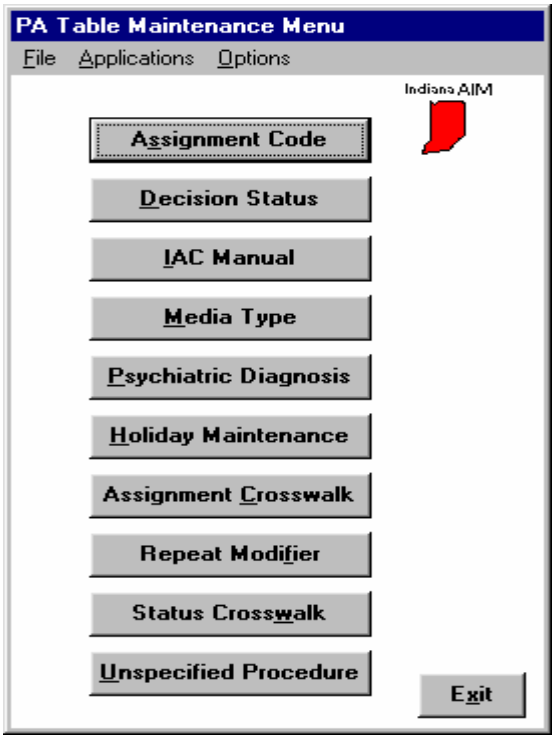
2. **Prior Authorization:** The main area for entering requests and for viewing information related to a request once it has been entered.

3. **Table Maintenance:** This window will allow the user to access six areas used within Prior Authorization in order to facilitate data. These areas consist of the following: Assignment Code, Decision Status, IAC Manual, Media Type, Psychiatric Diagnosis, and Holiday Maintenance.

4. **Search for Requests:** The window allows the user to search for all PA requests including 278 electronic transactions. This screen allows the reviewer to search a PA by electronic, paper, and fax. The search can also be sorted by the assignment category.

FIGURE III-5

WINDOW: PA TABLE MAINTENANCE MENU

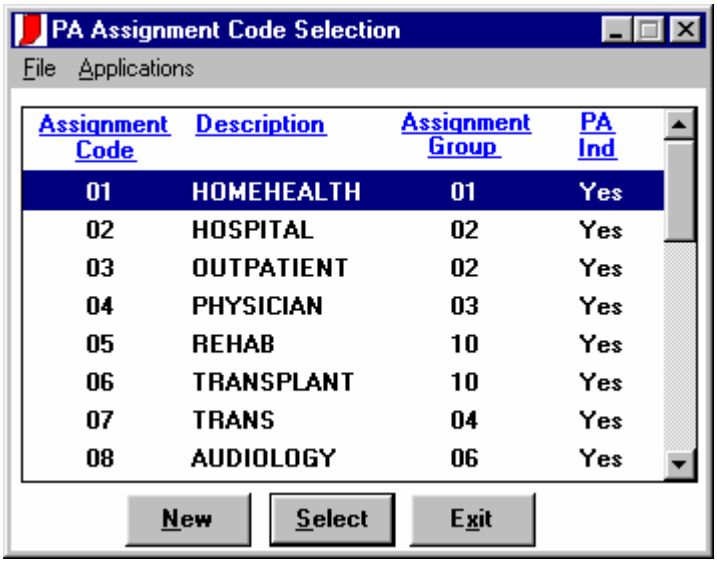


The PA Table Maintenance Menu is viewed upon entry from the PA Main Menu. This window gains access to one of the following 10 PA table maintenance selection windows:

Assignment Code
Decision Status
IAC Manual
Media Type
Psychiatric Diagnosis
Holiday Maintenance
Assignment Crosswalk
Repeat Modifier
Status Crosswalk
Unspecified Procedure

FIGURE III-6

WINDOW: PA ASSIGNMENT CODE SELECTION



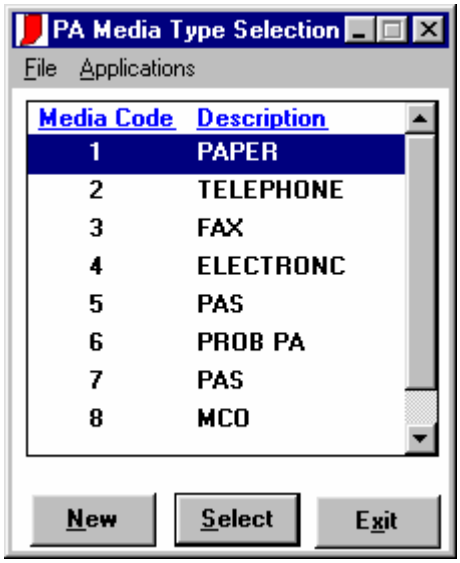
Assignment Code	Description	Assignment Group	PA Ind
01	HOMEHEALTH	01	Yes
02	HOSPITAL	02	Yes
03	OUTPATIENT	02	Yes
04	PHYSICIAN	03	Yes
05	REHAB	10	Yes
06	TRANSPLANT	10	Yes
07	TRANS	04	Yes
08	AUDIOLOGY	06	Yes

The Table Maintenance Menu is used to store the valid assignment codes. These are the 24 categories of service used in Prior Authorization.

01	Home Health	HE	Hospice
02	Hospital	LT	LTC
03	Outpatient	UN	Unknown
04	Physician		
05	Rehab		
06	Transplant		
07	Transportation		
08	Audiology		
09	Speech		
10	Mental HS		
11	DME		
12	Occupational Therapy (OT)		
13	Physical Therapy (PT)		
14	Respiratory Therapy (RT)		
15	Dental		
16	Optometric (OD)		
17	Podiatry		
18	Chiropractic		
19	Pharmaceutical		
20	1261A		
21	TBI		

FIGURE III-7

WINDOW: PA MEDIA TYPE SELECTION

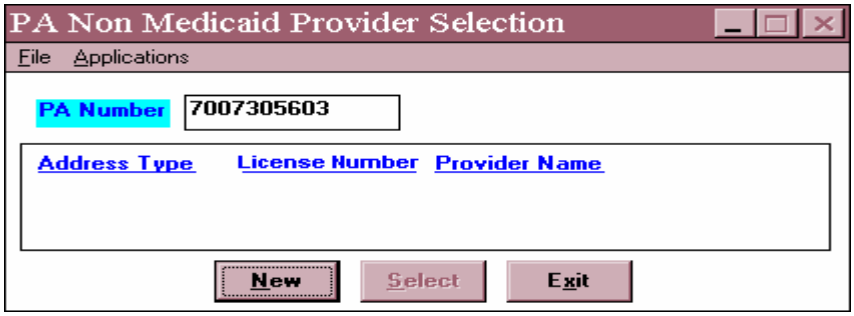


The PA Table Maintenance Menu is used to store the PA media types. These types are used to identify the various ways to receive a PA request.

1. Paper
2. Telephone
3. Fax
4. Electronic (278 transaction)
5. PAS
6. PROB PA
7. PAS
8. MCO
9. Plan Care

FIGURE III-8

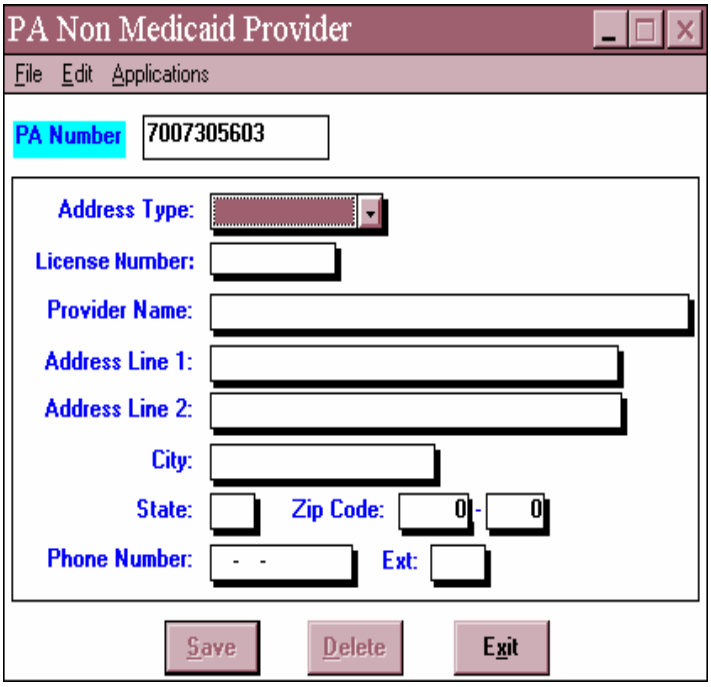
WINDOW: PA NON-MEDICAID PROVIDER



The PA Non-Medicaid Provider window is used to enter a non provider for PA purposes.

FIGURE III-9

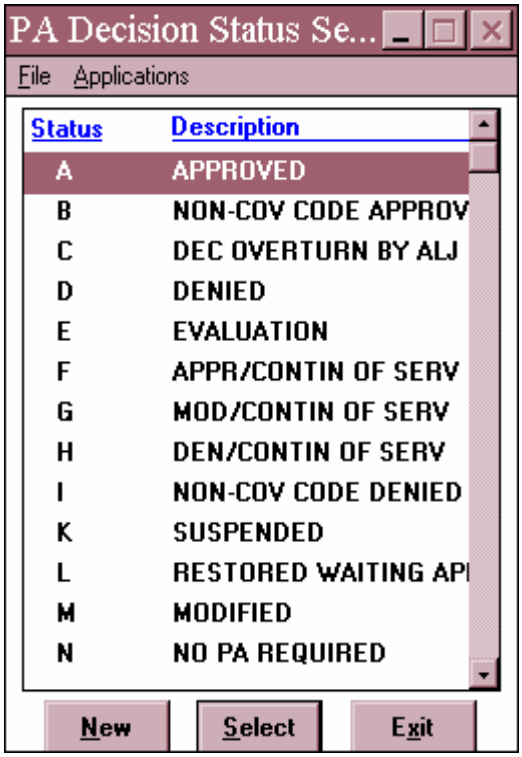
WINDOW: PA NON-MEDICAID PROVIDER SELECTION



The PA Non-Medicaid Provider Selection window is used to view a non-provider information for PA purposes.

FIGURE III-10

WINDOW: PA DECISION STATUS SELECTION



The PA Table Maintenance Menu is used to store PA decision codes. Valid values include:

A	Approved
B	Non-covered code, PA authorized
C	Decision overturned by ALJ
D	Denied
E	Evaluation
F	Approved Continuation of Service
G	Modified Continuation of Service
H	Denied Continuation of Service
I	Non-Covered Code Denied
K	Suspended, Awaiting Additional Information (currently not in use)
L	PA restored to previous level waiting outcome of appeal
M	Modified
N	No PA required

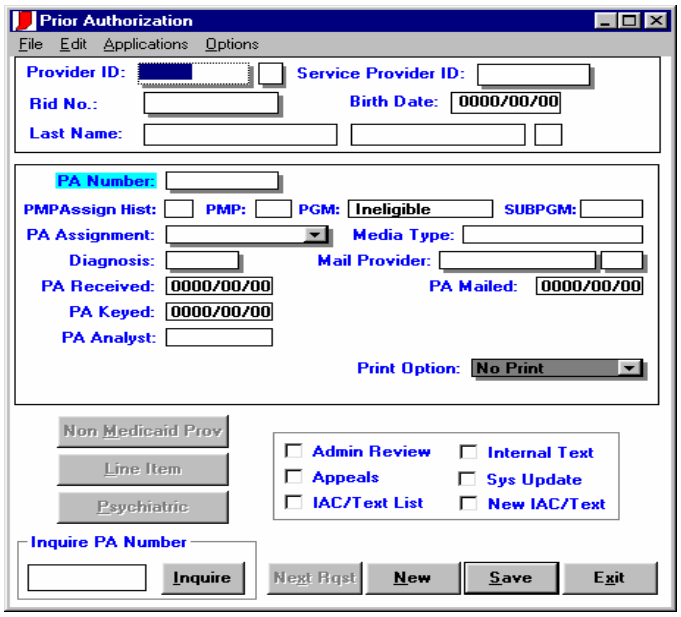
FIGURE III-10 (Continued)

WINDOW: PA DECISION STATUS SELECTION

O	No PA required when requested by a PMP
P	Pending pays the same as denied
Q	Incorrect PMP
R	Rejected, PA denied for Administrative reason (Currently not in use)
S	Dismiss – No Hearing Approve
T	Dismiss – No Hearing Modified
U	Dismiss – No Hearing Denied
V	Modified through Court
W	Decision Upheld by ALJ
X	Modified Through Administrative Review
Y	Approved Through Administrative Review
Z	Automatic approval after 10 working days

FIGURE III-11

WINDOW: PRIOR AUTHORIZATION



The prior authorization window is used to view, add, or update a prior authorization request. Clicking on the "New" button retrieves a blank Prior Authorization Window to allow entry of a new PA.

1. **Provider ID**: The nine character numeric of the Requesting Provider (also referred to as the requesting provider).

2. **Service Provider ID**: The nine character numeric of the Provider of Service. (This number may or may not be included on the request. This number is referred to as the rendering provider.)

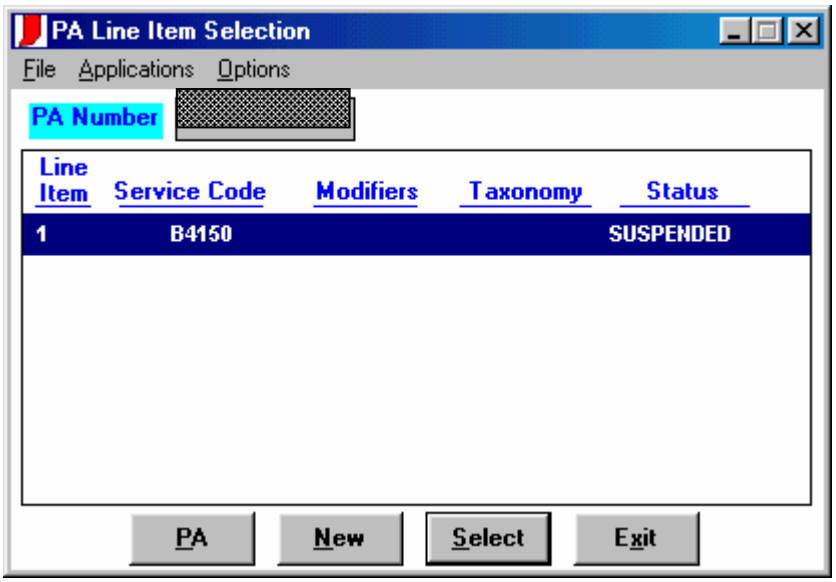
3. **RID No.**: The 12 character numeric of the member.

4. **PA Number**: The 10 character PA number. This must be a unique number.

5. **PA Assignment**: The two digit number utilized to categorize the PA's received. When an assignment code of 10 is entered, the psychiatric button at the bottom of the screen will be available to enter data into the 1261A drop down list box. This box is accessed by clicking on the Psychiatric button with your mouse or by pressing the Alt + P buttons on your keyboard.

FIGURE III-12

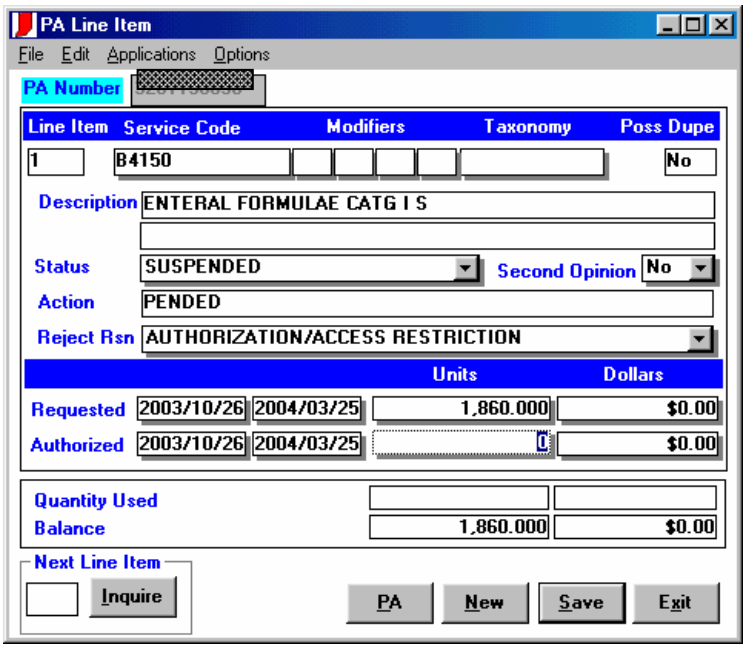
WINDOW: PA LINE ITEM SELECTION



The PA Line Item Selection window is used to view the detailed line items for per PA request. If further inquiry into a specific line item is desired, highlight the line item and click on the select button.

FIGURE III-13

WINDOW: PA LINE ITEM

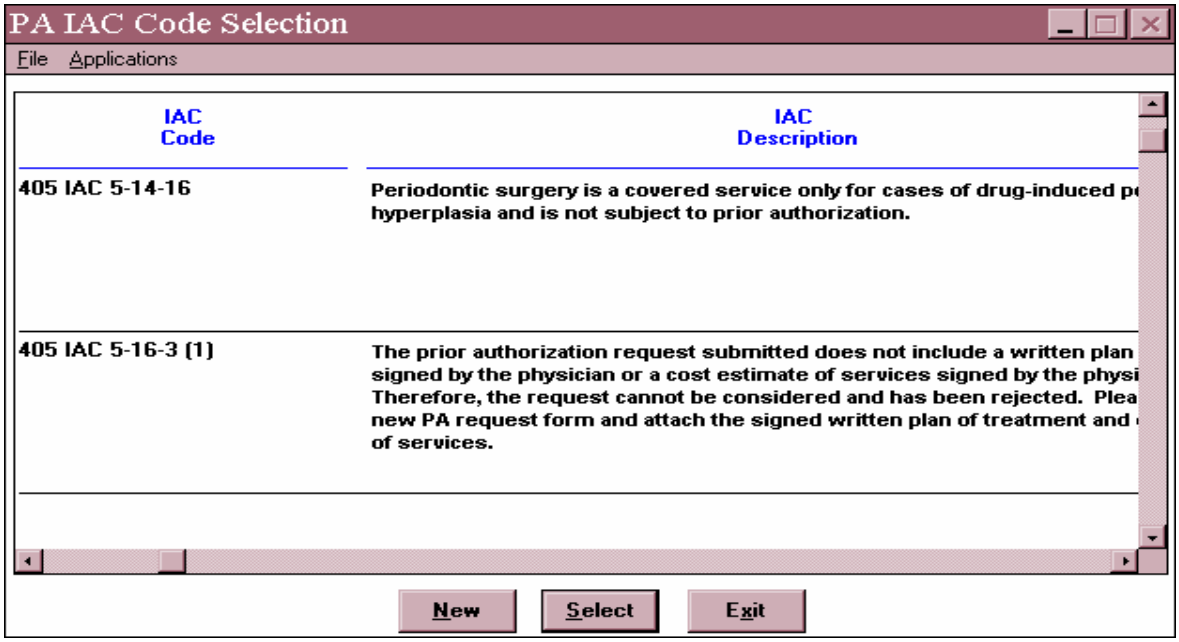


The PA Line Item window is used to enter, and work a PA request.

1. Line Item: The numeric character distinguishing each line item on a PA request.
2. Service Code: The correct five character HCPC, CPT, ADA or NDC code.
3. Modifier: Enter the alphanumeric characters as supplied by the requesting provider.
4. Taxonomy is optional for the provider.
5. Service Code Description (auto populates).
6. Status: The correct status selected from the drop down list box.
7. Second Opinion: Change from “No” to “Yes” if this is an IHCP-required second opinion request.
8. Action: Auto populates based on HIPAA-required language
9. Reject Reason: Select the appropriate code from the drop down list box
10. Requested Effective Date: The requested start date is CCYYMMDD format.
11. Requested End Date: The requested end date in CCYYMMDD format.
12. Requested Units: The number of requested units.
13. Requested Dollars: The number of requested dollars, if applicable.
14. Authorized Effective Date: The authorized start date in CCYYMMDD format.
15. Authorized End Date: The authorized end date in CCYYMMDD format.
16. Authorized Units: The number of authorized units.
17. Authorized Dollars: The number of authorized dollars, if applicable.
18. Quantity Used: These fields are populated from claims paid.
19. Balance: Auto populates reflective of the units authorized.

FIGURE III-14

WINDOW: PA IAC CODE SELECTION



The PA Table Maintenance Menu is used to store frequently used IAC references. Each code is listed along with the written narrative. By double clicking, the desired text can be brought into the external text, and will print on the PA decision form.