MHS Prior Authorization
Agenda

• Prior Authorization (PA)
  • PA requirements
    • Recent Updates
    • Helpful Tips
  • Web
  • Telephone
  • Fax
• Referrals
• Appeals Process
• Need to Know
• Questions and Answers
Prior Authorization

Prior Authorization (Medical Services)

Prior Authorization is an approval from MHS to provide services designated as needing approval before treatment and/or payment

- Inpatient authorizations = IP + 10 digits
- Outpatient authorizations = OP + 10 digits
- Emergent = 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 procedures. Determination within 15 calendar days

Benefit limitations apply
Prior Authorization

MHS Medical Management will review state guidelines and all available clinical documentation and seek Medical Director input as needed

- PA for observation level of care (up to 72 hours) and for diagnostic services do not require an authorization for contracted facilities. For non-diagnostic services, authorization requirements remain the same
- If the provider requests an inpatient level of care for a covered/eligible condition, or procedure and documentation supports an outpatient/observation level of care, we will send the case for Medical Director review
Prior Authorization

Outpatient Services

• All elective procedures must have prior authorization from MHS at least two business days prior to the date of service
• All urgent and emergent services do not require prior authorization, but must be called in to MHS within two business days following the admit.
• Prior Authorizations are not a guarantee of payment
• Members must be Medicaid Eligible on the date of service

*Failure to obtain prior authorization will result in a denial for related claims
Prior Authorization

Transfers

• MHS requires **notification and approval** for all transfers 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
• Level of care changes
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 (benefit limitations apply)
- In-home infusion therapy
- Orthopedic footwear
- Orthotics and prosthetics, if cost is greater than $250
- Respiratory therapy services
- Pulmonary rehabilitation
Prior Authorization

Is Prior Authorization Needed?

• MHS website mhsindiana.com

• Quick reference guide
  • Non-contracted provider services require prior authorization
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

<table>
<thead>
<tr>
<th>Types of 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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<td>Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?</td>
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<td>Are anesthesia services being rendered for pain management?</td>
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<tr>
<td>Is the member receiving dialysis?</td>
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To submit a prior authorization Please [Login Here](#).
Types of Services

| YES | NO |
|----------------|
| Is the member being admitted to an inpatient facility? | ☐ | ☑ |
| Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home? | ☐ | ☑ |
| Are anesthesia services being rendered for pain management? | ☐ | ☑ |
| Are services for infertility? | ☐ | ☑ |
| Is the member receiving dialysis? | ☐ | ☑ |

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

99394

Check

99394 - PREV VISIT EST AGE 12-17
Pre-authorization is required if service is rendered at home except for Primary Care Providers or Health Department. In all other locations, Pre-authorization is required for non-participating providers.

This service requires prior authorization. Login Here to submit authorization

To submit a prior authorization Login Here.
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 Physician with NPI number
• HCPCS/CPT codes requested for approval
• Diagnosis code
• Contact person, including phone and fax numbers
• Clinical information to support medical necessity
  • 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
Recent PA Updates
Therapy Services - (Speech, Occupational, Physical Therapy)

• 10/1/17 authorization is no longer required
  • Benefit limitations are applicable
• Must follow billing guidelines (GP, GN, GO modifiers)
• National Imaging Associates, Inc. (NIA) will conduct retrospective review to evaluate medical necessity
  • If requested, medical records can be uploaded to www.RadMD.com or faxed to NIA at 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 800-424-5391
Durable & Home Medical Equipment

• Members and referring providers will no longer need to search for a DME provider or provider of medical supplies to service their needs
• Order is submitted directly to MHS, coordinated by Medline and delivered to the member
• Availability via Medline’s web portal to submit orders and track delivery
• Prior authorization required by the ordering physician for all non-participating DME providers
• Does not apply to items provided by and billed by physician office
• Exclusions applicable to specific hospital based DME/HME vendors

ALL 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.” Choose DME and you will be directed to the Medline portal for order entry
Helpful Tips when requesting PA
DME PA Requests

• Completed certificate of medical necessity with current (from within three months) information and MD signature from within the year

• Medical Clearance Form
  • These forms are on the IHCP provider website – go to quick links on the right side and click forms.
  • The form is under medical clearance forms and certifications of medical necessity. (There are also hospice forms, prior authorization forms)

• Physician’s order

• Whether request is for authorization of purchase or rental

• Power wheelchairs must have home evaluation

• Enteral/Formula: Current height/weight, growth charts, nutrition history, previous testing/imaging/surgeries, current MD office visit notes related to the request
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 contraindications or imaging studies
• Include prior injection test results for injection series

Home Health
• Physician’s orders, including most recent MD notes about the issue at hand
• Home care plan, including home exercise program
• Progress notes for medical necessity determination
Outpatient Radiology PA Requests

• MHS partners with NIA for outpatient Radiology PA Process

• PA requests can be submitted
  • NIA Web site at www.RadMD.com
  • 1-866-904-5096
  • Not applicable for ER and Observation requests
Pharmacy PA Requests

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 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**

• Providers also can check 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.

Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect
The Registration is complete and the Secure Portal homepage will be visible!

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
Create a New Authorization

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

- Select a Service Type
Creating a New Authorization

Select Provider NPI  Add Primary Diagnosis
Creating a New Authorization

- If required Add Additional Procedures
Creating a New Authorization

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

Submit a new Authorization
- Confirmation Number

Success!
- Your confirmation number is #1073867.
Telephonic
Telephone Authorization

- Providers can initiate Prior Authorization through 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

1-866-912-4245  MHS Medical Management Department

- **Member RID, name, and DOB required.**
- **Diagnosis code(s) required**
- **Check service category**
## Fax Authorization

### Requesting Provider Information:

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<tr>
<td>NPI#</td>
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<td>Tax ID#</td>
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<tr>
<td>Service Location Code</td>
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<td>Provider Name</td>
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### Rendering Provider Information

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## Fax Authorization

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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*
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 this.

• And the member already has been discharged, the attending physician must submit an appeal in writing within **33 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

- Send Prior Authorization/Medical Necessity Appeals to:
  Managed Health Services
  Attn: Appeals Coordinator
  550 North Meridian Street, Suite 101
  Indianapolis, IN 46204

- Providers must initiate appeals within **33 days** of the receipt of the denial letter for MHS to consider

- We will communicate determination to the provider within **20 business days** of receipt

- *A prior authorization appeal is different than a claim appeal request*

- *Applicable to members and non-contracted providers*
Need to Know
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 in:

- Dates of service
- CPT/HCPCS codes
- Physician

*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 – e.g. handwriting is illegible or fax is otherwise not readable
- Request requiring Medical Director review

MHS has up to seven days to render PA decisions.
Prior Authorization (PA) Request

• PA approval requires the need for medical necessity

• If your claim is denied, please contact Provider Services at 1-877-647-4848 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.

- Reference: MHS Provider Manual Chapter 6
# MHS Provider Relations Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Contact Information</th>
<th>Email</th>
</tr>
</thead>
<tbody>
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Review

• Learned about the PA process and timelines

• Highlighted the recent change regarding DME/HME and Therapy PA requirements

• Reviewed PA submission options

• Reviewed the Appeals Process
Questions

Thank you for partnering with MHS