Utilization Management (UM)
also known as Prior Authorization (PA)
Prior Authorization

Who determines it?

• The MCE must operate and maintain its own utilization management program
• The MCE may limit coverage based on medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose
• The MCE is prohibited from arbitrarily denying or reducing the amount, duration, or scope of required services, solely because of diagnosis, type of illness, or condition
Prior Authorization

What is it?

• The MCE may accept a nationally recognized set of guidelines, including but not limited to Milliman Care Guidelines or InterQual

• Additional considerations:
  • ASAM
  • IAC
  • Right Choices Program
  • Clinical Guidance
  • DUR Board
  • Medicaid Contract
  • IHCP Provider Reference Modules
  • IHCP Bulletins and Banners
Prior Authorization

When *is* it needed?
• Inpatient care – *always*
• Continuation of emergent care
• Surgery
• Changes in level of care
• Non-contracted providers
• Right Choices Program
• and more…
Prior Authorization

When is it *not* needed?

- Preventative services
- Self-referral services
- Emergencies
- Ongoing care
- Home health post-discharge
- Preferred drug list
- And more…
Prior Authorization

Where is the information?

• Code of federal regulations (CFR)
• Indiana administrative code (IAC), 405 IAC 5-3
• IndianaMedicaid.com
  – Banners, bulletins, medical policy manual, PA module, etc.
• MCE websites
Prior Authorization

Where is the information?
Prior Authorization

Where is the information?

MCE Websites, for all the programs:

- HIP Plus (x4)
- HIP Basic (x4)
- HIP State Plan Plus (x4)
- HIP State Plan Basic (x4)
- HIP Maternity (x4)
- HIP Plus Copay (x4)
- Presumptive Eligibility (x4)
- Hoosier Healthwise (x4)
- Hoosier CareConnect (x2)

34 Programs!

Don’t forget: fee-for-service, Medicaid rehabilitation option, waiver programs, and others…
Prior Authorization

Where is the information?

• Pièce de résistance: Universal PA
Prior Authorization

Why have it?
• Care Management
• Disease Management
• Utilization of Services (under and over)
• Fraud, Waste, and Abuse (FWA)
• Quality of Care
• Health Outcomes
• Early Detection
Prior Authorization

How do I get a Prior Authorization?

• Call me
• Fax me
• Hit me up online

CareSource™
Prior Authorization

Questions?
Claim Submission Timelines:

- Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.
- Non-Contracted or Out-of-Network providers:
  - 365 calendar days from the date of service or discharge date
  - Effective January 1, 2019 180 calendar days from the date of service or discharge date

Exceptions:

- Newborns: Services rendered within the first 30 days of life have a 365 day timely filing limit.
Billing requirements for CMS-1500:
• Box 24J – rendering provider NPI
• Box 33 – group/billing provider’s address/service location on file with IHCP-complete address with complete 9-digit zip code
• Box 33A – billing provider NPI
• Box 33B – billing taxonomy code

Billing requirements for UB-04
• Box 1– billing provider service location name, address and expanded ZIP Code + 4
• Box 56–10 digit NPI for the billing provider

Note: The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are required on all claims.

Note: Remember to attest all of your NPI numbers with the State of Indiana at www.indianamedicaid.com.
Claims Processing Timelines

**Processing time:**

- 21 days for electronic clean claims
- 30 days for paper clean claims
- Before you resubmit, check the claim status via the portals. If there is no record of the claim, resubmit.

Note: A “clean claim” is one in which all information required for processing the claim is present.
Claims disputes must be:

• Filed within 60-calendar days from the date on the remittance (MHS allows 67 days)
• Submitted in writing (Anthem takes verbally, CareSource can be done via portal)
• Completed prior to requesting an appeal

Note:
• Disputes that are not filed within the defined time frames will be denied without a review for merit.
• Disputes are available for participating and non-participating providers
Claim Appeals

Appeals must:

• Be filed after the dispute decision
• While FFS requires filing within 15 days of the date of dispute determination, Anthem allows 30 days and CareSource, MDwise and MHS allow 60 days

Appeals will be resolved within 45 calendar days from the date of the receipt of the appeal.

All appeal decisions are final.
## Claim Statistics

### Claims Timeliness

<table>
<thead>
<tr>
<th>Type of Claims</th>
<th>Metric</th>
<th>MDwise Quarter 3 2018</th>
<th>Anthem Quarter 3 2018</th>
<th>Caresource Quarter 3 2018</th>
<th>MHS Quarter 3 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional paper claims processing timeliness</strong></td>
<td>Metric Target &gt;=98%</td>
<td>HHW: 86.53%</td>
<td>HIP: 76.71%</td>
<td>HHW: 98.33%</td>
<td>HIP: 99.24%</td>
</tr>
<tr>
<td><strong>Professional electronic claims processing timeliness</strong></td>
<td>Metric Target &gt;=98%</td>
<td>HHW: 95.00%</td>
<td>HIP: 94.14%</td>
<td>HHW: 99.82%</td>
<td>HIP: 99.77%</td>
</tr>
<tr>
<td><strong>Institutional paper claims processing timeliness</strong></td>
<td>Metric Target &gt;=98%</td>
<td>HHW: 73.15%</td>
<td>HIP: 72.64%</td>
<td>HHW: 99.63%</td>
<td>HIP: 99.43%</td>
</tr>
<tr>
<td><strong>Institutional electronic claims processing timeliness</strong></td>
<td>Metric Target &gt;=98%</td>
<td>HHW: 85.55%</td>
<td>HIP: 88.56%</td>
<td>HHW: 99.71%</td>
<td>HIP: 99.52%</td>
</tr>
</tbody>
</table>

### Metric Targets
- Professional paper claims processing timeliness (CMS 1500): >=98%
- Professional electronic claims processing timeliness (CMS 1500): >=98%
- Institutional paper claims processing timeliness (UB-04): >=98%
- Institutional electronic claims processing timeliness (UB-04): >=98%
## Denial Rates & Provider Call Statistics

### Denial Rates

<table>
<thead>
<tr>
<th>Type of Claims</th>
<th>Metric</th>
<th>MDwise Quarter 3 2018</th>
<th>Anthem Quarter 3 2018</th>
<th>Caresource Quarter 3 2018</th>
<th>MHS Quarter 3 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>HHW</td>
<td>HIP</td>
<td>HHW</td>
<td>HIP</td>
</tr>
<tr>
<td>Professional claims overall denial rate (CMS 1500)</td>
<td>Metric Target &lt;=15%</td>
<td>14.10%</td>
<td>15.52%</td>
<td>14.28%</td>
<td>16.35%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.09%</td>
<td>13.62%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8.36%</td>
<td>9.77%</td>
</tr>
<tr>
<td>Institutional claims overall denial rate (UB-04)</td>
<td>Metric Target &lt;=15%</td>
<td>13.74%</td>
<td>11.39%</td>
<td>18.08%</td>
<td>17.01%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6.70%</td>
<td>7.80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9.30%</td>
<td>7.15%</td>
</tr>
</tbody>
</table>

### Call Center Statistics

<table>
<thead>
<tr>
<th>Type of Claims</th>
<th>Metric</th>
<th>MDwise Quarter 3 2018</th>
<th>Anthem Quarter 3 2018</th>
<th>Caresource Quarter 3 2018</th>
<th>MHS Quarter 3 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>HHW</td>
<td>HIP</td>
<td>HHW</td>
<td>HIP</td>
</tr>
<tr>
<td>% Calls Answered within 30 Seconds</td>
<td></td>
<td>≥ 85%</td>
<td>94.48%</td>
<td>95.02%</td>
<td>89.49%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>88.06%</td>
<td>85.40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>85.66%</td>
</tr>
</tbody>
</table>
Questions?
Managed Care Provider Portal and Provider Representative Responsibility
How to Access the IHCP Portal

Through the Indiana Health Coverage Programs (IHCP) secure and easy-to-use internet portal, healthcare providers can:

• Submit claims
• Check on the status of their claims
• Inquire on a patient's eligibility
• View their Remittance Advices
• Request prior authorization
Managed Care Entities (MCE) Provider Portals

- Anthem – via Availity
- CareSource
- Managed Health Services
- MDwise

Through the MCE portals providers can:

- Enroll, disenroll, and update primary medical providers
- Review their encounter claims
- Inquire on a managed care member's eligibility
Availity is a secure multi-health plan portal that will get you the information you need instantly. It can be accessed at www.availity.com and used to do the following:

- Eligibility and Benefits Inquiry
- Claim Submission and Inquiry
- Patient Care Summaries
- Care Reminders
- Member Certificate Booklets
- Online Remittances
- Request Prior Authorization through the Interactive Care Reviewer (ICR)
- Obtain status of an Authorization request through the ICR.
The CareSource Provider Portal allows providers to save money and time. Providers can access the following:

- Prior Authorization
- Provider Grievance
- Provider Appeals
- Submit Claims
- Review Quality Ratings
- Provider Maintenance
MHS Secure Provider Portal

Providers may register at mhsindiana.com to access MHS’ Secure Provider Portal, where they can:

- Manage multiple practices under one account
- Check member eligibility
- View member panels
- View medical history and gaps in care
- Submit/check authorizations
- Submit/check/adjust claims
- Submit claims in batch
- View HEDIS Pay for Performance Reports
- Access explanation of payments
- Communicate electronically with MHS, with one business day response time
- Access electronic copies of manuals, presentations, training material and various forms
- Access free online health library with click & print patient education material
myMDwise Provider Portal

• The myMDwise provider portal allows registered providers to view member eligibility information securely online for IHCP/Medicaid.

Included are the following online features:
• View member eligibility information.
• View member claims information.
• View member delivery system information.
• View member PMP information.
• View patient roster. (PMP Only)
• Access to online Provider Opioid Resource Center
• Submit requests for care management disease management programs.
• Request access to Quality Reports.
• Request access to Member Health Profile.
• Contact MDwise Provider Relations online.
MCE Portals - Links


MHS:  https://www.mhsindiana.com/providers.html

MDwise:  https://www.mdwise.org/for-providers/mymdwise-provider-porta

CareSource:  https://providerportal.caresource.com/IN/User/Login.aspx
Role of the Provider Education Representative

What is Provider Relations?
Provider Relations

• The purpose of the Provider Relations Representative is to provide exceptional customer service by supporting providers.

• Provider Relations Representatives are liaisons between the provider and health plan.

• We are here to answer provider inquiries regarding verification of benefits and claims status and engage in a variety of other duties such as providing education, answering inquiries and assisting with navigating health plan processes.
Provider Relations

• Our goal is to proactively educate providers on how to utilize available resources from the health plan and the state and navigate systems efficiently to accurately verify eligibility and provide verification of benefits for members

• Think of your Provider Relations Representative as a concierge to help enhance your experience working with the health plan as you care for our members
MHS Behavioral Health Network Territories

**Behavioral Health**

**PROVIDER NETWORK TERRITORIES**

**WEST TERRITORY**

Mary Schermer  
Provider Relations Specialist  
1-877-647-4848 ext. 20268  
mcschermer@mhsindiana.com

**EAST TERRITORY**

LaKisha Browder, MBA  
Provider Relations Specialist  
1-877-547-4848 ext. 20224  
lbrowder@mhsindiana.com

**NETWORK LEADERSHIP**

Richard Elliott  
Indiana Network Manager  
Indianapolis Office  
1-877-647-4848 ext. 20143  
edithj@mhsindiana.com

Kelvin Orr  
Director of Network Operations  
1-877-647-4848 ext. 50049  
kelvind.orr@mhsindiana.com

---

Map of Indiana showing Behavioral Health Network Territories.
MHS Provider Network Territories

Physical Health
PROVIDER NETWORK TERRITORIES

TAWANNA DANZIE
Provider Performance Associate
1-877-647-4844 ext., 30024
tdanzie@mhsindiana.com

CHAD PRATT
Provider Performance Associate
1-877-647-4844 ext., 20564
rpratt@mhsindiana.com

TANEYA WAGAMAN
Provider Performance Associate
1-877-647-4844 ext., 30002
twagaman@mhsindiana.com

KAT GIBSON
Provider Performance Associate
1-877-647-4844 ext., 20539
kgibson@mhsindiana.com

ESTHER CERVANTES
Provider Performance Associate
1-877-647-4844 ext., 20547
escervantes@mhsindiana.com

JENNIFER GARNER
Provider Performance Associate
1-877-647-4844 ext., 20549
jgarner@mhsindiana.com

Exception to map: IU Health, Arnett Health
CareSource Health Partner Engagement Representatives

CareSource Health Partner Engagement Representatives

Denise Edick, Manager, Health Partnerships
317-361-6872
Denise.Edick@caresource.com

Amy Williams, Team Lead, Health Partnerships
317-741-3347
Amy.Williams@caresource.com

Angelina Warren, Behavioral Health Partner Engagement Specialist
317-658-4904
Angelina.Warren@caresource.com

Brian Groovich, Ancillary, Associations and Dental
317-296-4019
Brian.Groovich@caresource.com

Contracting Managers – Hospitals/Large Health Systems

Tentec Hill – North
317-220-0861
Tentec.Hill@caresource.com

Mandy Bratton – South
317-209-4404
Mandy.Bratton@caresource.com

Regional Representatives

Sylvia Vargas
216-713-7775
Syliva.Vargas@caresource.com
Franciscan Alliance, St. Joseph Regional Medical Center

Cathy Pollick
260-403-8657
Catherine.Pollick@caresource.com
Parkview, Lutheran

Tonya Thompson
216-214-3656
Tonya.Thompson@caresource.com
Union Hospital, American Health Network

Maria Crawford
317-416-6951
Maria.Crawford@caresource.com
Indiana University, St. Vincent Health Organization

Jeni Little
765-993-7119
Jennifer.Little@caresource.com
Community Health Network, Eskenazi

Donnie Wielock
513-404-5832
Donnie.Wielock@caresource.com
Des Moines & St. Vincent Health

Paula Garrett
812-447-3661
Paula.Garrett@caresource.com
KentuckyOne, Norton, Baptist Health Floyd

39
Thank You

Questions?

www.anthem.com/inmedicaiddoc

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc., independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.
Process for Grievances and Appeals
Utilization Management

🎉 Previously approved prior authorizations can be updated for changes in dates of service or CPT/HCPCS codes within 30 days of the original date of service.

🎉 Determination will be communicated to the provider within 20 business days of receipt.

🎉 Remember: Prior Authorization Appeals must be initiated within **33 calendar days** of the denial to be considered. Please note, this is different than a claim appeal request which is **67 calendar days**.
Definition of Grievances

Grievances are defined by 42 CFR 43.8.400 (b) as any dissatisfaction expressed by the member, or a representative on behalf of a member, about any matter other than an action, as defined below:

- This may include dissatisfaction related to the quality of care of services rendered or available, rudeness of a provider or employee, or the failure to respect member’s rights.

Grievances are further defined in 760 IAC 1-59-3 as any dissatisfaction expressed by or on behalf of a member regarding the availability, delivery, appropriateness or quality of health care services and matters pertaining to the contractual relationship between an enrollee and a MCE group individual contract holder for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.
Grievance Timeline

❖ Grievances must be submitted within:
  • HHW/HIP = 33 calendar days
  • HCC = 60 calendar days

❖ MCE will acknowledge a grievance was received within 3 business days

❖ MCE will send a declaration letter within 5 business days
## Prior Authorization Grievance Statistics

<table>
<thead>
<tr>
<th>Grievance Type, Q3 2018</th>
<th>Metric</th>
<th>MHS</th>
<th>MDwise</th>
<th>Anthem</th>
<th>CareSource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Volume</td>
<td>164</td>
<td>642</td>
<td>1240</td>
<td>3,590</td>
</tr>
<tr>
<td></td>
<td>TAT</td>
<td>30 days</td>
<td>30 days</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td></td>
<td>% Timely</td>
<td>100%</td>
<td>100%</td>
<td>99.84%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Grievances per 1,000 members</td>
<td>0.66</td>
<td>1.64</td>
<td>2.82</td>
<td>28.17</td>
</tr>
</tbody>
</table>
Definition of Appeals

Appeal is defined as a request for review of an action and/or request to change a previous decision. An action, as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined the State; or
- Failure of an MCE to act within the required timeframes

For a resident of a rural area with only one MCE, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network

The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities
Prior Authorization Appeals Timeline

Appeals must be initiated within **33 calendar days** of the denial to be considered.

MCE will acknowledge an appeal was received within **3 business days**.

MCE will send decision letter within **5 business days** of the clinical decision/determination.
## Prior Authorization Appeals Statistics

<table>
<thead>
<tr>
<th>Appeal Type, Q3 2018</th>
<th>Metric</th>
<th>MHS</th>
<th>MDwise</th>
<th>Anthem</th>
<th>CareSource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Volume</td>
<td>545</td>
<td>165</td>
<td>385</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>TAT</td>
<td>30 days</td>
<td>30 days</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td></td>
<td>% Timely</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Appeals per 1,000 members</td>
<td>2.21</td>
<td>0.42</td>
<td>0.88</td>
<td>0.13</td>
</tr>
</tbody>
</table>
Questions?