How to Make Prior Authorizations Work for You
Agenda

- Prior Authorization (PA)
- Need to Know
- Web Portal
- Telephonic Requests
- Fax Requests
- Appeals Process
- MHS Team
- Questions and Answers
Prior Authorization

Prior Authorization (Medical Services):

Prior Authorization (PA) is an approval from MHS to provide services designated as needing authorization before treatment and/or payment.

- **Inpatient (IP) authorizations** = IP + 10 digits

- **Outpatient (OP) authorizations** = OP + 10 digits

- Emergent ER Symptoms suggesting imminent, life-threatening condition no PA required, but notification requested within **two business days**.

- **Urgent concurrent** = Emergent inpatient admission. Determination timeline within **24 hours** of receipt of request.

- **Pre-service non urgent** = Elective scheduled procedures. Determination within **15 calendar days**. Benefit limitations apply (dependent on product).
Prior Authorization

MHS Medical Management will review state guidelines and clinical documentation. Medical Director input will be available if needed.

 сравнительная характеристика

🎉 PA for observation level of care (up to 72 hours for Medicaid), diagnostic services do not require an authorization for contracted facilities.

🎉 If the provider requests an inpatient level of care for a covered/eligible condition, but procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.
Prior Authorization

Outpatient Services:

👩‍⚕️ All elective procedures that require prior authorization must have submitted request to MHS at least **two business days** prior to the date of service.

👩‍⚕️ All urgent and emergent services do not require prior authorization, but admission must be called into MHS Prior Authorization Dept within **two business days** following the admit.

👩‍⚕️ Members **must** be Medicaid Eligible on the date of service.

👩‍⚕️ Prior Authorizations are not a guarantee of payment.

👩‍⚕️ **Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims.**
Prior Authorization

Transfers:

MHS requires **notification and approval** for all transfers from one facility to another at least two business days in advance.

MHS requires **notification** within two business days following all emergent transfers. Transfers include, but are not limited to:

- Facility to facility
- Higher level of care changes require PA and it is the responsibility of the transferring facility to obtain.
Prior Authorization

Services that require prior authorization regardless of contract status:

- Injectable drugs (see mhsindiana.com/provider-guides for up-to-date list of codes)
- Nutritional counseling (unless diabetic)
- Pain management programs, including epidural, facet and trigger point injections
- PET, MRI, MRA and Nuclear Cardiology/SPECT scans
- Cardiac rehabilitation
- Hearing aids and devices
- Home and Institutional hospice (coverage varies by product)
- In-home infusion therapy
- Orthopedic footwear
- Respiratory therapy services
- Pulmonary rehabilitation
- Home care (except after an IP admission with benefit limitations)
- Physical Therapy, Occupational, and Speech Therapy
Prior Authorization

🎉 Is Prior Authorization Needed?

- MHS website: mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers
Prior Authorization

Medicaid Pre-AUTH Needed?

DISCLAIMER: All attempts are made to provide the most current information on the Pre-AUTH Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by Envolve Vision

Complex Imaging, MRA, MRI, PET and CT scans need to be verified by NIA

Hoosier Healthwise dental services need to be verified by State

Healthy Indiana Plan (HIP) and Hoosier Care Connect dental services need to be verified by Envolve Dental

Ambulance and Transportation services need to be verified by LCP Transportation

Behavioral Health/Substance Abuse need to be verified by Cenpatico

Non-participating providers must submit Prior Authorization for all services

For non-participating providers, Join Our Network.

Are Services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

YES [ ] NO [ ]

Types of Services

<table>
<thead>
<tr>
<th>Services</th>
<th>YES</th>
<th>NO</th>
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<tr>
<td>Is the member being admitted to an inpatient facility?</td>
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Prior Authorization

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Enter the code of the service you would like to check:

99394

99394 - PREV VISIT EST AGE 12-17
No Pre-authorization required for all providers.
Prior Authorization

Information Needed to Complete All PAs:
- Member’s Name, RID, and Date of Birth
- Type of service needed (e.g. office visit, outpatient surgery, DME, inpatient admission, testing, physical therapy, occupational therapy, speech therapy etc.)
- Date(s) of service
- Ordering Physician with NPI number
- Servicing/Rendering Physician with Rendering NPI number
- HCPCS/CPT codes requested for approval
- Diagnosis code
- Contact person, including phone and fax numbers
- Clinical information to support medical necessity (home care requires a signed Plan of Care POC)
  - Including current (within three months) clinical that is pertinent to the requested service, history of symptoms, previous treatment and results, physician rationale for ordering treatments and/or testing (MD exam notes).

*Providers must request updates to prior authorizations within 30 days from the original date of service before claim submission.*
Need to Know
Self-Referral Services

Exceptions to prior authorization requirements.

Members can see these specialists and get these services without a direct referral from their PMP:

- Podiatrist
- Chiropractor
- Family planning
- Immunizations
- Routine vision care
- Routine dental care
- Behavioral health by type and specialty
- HIV/AIDS case management
- Diabetes self management

*Benefit limitations apply*
Therapy Services (Speech, Occupational, Physical Therapy)

Must follow billing guidelines (GP, GN, GO modifiers)

Effective July 1, 2019, physical, occupational and speech therapy (PT, OT, and ST) services will no longer be managed through a post-service review process for MHS. We remain committed to ensuring that these services provided to our members are consistent with nationally recognized clinical guidelines. Therefore, beginning July 1, 2019, prior authorization for PT, OT, and ST services will be required to determine whether services are medically necessary and appropriate.

The utilization management of these services will continue to be managed by NIA.

To get started, simply go to www.RadMD.com, click the New User button and submit a “Physical Medicine Practitioner” Application for New Account. Once the application has been processed and a password link delivered by NIA via e-mail, you will then be invited to create a new password.
Therapy Services (Speech, Occupational, Physical Therapy)

🔗 Links to the approved training/education documents are found on the My Practice page for those providers logged in as a Physical Medicine Practitioner.

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

🔗 Fax number to NIA at 1-800-784-6864

🔗 Medical necessity appeals will be conducted by NIA

🔗 Follow steps outlined in denial notification

🔗 NIA Customer Care Associates are available to assist providers at 1-800-424-5391.
Durable & Home Medical Equipment (DME)

🔹 Members and referring providers do not need to search for a DME provider or provider of medical supplies to service their needs.

🔹 Medline’s web portal is used to submit orders and track delivery.

🔹 Does not apply to items provided by and billed by physician office.

🔹 Exclusions applicable to specific hospital based DME/HME vendors.
Requests should be initiated via MHS secure portal:

- **Web Portal:** Simply go to mhsindiana.com, log into the provider portal, and click on “Create Authorization.” Click DME and you will be directed to the Medline portal for order entry.
- **Fax Number:** 1-866-346-0911
- **Phone Number:** 1-844-218-4932
Outpatient Radiology PA Requests

ימו partners with NIA for outpatient Radiology PA Process
PA requests must be submitted via:
  • NIA Web site at RadMD.com
  • 1-866-904-5096

*Not applicable for ER and Observation requests
Additional Information Needed

Bariatric Surgery:
- Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, and psychologist report.

Pain Management:
- Must have documentation of at least six weeks of therapy on area receiving treatment.
- Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies.
- Include prior injection test results for injection series.

Home Health:
- Physician’s orders and signed plan of care, including most recent MD notes about the issue at hand.
- Home care plan, including home exercise program.
- Progress notes for medical necessity determination.
Musculoskeletal Safety & Quality Program

Managed Health Services (MHS) provides health coverage for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP), Hoosier Care Connect, Ambetter from MHS, and Allwell from MHS. In keeping with our commitment of promoting continuous quality improvement for services provided to our members, MHS has entered into an agreement with TurningPoint Healthcare Solutions, LLC, to implement a Musculoskeletal Surgical Quality and Safety management program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Under terms of the agreement between MHS and TurningPoint Healthcare Solutions, MHS will oversee the TurningPoint Healthcare Solutions program and continue to be responsible for claims adjudication.

Based on a June 1, 2019, implementation, this correspondence serves as notice under your MHS Participating Provider Agreement of changes to the program.

TurningPoint Healthcare Solutions will manage prior authorization for medical necessity and appropriate length of stay (when applicable) for services listed below through MHS’ existing contractual relationships. Prior authorization will be required for the following musculoskeletal surgical procedures:

**MUSCULOSKELETAL**

**Orthopedic Surgical Procedures**
- Knee Arthroplasty
- Unicompartmental/Bicompartmental Knee Replacement
- Hip Arthroplasty
- Shoulder Arthroplasty
- Elbow Arthroplasty
- Ankle Arthroplasty
- Wrist Arthroplasty
- Acromioplasty and Rotator Cuff Repair
- Anterior Cruciate Ligament Repair
- Knee Arthroscopy
- Hip Resurfacing
- Meniscal Repair
- Hip Arthroscopy
- Femoroacetabular Arthroscopy
- Ankle Fusion
- Shoulder Fusion
- Wrist Fusion
- Osteochondral Defect Repair

**Spinal Surgical Procedures**
- Spinal Fusion Surgeries
  - Cervical
  - Lumbar
  - Thoracic
  - Sacral
  - Scoliosis
- Disc Replacement
- Laminectomy/Discectomy
- Kyphoplasty/Vertebroplasty
- Sacroiliac Joint Fusion
- Implantable Pain Pumps
- Spinal Cord Neurostimulator
- Spinal Decompression
Turning Point

Emergency Related Procedures do not require authorization

It is the responsibility of the ordering physician to obtain authorization

Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims

Clinical Policies are available by contacting TurningPoint at 574-784-1005 for access to digital copies

• TRAINING:
  – Informational webinars are available! Please register at: https://register.gotowebinar.com/rt/7079530369468972290
Turning Point’s Utilization Management

• Web Portal Intake:
  – myturningpoint-healthcare.com

• Telephone Intake:
  – 574-784-1005 | 855-415-7482

• Fax Intake: 463-207-5864
Managed Health Services (MHS) provides health coverage for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect. MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in subacute facilities at least every 3-5 days. It is important that you provide a complete current clinical update on our member’s status at each review.

- The review should include current information (within one day) on:
  - Member’s condition
  - Level of functioning (prior to admission)
  - Medications
  - Therapies provided
  - Participation in therapies
  - Progress toward goals
  - New or amended goals
  - Updates from care conferences
  - Updates to our member’s plan of care
  - Discharge plans and needs identified (home health/DME, etc.)
  - Anticipated discharge date

Indiana Code requires that individuals requesting a nursing facility admission to a Medicaid-certified NF meet a nursing facility level of care (405 IAC 1-3-1 and 405 IAC 1-3-2). A PASRR is required before admission and must be submitted with the admission request and when updated according to IAC requirements.

Please submit this information as requested by MHS nurse reviewer every 3-5 days.
Prior Authorization (PA) Request

Providers can update previously approved PAs within 30 days of the original date of service prior to claim denial for changes to:

• Dates of service
• CPT/HCPCS codes
• Provider

*Providers may make corrections to the existing PA as long as the claim has not been submitted.
Prior Authorization (PA) Request

MHS strives to return a decision on all PA requests within **two business days** of request.

Reasons for a delayed decision may include:
- Lack of information or incomplete request
- Illegible faxed copies of PA forms – i.e handwriting is illegible or fax is otherwise not readable
- Request requiring Medical Director review

MHS has up to **seven days** to render PA decisions.

**Denied Authorizations** must follow the authorization appeal process, not the claims appeal process, claims appeals can not change the status of a denied authorization.
Prior Authorization (PA) Request

💰 PA approval requires the need for medical necessity.

💰 If your PA is denied, please contact Utilization Management at 877-647-4848 to determine the cause of the denial.

💰 Medical Management **does not** verify eligibility or benefit limitations:

  • Provider is responsible for eligibility and benefit verification
Continuity of Care PA Request

🎉 MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.

*Reference: MHS Provider Manual Chapter 6*
Pharmacy Requests

MHS Pharmacy Benefit Manager is Envolve Envolve Pharmacy Solutions:

🎉 Preferred Drug Lists and authorization forms are available at mhsindiana.com/provider/pharmacy:
  • PA requests
  • Phone 1-866-399-0928
  • Fax non specialty drugs 1-866-399-0929
  • Specialty drugs 1-866-678-6976
  • pharmacy.envolvehealth.com

🎉 Formulary integrated into many Electronic Health Records (EHR) solutions

🎉 Online PA submission available through CoverMyMeds:
  • covermymeds.com

🎉 Online PA forms for Specialty Drugs on mhsindiana.com
Web Portal
Web Authorization

 Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at mhsindiana.com/login:

• When using the portal, providers can upload supporting documentation directly.

Exceptions: Must submit hospice, home health and biopharmacy PA requests via fax 1-866-912-4245

 Providers can check the authorization status on the portal.
Secure Portal Registration or Login

Portal Login

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login button. A new window will open. You can login or register.

Creating an account is free and easy.

By creating a MHS account, you can:
- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

Please note that Clear Claim Connection does not provide an all-inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

Behavioral Health Secure Portal

Click here for the Cenpatico behavioral health portal.

Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our Become a Provider page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

FOR PROVIDERS

Login

Become a Provider

Prior Authorization

Dental Providers

Pharmacy

Provider Resources

QI Program

Provider News

FOR MEMBERS

FOR PROVIDERS

GET INSURED
Registration

Please allow 24-48 hours for your account to be verified. An email will be sent once access to the portal tools have been granted to the respective account.
## Authorizations:

➢ View, create and filter group authorizations

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### Authorizations

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<th>STATUS</th>
<th>AUTH ID</th>
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<th>TO DATE</th>
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<td>APPROVE</td>
<td>C........1</td>
<td>All.... H</td>
<td>07/24/2017</td>
<td>10/24/2017</td>
<td>E11.9</td>
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<td>DME</td>
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<td>[Redacted]</td>
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<td>09/19/2017</td>
<td>B07.9</td>
<td>OUTPATIENT</td>
<td>Office Visit</td>
</tr>
</tbody>
</table>

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.
Creating a New Authorization

- Click **Create Authorization.**
- Enter **Member ID or Last Name** and **Birthdate.**
Creating a New Authorization

Select a Service Type

By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests.

Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.

As of 10/1/15 Retro Authorizations with ICD-9 codes should not be submitted on the web. Authorizations after 10/1/15 should use ICD-10 codes.
Creating a New Authorization

Select Provider NPI  Add Primary Diagnosis
Creating a New Authorization

🌟 If required Add Additional Procedures
Creating a New Authorization

Service Line Details:

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

Submit a new Authorization:
- Confirmation number.
Telephone Authorizations
Providers can initiate Prior Authorization via the MHS referral line by calling 1-877-647-4848:

- Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
- After hours, MHS 24-hour nurse line available to take emergent requests.

The PA process begins at MHS by speaking with the MHS non-clinical referral staff.

For procedures requiring additional review, we will transfer providers to a “live” nurse line to facilitate the PA process.

Please have all clinical information ready at time of call.
Fax Authorization
Fax Authorization

MHS Medical Management Department at 1-866-912-4245:

Member ID/RID, DOB
Patient name, required

Medical Diagnosis code(s) required

Check service category
# Fax Authorization

## Requesting Provider Information:
- NPI#:
- Tax ID#:
- Service Location Code:
- Provider Name:

## Rendering Provider Information
- Ordering Physician NPI#:
- Tax ID#:
- Name:
- Address:
- City/State/Zip:
- Phone:
- Fax:

Enter the **Requesting** provider’s information

Enter the **Rendering** provider’s individual NPI#
## Fax Authorization

<table>
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<th>Dates of Service Start</th>
<th>Procedure/Service Codes</th>
<th>Modifier(s)</th>
<th>Requested Service</th>
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Allwell from MHS | Ambetter from MHS | Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect
Prior Authorization
Denial and Appeal Process
PA Denial and Appeal Process

If MHS denies the requested service:

• And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request the expedited appeal.
• And the member already has been discharged, the attending physician must submit an appeal in writing within **60 days** of the denial.

The attending physician has the right to a peer-to-peer discussion with an MHS physician:

• Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.
• They must request peer-to-peer within **10 days** of the adverse determination.

*Prior authorization appeals are also known as medical necessity appeals.*
PA Denial and Appeal Process

.sendStatusPriorAuthorization/MedicalNecessityAppealsTo:
ManagedHealthServices
Attn:AppealsCoordinator
POBox441567
Indianapolis,IN46244

Providersmustinitiateappealswithin60daysoftherceiptofthedenialletterformHS
toconsider.
Wewillcommunicatedeterminationtotheproviderwithin20
businessdaysofreceipt.
A prior authorization appeal is different than a claim appeal request.
This process is applicable to members and non-contracted providers.
Provider Relations Team
# MHS Provider Network Territories

## PROVIDER GROUPS
- Beacon Medical Group
- Community Care Network
- Franciscan Alliance
- Goshen Health System
- Health Inc.
- Heart City Health Center
- Indiana Health Centers
- Lutheran Medical Group
- Northshore Health Centers
- Parkview Health System
- South Bend Clinic

## PROVIDER GROUPS
- American Health Network of Indiana
- Columbus Regional Health
- Community Physicians of Indiana
- Good Samaritan Hospital Physician Services
- HealthNet
- Health & Hospital Corporation of Marion County
- Indiana University Health
- Little Company of Mary Hospital of Indiana
- Riverview Hospital
- St. Vincent Medical Group

## INTERNAL REPRESENTATIVES
### JENNIFER DEAN
Provider Network Specialist  
1-877-647-4848 ext. 20221  
jdean@mhsindiana.com

## LAKISHA BROWDER
Provider Relations Specialist  
1-877-647-4848 ext. 20224  
lbrowder@mhsindiana.com

## ENVOLE DENTAL, INC.  
### MICHAEL J. WILLIAMS
Provider Relations Specialist  
1-727-437-1832  
Dental Provider Services: 1-855-609-5157  
Michael.Williams@Envolvedentalhealth.com
What you learned today:

- PA process and timelines
- DME/HME and Therapy PA requirements
- PA submission options
- Appeals Process
Questions?

Thank you for being our partner in care.
Session Survey

• Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1020