February 25, 2015

Bulletin 214

PRIOR AUTHORIZATION

This Bulletin is directed to all insurers writing policies of accident and sickness insurance, as defined by IC 27-8-5-1; all health maintenance organizations (HMOs), as defined by IC 27-13-1-19 and IC 27-13-36.2-2(a); all third-party administrators, including those defined at IC 27-1-25-1(a) and those administering self-insured plans; and other persons involved in reviewing claims and providing prior authorization for procedures. For purposes of this Bulletin, "prior authorization" will include any preapproval, preauthorization, prior approval, prior notification, or similar requirement in a policy or contract; however, it does not include pre-treatment payment estimates. The purpose of this Bulletin is to encourage all entities involved in the prior authorization process to use a common form for prior authorization, thereby reducing costs to insurers and health care providers, and avoiding unnecessary delays for patients.

Prior authorization requests and subsequent approvals should be made in writing, which may include online processes, electronic correspondence, facsimile correspondence, or other reproducible format, to avoid disputes over oral representations. When a written request is not possible, prior authorization requests may be made by phone or otherwise orally if the insurer allows. The Department has worked with representatives of insurers, health care providers, and patients, and has determined that the attached form, substantially similar to one already in use in Texas, is a reasonable form for obtaining necessary information to make a determination on a prior authorization request, whatever process is used. Therefore, the Department encourages insurers, HMOs, administrators, and others, to use the attached form.

Furthermore, the Department understands that no prior authorization is required by insurers for a patient with a life-threatening condition; therefore, this form has no application in a life-threatening situation. If, during a prior authorized surgical or other invasive procedure, a provider performs an additional related covered procedure due to unforeseen medical necessity, the Department encourages insurers, HMOs, and TPAs not to deny coverage solely for lack of prior approval, although the additional procedure was not included in the original prior approval. Denials or partial denials should be explained to the requesting provider.

The Department is considering the adoption of an administrative rule that would require the use of a standard prior authorization form for entities subject to the Department's jurisdiction. Voluntary use of the form following this Bulletin will provide practical experience and more valuable feedback during any rulemaking. Therefore, insurers and others are urged to begin use of this form as soon as practicable.

INDIANA DEPARTMENT OF INSURANCE

Stephen W. Robertson, Commissioner

Prior Authorization Request Form for Health Care Services for Use in Indiana

Section I — Submission

Issuer Name	Phone ( )	Fax ( )	Date and Time Submitted / / ____am/pm ET/CT

Section II — General Information

Review Type ☐ Non Urgent ☐ Urgent	Clinical reason for urgency
Request Type ☐ Initial Request	☐ Extension/Renewal/Amendment (Prev. Auth. #:)

Section III — Patient Information

Name	Patient Contact Phone ( )	DOB / /	Sex ☐ Male ☐ Female ☐ Unknown
Subscriber Name (if different)	Member or Medicaid ID #	Group #	

Section IV — Provider Information

Requesting Provider or Facility		*Service Provider or Facility*	
Name		Name	
NPI #	Specialty	NPI #	Specialty
Phone ( )	Fax ( )	Phone ( )	Fax ( )
Contact Name and Phone		Name of Primary Care Provider (see instructions)	
Requesting Provider's signature and date (if required)		Phone ( )	Fax ( )

Section V — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)

Planned Service or Procedure	*Code*	*Start Date*	*End Date*	*Diagnosis Description (ICD Version ____), if available*	*Code*
		/ /	/ /		
		/ /	/ /		
		/ /	/ /		

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other (specify)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of sessions Duration Frequency Other

☐ Home Health (MD signed Order attached? ☐ Yes ☐ No) (Nursing Assessment attached? ☐ Yes ☐ No)

Number of visits requested Duration Frequency Other

☐ DME (MD signed order attached? ☐ Yes ☐ No) (*Medicaid only:* Title 19 Certification attached? ☐ Yes ☐ No)

Equipment/supplies (Include any HCPCS Codes) Duration

Section VI — Clinical Documentation (See Instructions Page, Section VI)

An issuer needing more information may call the requesting provider or authorized representative directly at: ( ) _____ - _____ (ext. _____) or via email at _____. Preferred method of contact is ☐ phone or ☐ email.

Section VII — Reason for Denial or Partial Denial (To be completed by the issuer)

PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES FOR USE IN INDIANA

Please read all instructions before completing the form.
Do not send the completed form to the Indiana Department of Insurance or to the patient's or subscriber's employer.

The Indiana Department of Insurance encourages all insurers, HMOs, administrators, and others to accept the Standardized Prior Authorization Request Form for Health Care Services for Use in Indiana if the plan requires prior authorization of a health care service.

Intended use: When an issuer requires prior authorization of a health care service, use this form to request the authorization **by mail**. An issuer also may provide on its website an **electronic version of this form** that can be completd and submitted to the issuer electronically via the issuer's portal.

Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, or 6) to request a referral to an out-of-network physician, facility or other health care provider.

Additional information and instructions:

Section I. An issuer may have already prepopulated its contact information on the copy of this form posted on its website.

Section II. *Urgent reviews:* Request an urgent review for a patient who is currently hospitalized, ***or*** to authorize treatment following stabilization of an emergency condition. You also may request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review, to prevent a serious deterioration of the patient's condition or health.

Section IV.
- If the *Requesting Provider or Facility* also will be the *Service Provider or Facility*, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI.
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.), if needed.

Section VII.
- Give a brief narrative of why the request was denied or partially denied.

Note: Some issuers may require more information or additional forms to process your request. If you think an additional form may be needed, please check the issuer's website before transmitting your request.

If the requesting provider wants to be called directly about missing information that the issuer must have to process this request, and the provider's contact information is not the contact information listed in Section IV, enter the provider's contact information in the space given at the bottom of the request form. *This call is intended only to ensure that the issuer receives the information it needs to review the request. It is* ***not*** *a peer-to-peer discussion afforded by a utilization review agent (URA) before issuing an adverse determination, as required by 28 TAC §19.1710.*