INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

# Prior Authorization

*Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletins, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:*

- *BT2025157 – MDwise to end participation as a managed care health plan for HIP and Hoosier Healthwise*
- *BT202496 – Guidance provided regarding continuity of care for members transitioning between IHCP programs*
- *BT202434 – IHCP aligns fee-for-service continuity of care with managed care*

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# Revision History

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| 7.0 | Policies and procedures as of July 1, 2023<br>Published: July 1, 2023 | Scheduled update:<br>• Edited and reorganized text as needed for clarity<br>• Removed references to IHCP banner pages<br>• Replaced Gainwell PA information with IHCP FFS PA-UM contractor information<br>• Replaced Southeastrans with the NEMT brokerage contractor<br>• Added the *Utilization Management Hierarchy* section<br>• Updated the *Managed Care Prior Authorization* section | FSSA and Gainwell |

| Version | Date | Reason for Revisions | Completed By |
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| | | • Updated the *Prior Authorization Policy Requirements* section<br>• Updated information about school corporation services in the *Prior Authorization Exceptions* section<br>• Updated the *Time Parameters for Prior Authorization Requests* section and its subsections<br>• Added a note about treatment plans/plans of care in the *Supporting Documentation* section<br>• Updated the *Prior Authorization Request Status and Notification Letter* section<br>• Updated the *Revising PA Requests* section<br>• Removed DMHA reference from the *1915(c) HCBS Waiver Authorizations* section<br>• Added a note about timely filing to the *Retroactive Prior Authorization* section<br>• Updated information in *Table 2 – IHCP Prior Authorization Request Form Instructions* about who will be contacted if the requesting provider is not enrolled in the IHCP<br>• Renamed and updated the *Submitting PA Requests Through the Provider Portal* section, and removed subsections<br>• Updated the *Submitting PA Requests by 278 Electronic Transaction* section for the new FFS PA-UM contractor<br>• Updated the *Submitting PA Requests by Telephone* section<br>• Updated the *Administrative Review of PA Decisions* section | |
| 7.1 | Policies and procedures as of July 1, 2023<br>Published: Nov. 12, 2025 | Interim update:<br>• Added note on title page pointing to *IHCP Bulletin BT2025157* | FSSA and Gainwell |

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| 7.2 | Policies and procedures as of July 1, 2023<br>Published: Nov. 20, 2025 | Interim update:<br>• Added note on title page pointing to *IHCP Bulletins BT202496 and BT202434* | FSSA and Gainwell |

# Table of Contents

# Section 1: Introduction to Prior Authorization

> *Note: The information in this document applies to prior authorization for Indiana Health Coverage Programs (IHCP) nonpharmacy services. For information about pharmacy-related prior authorization, see the Pharmacy Services module.*
>
> *Although this module contains some general information regarding prior authorization for services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual for policies and procedure specific to each health plan. MCE contact information is included in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

The Indiana Health Coverage Programs (IHCP) requires prior authorization (PA) based on medical necessity for certain services. Certain services also require submitting PA requests for additional units when normal limits are exhausted.

## Utilization Management Hierarchy

The IHCP uses the following utilization management (UM) hierarchy for medical review criteria:

1. Code of Federal Regulations (CFR)
2. Indiana Code (IC)
3. Indiana State Plan
4. Indiana Administrative Code (IAC)
5. IHCP policy:
   - IHCP bulletins
   - IHCP provider reference modules
6. Nationally recognized clinical guidelines, such as Milliman Care Guidelines (MCG) or InterQual
7. Professional society guidelines, guided by published, peer-reviewed literature
8. Professional references/subject-matter expert, guided by published, peer-reviewed literature
9. Best standards of care, guided by published, peer-reviewed literature

> *Note: Effective April 1, 2023, managed care entities (MCEs) must follow this same UM medical criteria hierarchy for all IHCP managed care programs, including Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise. MCEs cannot have medical criteria or UM policies that are more restrictive than those described in IHCP policy, and for certain services, MCEs must follow IHCP policy exactly. The MCE must use the full suite of non-customized InterQual or MCG clinical guidelines. For areas not addressed by IHCP policy or MCG/InterQual, the MCE may develop their own UM policy and criteria, but they must be preapproved by the state.*
>
> *Some professional society guidelines may supersede national or MCE-derived guidelines if specifically noted in the scope of work (such as the American Society of Addiction Medicine (ASAM).*

# Prior Authorization Contractors

Multiple entities provide PA for IHCP services. The first step in determining which entity to contact for PA is establishing whether the service is reimbursed through the fee-for-service (FFS) or managed care delivery system, as described in the following sections.

Contact information for all IHCP PA contractors is available in the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.

## *Fee-for-Service Prior Authorization*

For services delivered on an FFS basis (such as under the Traditional Medicaid program), PA is managed by one of the following contractors:

- For pharmacy services – IHCP FFS pharmacy benefit manager (PBM)
- For all other services – IHCP FFS prior authorization and utilization management (PA-UM) contractor

> *Note: For nonemergency medical transportation (NEMT) that is subject to brokerage for FFS members, the NEMT brokerage contractor is responsible for obtaining PA through the IHCP FFS PA-UM contractor, as needed. Transportation providers are not required to submit PA requests when the service is brokered through the NEMT brokerage contractor. See the Transportation Services module for more information.*

The IHCP FFS PA-UM contractor reviews all PA requests on an individual, case-by-case basis. The unit's decisions to authorize, modify or deny a given request are based on medical necessity and administrative criteria.

See the *Pharmacy Services* module for more information about pharmacy-related PA.

## *Managed Care Prior Authorization*

For services covered under the Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise programs, the MCEs (Anthem, CareSource, Managed Health Services [MHS], MDwise and UnitedHealthcare) or their subcontractors are responsible for determining which services require PA, and for processing PA requests for their members and notifying them about PA decisions. All MCEs must follow the same hierarchy for medical review criteria as outlined in the *Utilization Management Hierarchy* section. For areas not addressed by IHCP policy or national clinical guidelines (MCG or InterQual), the MCE may develop its own internal UM policy and criteria, but they must be preapproved by the state.

> *Note: Effective Jan. 1, 2026, MDwise is no longer participating as an IHCP MCE.*

Additional information about MCE authorization procedures can be requested from the member's assigned MCE or the MCE's dental benefit manager (DBM) or pharmacy benefit manager (PBM). MCE assignment information is provided during eligibility verification via the following:

- IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers
- IHCP virtual assistant (GABBY) on the Provider Customer Assistance line at 800-457-4584, option 2
- 270/271 electronic transaction

Contact information for all MCEs and their subcontracted DBM and PBM is available in the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.

Certain services are carved out of managed care and covered under the FFS delivery system for *all* IHCP members, including those enrolled with an MCE. PA requests for these carved-out services must be submitted to, and are processed by, the IHCP FFS PA-UM contractor (or the FFS PBM, in the case of carved-out pharmacy services). See the *Member Eligibility and Benefit Coverage* module for a list of services that are carved out of managed care.

### *Transferring Outstanding Prior Authorizations Between Contractors*

If a member changes from managed care (with an MCE assignment) to fee-for-service (no MCE assignment) or from fee-for-service to managed care – or if a managed care member switches from one MCE to another – the member's new PA contractor must honor all existing PAs for one of the following durations, whichever comes first:

- The first 30 calendar days, starting on the member's effective date in the new plan
- The remainder of the PA dates of service
- Until approved units of service are exhausted

This policy extends to PAs for a specific procedure (such as a surgery), as well as for ongoing services authorized for a specified duration (such as physical therapy or home health care). MCEs may be required to reimburse out-of-network providers during the transition period.

Providers should always check eligibility before rendering services. If there has been a change in the member's MCE assignment, providers should notify the new PA contractor of any outstanding PAs and supply documentation to substantiate the PA.

The entity that issued the original PA is required to provide the newly assigned PA entity with the following information:

- Member's IHCP Member ID
- Requesting provider's National Provider Identifier (NPI) (or IHCP Provider ID, if atypical provider)
- Procedure codes
- Duration and frequency of authorization
- Other information pertinent to the determination of services provided

> *Note: If, in addition to a change in MCE assignment, the member's* ***coverage*** *has also changed (for example, from Full Medicaid to HIP Basic, or from Package A to Family Planning Eligibility Program), the authorized service must be a covered service under the new benefit plan assignment for IHCP reimbursement of the previously authorized service.* ***PA is not a guarantee of payment.***

## Prior Authorization Policy Requirements

Criteria pertaining to PA requirements can be found in *405 IAC 5*. IHCP providers are responsible for reading the portions of this code that apply to their specific areas of service as well as the general PA criteria found in *405 IAC 5-3.* Information about how this code applies to specific IHCP services is included in the appropriate IHCP provider reference modules, available from the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers. This module provides some general PA guidelines, but the resources listed in the *Utilization Management Hierarchy* section – including the IAC and applicable provider reference modules – should be referred to as the primary references for PA policy.

Providers can obtain applicable sections of the FFS internal PA criteria by referring to the appropriate provider reference module or by submitting a request to the Office of Medicaid Policy and Planning (OMPP) as described on the *Policy Consideration Requests* page at in.gov/medicaid/providers.

> *Note: For HIP, Hoosier Care Connect and Hoosier Healthwise members, providers should contact the applicable MCE for specific PA policies and procedures.*

## Prior Authorization Policies for Out-of-State Providers

All services provided by out-of-state providers require PA, except in the circumstances presented in the *Out-of-State Providers* module.

## Prior Authorization Exceptions

The following PA exceptions are described in *405 IAC 5-3-12:*

- School corporation services do not require a separate PA from the IHCP. The Medicaid-enrolled student's educational program or plan as required by the *Individuals with Disabilities Education Act* (IDEA) or Section 504 of the federal *Rehabilitation Act of 1973* (*United States Code 29 USC 794*) serves as the PA for these services. See the *School Corporation Services* module for details.
- When a member's physician determines that an inpatient hospital setting is no longer necessary but that IHCP-covered services should continue after the member is discharged, up to 120 hours of such services may be provided within 30 days of discharge without prior authorization, if the physician has specifically ordered such services in writing upon discharge from the hospital. This exemption does not apply to durable medical equipment, neuropsychological and psychological testing, or out-of-state medical services. Physical, speech, respiratory and occupational therapies may continue for a period not to exceed 30 hours, sessions or visits in 30 days without prior authorization if the physician has specifically ordered such services in writing upon discharge or transfer from the hospital. See the *Home Health Services* and *Therapy Services* module for details.
- Emergency services do not require PA. Providers must follow the guidelines outlined in the *Emergency Services* module.

> *Note: Although emergency services do not require PA, any resulting inpatient stay does require PA, with the exception of inpatient stays for burn care with an admission of type 1 (emergency) or type 5 (trauma). All other emergency admissions must be reported to the PA contractor within 48 hours of admission, not including Saturdays, Sundays or legal holidays, as indicated in the Inpatient Hospital Services module.*

## 590 Program

PA requirements for the 590 Program differ from those of other IHCP programs. For 590 Program members, PA is required for any service estimated to be $500 or more, and PA is not required (unless rendered by an out-of-state provider) for any service estimated to be less than $500. See the *590 Program* module for more information.

## Prior Authorization Required for Specific Medical Services

Specific PA criteria for physician services are found in *405 IAC 5-25*. In addition, as specified in *405 IAC 5-3-13(a),* the following medical services require PA:

- Reduction mammoplasties
- Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem

- Intersex surgery
- Blepharoplasties for significant obstructive vision problems
- Sliding mandibular osteotomies for prognathism or micrognathism
- Reconstructive or plastic surgery
- Bone marrow or stem-cell transplants
- All organ transplants covered by the Medicaid program
- Home health services
- Maxillofacial surgeries related to diseases of the jaws and contiguous structures
- Temporomandibular joint (TMJ) surgery
- Submucous resection of nasal septum and septoplasty when associated with significant obstruction
- Weight reduction surgery, including gastroplasty and related gastrointestinal surgery
- Procedures ordinarily rendered on an outpatient basis, when rendered on an inpatient basis
- Dental admissions
- Brand medically necessary drugs
- Psychiatric inpatient admissions, including admissions for substance abuse
- Rehabilitation inpatient admissions
- Orthodontic procedures for members under 21 years of age for cases of craniofacial deformity or cleft palate
- Genetic testing for detection of cancer of the breasts or ovaries
- Medicaid Rehabilitation Option (MRO) services
- Partial hospitalization, as provided under *405 IAC 5-20-8*
- Neuropsychological and psychological testing

> *Note: Any physician services that require but do not receive PA are not reimbursed, including services rendered during an office visit and services rendered during an inpatient hospital stay paid for under a level-of-care (LOC) methodology – such as psychiatric, rehabilitation and burn stays.*

# Prior Authorization Limitations for Reimbursement

The IHCP does not reimburse providers for any IHCP service requiring PA unless PA is obtained first. If a PA request qualifies for retroactive eligibility, as defined in the *Retroactive Prior Authorization* section of this module, a determination must be made prior to submitting a claim. PA is monitored by concurrent or postpayment review. Exceptions to this policy are noted later in this document.

Any authorization of a service by an IHCP PA contractor is limited to authorization for payment of IHCP allowable charges. It is not an authorization of the provider's estimated fees.

**PA is not a guarantee of payment.** Notwithstanding any PA by the IHCP, the provision of all services and supplies must comply with the following resources:

- IHCP Provider Agreement
- IHCP provider reference modules
- IHCP bulletins
- Remittance Advice (RA) statements or 835 transactions
- PA criteria requested by and issued to providers
- Any applicable state or federal statute or regulation

# Section 2: Prior Authorization Procedures

The Indiana Health Coverage Programs (IHCP) requires prior authorization (PA), based on medical necessity, for certain services. Certain services also require submitting PA requests for additional units when normal limits are exhausted. Providers must verify eligibility before delivery of a service and must monitor the number of units of each prior-authorized service.

## Prior Authorization and Eligibility Verification

The PA contractor determines whether a PA request is approved, based on medical necessity and administrative criteria. Granting PA confirms medical necessity, but is valid only if a member is eligible on the date services are rendered. Providers can verify eligibility by using the IHCP virtual assistant (GABBY) on the Customer Assistance Line, IHCP Provider Healthcare Portal (IHCP Portal) or 270/271 electronic transaction. See the *Member Eligibility and Benefit Coverage* module for details about verifying member eligibility.

> *Note: It is not the responsibility of the PA contractor to ensure the eligibility status of a member. PA is not a guarantee of payment, and member eligibility should be verified by the provider before services are rendered.*

The eligibility verification process also helps providers determine which entity to contact for PA, based on whether the member's benefits are provided through a managed care program. For managed care members, the eligibility verification provides the name of the managed care program – Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise – and the name and contact information of the managed care entity (MCE) to which the member is assigned. See the *Prior Authorization Contractors* section for information about obtaining PA under fee-for-service (FFS) versus managed care delivery systems.

Providers should also determine whether the member has third-party liability (TPL) coverage and whether PA from the third-party carrier is necessary. Because the IHCP is the payer of last resort, claims must be submitted to the third-party carrier before they are submitted to the IHCP. The third-party carrier, as well as the IHCP, may require PA. See the *Prior Authorization and Third-Party Liability* section for more information.

## Provider Requests for Prior Authorization

Providers can request PA on behalf of the IHCP member. See *Section 3: Methods for Submitting Prior Authorization Requests* for information about submitting PA requests electronically or by fax, mail or telephone.

After PA is obtained, the member can choose the provider that will render the authorized service, as long as the member is not restricted to a specific provider of service, such as members enrolled in the Right Choices Program (RCP) and members assigned to a primary medical provider (PMP) within a managed care program. It is important to note that the member may have a prior-authorized service performed by a provider other than the one who requested the PA; the approved PA belongs to the *member*, not to the provider.

> *Note: If a member has other health insurance, and a service that is covered by Medicaid requires PA from both payer sources, the provider must obtain PA from both sources before rendering services.*

## *Providers Allowed to Submit PA Requests*

In accordance with IHCP policy, PA requests can be signed and submitted by the following providers, within the scope of practice for the applicable licensure:

- Physician (doctor of medicine [MD] or doctor of osteopathy [DO])
- Dentist
- Optometrist
- Podiatrist
- Chiropractor
- Nurse practitioner
- Certified nurse midwife
- Clinical nurse specialist
- Physician assistant
- Psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed clinical addiction counselor (LCAC)
- Home health agency (authorized agent)
- Hospital (authorized agent)
- Transportation provider (authorized agent)
- For drugs subject to prior authorization, any provider with prescriptive authority under Indiana law

PA request forms that are signed by a provider ***not*** meeting the preceding qualifications must include a signed, dated order from an attending provider that ***does*** meet these qualifications. Otherwise, the PA will be placed in *pended* status.

For PA requests submitted electronically (via 278 transaction or using the PA contractor's designated provider portal), if the request is submitted by a provider type other than those listed previously, the requester must submit an order, signed and dated by an attending provider who meets the qualifications for submitting a PA request for that service. For requests submitted to the provider portal used by the IHCP FFS prior authorization and utilization management (PA-UM) contractor, this additional documentation may be uploaded as an attachment to the portal request, or else must be sent by fax or mail. Unless the attachment is submitted via the portal at the time the request is made, the original request is pended for documentation of the attending provider's order. Failure to submit additional documentation within 30 calendar days of the request results in denial of the request.

> *Note: The specific provider specialties allowable for requesting PA (or signing accompanying orders) vary by the type of service being requested. The provider must be enrolled in the IHCP under one of the provider types or specialties listed in this section, and it must be within the scope of that provider's licensure to order the service in question.*

## PA Signature Policies

Pursuant to *405 IAC 5-3-5(c)(2)*, the provider must sign the PA request by personal signature, or providers and their designees may use a signature stamp or, for requests submitted via the PA contractor's designated provider portal, an electronic signature. Providers that are agencies, corporations or business entities may authorize one or more representatives to sign requests for PA.

Electronic signatures are accepted on supporting documents as long as the provider's electronic health record system provides the appropriate protection and assurances that the rendering provider signed the document and the signature can be authenticated. If the appropriate controls are in place, electronic signatures are acceptable. Providers using electronic systems need to recognize the potential for misuse or abuse with alternate signature methods. Providers bear the responsibility for the authenticity of the documentation and signatures. Providers are encouraged to check with their attorneys and malpractice insurers regarding electronic signatures. Any provider using an electronic signature must follow the requirements of *IC 26-2-8-116*.

## Time Parameters for Prior Authorization Requests

> *Note: The information in this section is specific to FFS nonpharmacy PA. For **managed care** PA requests, contact the appropriate PA contractor for authorization time parameters and related procedures. For FFS **pharmacy** PA requests, contact the IHCP FFS pharmacy benefit manager. See contact information in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*

The decision regarding a PA request is made as quickly as possible. For FFS nonpharmacy requests, if a decision is not made within **seven calendar days** after receipt of all required documentation, authorization is deemed to be granted within the coverage and limitations specified *(405 IAC 5-3-14).*

Before billing for a service that requires PA, the provider must wait until notification of approval (such as PA notification letter, portal authorization status or 278 transaction response) – or until verification can be made that the PA contractor received the request and did not render a decision within the time parameters listed previously. See the *Prior Authorization Request Status and Notification Letter* section for information about checking the status of a PA request. To speak with a live representative regarding a PA request, contact the PA contractor (see contact information in the *IHCP Quick Reference Guide* at in.gov/medicaid/providers).

### Requests for Additional Information

For the PA reviewer to determine whether a service or procedure is medically necessary, the PA contractor may request more information from the member and provider. Additional clinical information to justify medical necessity or additional information needed for clarification – including, but not limited to, X-rays, ultrasound, lab and biopsy reports – may be required. Photographs may be necessary in some instances, such as breast reduction surgery or wound management. Other reasons a PA request may require additional information include lack of complete medical history, missing medical clearance forms or missing plan of treatment.

When additional information is requested, the time parameters described previously begin upon receipt of the information by the PA contractor. The established mechanism to allow time for the provider to supply this information is achieved by placing the first request in *pended* status and having the provider submit the additional information as follows:

- Through the PA contractor's designated provider portal, such as, within the FFS PA-UM contractor's provider portal, by uploading the supporting documentation as an authorization revision to the pended authorization request
- By mail or fax, using the *IHCP Prior Authorization System Update Request Form,* available on the *Forms* page at in.gov/medicaid/providers

> *Note: Placing the request in a pended status does not mean the request is denied; it gives the provider additional time to provide clinical information that facilitates a more accurate and appropriate determination.*

The PA contractor must receive this additional information within 30 calendar days of the receipt of the original authorization request. If the PA contractor determines medical necessity after receiving the additional information, the dates authorized are those on the original, pending PA request. If the additional information is not received within 30 days, the request is systematically denied.

### New PA Requests for Continuation of Ongoing Services

The provider is responsible for submitting new PA requests for continuation of ongoing services (such as home health care) at least 30 calendar days before the current authorization period expires, to ensure that services are not interrupted.

If the PA contractor makes a determination that involves a denial or modification of a continuing service, at least 10 days' notice plus three days' additional mailing time must be given before the effective date of the change begins.

## Supporting Documentation

Depending on the type of service requested, various supporting documents must be included with the PA request, such as a current treatment plan, progress notes and medical documentation.

> *Note: Providers must clearly sign the treatment plans (or plans of care) that accompany the PA request. Electronic or stamped signatures are allowable. The plan cannot indicate multiple names for the signee. For example, if both a typed name and handwritten signature are included on the plan, the names must match. Signing providers must be within the scope of practice for their applicable licensure.*

Certain types of supporting documentation must be submitted using designated forms, available on the *Forms* page at in.gov/medicaid/providers.

### *Medicaid Second Opinion Form*

Providers may be required to submit a second or third opinion to substantiate the medical necessity of certain services. If required, the *Medicaid Second Opinion Form* (accessible from the *Forms* page at in.gov/medicaid/providers) should be completed as directed in the form's narrative and submitted to the appropriate PA contractor based on the program assignment of the member. Completed forms may be submitted by fax or mail, or uploaded as an attachment to the PA request submitted via the PA contractor's provider portal.

### *Medical Clearance Forms for DME or Medical Supplies*

Providers must submit medical clearance forms to justify the medical necessity of designated DME or medical supplies when requesting PA. DME or medical supplies that require medical clearance forms when requesting PA include the following services:

- Augmentative communication devices – *Augmentative Communication System Selection Form*
- Enteral and parenteral nutrition – *Durable Medical Equipment Information Form: Enteral and Parenteral Nutrition*
- Hearing aids – *Medical Clearance and Audiometric Test Form*

- Home oxygen therapy – *Certificate of Medical Necessity for Oxygen*
- Hospital and specialty beds – *Medical Clearance Form for Hospital and Specialty Beds*
- Motorized wheelchairs or other power-operated vehicles –*Medical Clearance Form for Motorized Wheelchair Purchase*
- Negative pressure wound therapy – *Medical Clearance Form for Negative Pressure Wound Therapy*
- Nonmotorized wheelchairs – *Medical Clearance Form for Nonmotorized Wheelchair Purchase*
- Standing equipment – *Medical Clearance Form for Standing Equipment*
- Transcutaneous electrical nerve stimulator (TENS) units – *Medical Clearance Form for TENS Unit*

When requesting PA for the DME or medical supplies listed in this section, providers must complete the appropriate clearance form (accessible from the *Forms* page at in.gov/medicaid/providers) and attach it to a completed *IHCP Prior Authorization Request Form* or upload it as an attachment to the PA request submitted via the PA contractor's designated provider portal. Failing to provide appropriate medical clearance forms with a PA request results in a pended status, not a denial of the PA request. Forms should be completed in sufficient detail to enable a decision about medical necessity.

**Providers should retain for their records photocopies of any medical clearance forms included with their submissions.** PA contractors can receive the completed medical clearance forms by fax, mail or as attachments uploaded via the PA contractor's designated provider portal.

### *Behavioral Health Related Forms*

See the *Behavioral Health Services* module for information about the following forms:

- Certification of need form with PA requests for inpatient psychiatric hospital services
- Initial assessment and reassessment forms required with PA requests for residential or inpatient substance use disorder (SUD) admission and continued treatment
- Admission assessment form required with PA requests for psychiatric residential treatment facility (PRTF) services (as well as an extension request tool
- A checklist of supporting documentation required with a PA request for applied behavior analysis (ABA) services

## Prior Authorization Request Status and Notification Letter

> *Note: The information in this section applies to PA requests submitted to the FFS nonpharmacy PA-UM contractor. Separate procedures exist for viewing the status of, and receiving notification about, pharmacy, home-and community-based services (HCBS), Medicaid Rehabilitation Program (MRO), and managed care authorizations.*

Providers can check the status of FFS, nonpharmacy PA requests using either of the following methods:

- Online, using the IHCP FFS PA-UM contractor's designated provider portal, accessible from the *Portal Links for Providers* page at in.gov/medicaid/providers
- Via 278 electronic transaction response

If the PA contractor requires additional information to make a determination, the request is placed in a pended status and the provider is notified about what is needed. For pended FFS nonpharmacy requests, the FFS PA-UM contractor will contact the provider by live phone call, confidential voicemail and/or through fax via a state-approved fax template. Providers can also receive secure messaging through the FFS PA-UM contractor's provider portal.

After reaching a decision about the request, the IHCP FFS PA-UM contractor will send an *Indiana Medicaid Prior Authorization Notification* letter (PA notification letter). PA notification letters are mailed to the member and the *requesting* provider. The provider's copy of the PA notification letter is sent to the mail-to address on file for the requesting provider. The rendering provider, if different from the requesting provider, must contact either the requesting provider or the member to secure a copy of the PA notification letter.

The *Indiana Medicaid Prior Authorization Notification* letter contains the following:

- Requesting provider information
- Member information
- Information about the specific service requested
- Narrative about the decision

If the PA request is not approved, additional information is included with the notification letter to explain the decision, such as the following:

- For *modified* or *denied* decisions, IAC references and administrative review and appeal rights are included in the letter.
- If the PA request is *rejected*, the PA notification letter notes that the PA was submitted to the wrong PA contractor based on the assignment of the member to a specific IHCP program.

# Revising PA Requests

Certain authorization information can be revised on an *existing* PA request, instead of by submitting another PA request. PA revisions may be requested electronically or by fax, mail or telephone. For FFS nonpharmacy authorizations, the preferred method for submitting a PA revision is using the PA Revision option within the IHCP FFS PA-UM contractor's designated provider portal, accessible from the *Portal Links for Providers* page at in.gov/medicaid/providers.

The following are examples of appropriate PA revision requests:

- A provider that discovers **a clerical error in the PA data entered** may perform a PA revision through the provider portal or may call, write or fax to request the correction, depending on the complexity of the situation. If the error does not require research or review of the original PA request, the correction can be revised over the telephone. However, some items may be too complicated to resolve with a telephone call and may require additional medical documentation to support the request. Providers may need to send the original request and the system-generated PA notification letter for review. An explanatory letter is helpful.
- A request to **increase home health services** in an existing authorization is appropriate when supporting documentation of medical necessity is submitted along with the PA revision request.
- **Extending the dates on an approved surgery because rescheduling was necessary** is appropriate for an authorization revision request.

For all PA revision requests, the PA must be active and current. Revisions cannot be made to expired PAs, and retroactive changes cannot be made to PA start dates.

| |
|---|
| *Note: Any request for a **new** service must be submitted as a new PA request.* |

Written PA revision requests may be submitted on the *IHCP Prior Authorization System Update Request Form,* available on the *Forms* page at in.gov/medicaid/providers. Written PA revision requests can also be submitted on the provider's letterhead, with **PRIOR AUTHORIZATION REVISION REQUEST** written boldly across the top. The following should be included with the PA revision request:

- Pertinent information, such as member name, Member ID and PA number
- Information to be corrected, changed or updated
- A copy of the original PA request and system-generated PA notification letter to verify the item to be revised

Fax or mail written PA revision requests to the appropriate PA contractor, using the contact information in the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.

When an existing FFS nonpharmacy PA is revised, the IHCP FFS PA-UM contractor sends an *Indiana Medicaid Prior Authorization Notification* (PA notification letter) to the member and the provider, highlighting the information that was changed. See the *Prior Authorization Request Status and Notification Letter* section for details.

# Prior Authorization Procedures for HCBS and MRO Programs

This section provides information about special PA procedures for IHCP home- and community-based services (HCBS) and Medicaid Rehabilitation Option (MRO) programs. As with any PA request, the requester must have a valid National Provider Identifier (NPI) that has been registered with the IHCP or, if an atypical provider, an IHCP Provider ID. The rendering provider must be enrolled in the IHCP to receive reimbursement for providing services to an IHCP member, ensuring that all service requirements are met.

## *1915(c) HCBS Waiver Authorizations*

In addition to waiver services, HCBS waiver members also receive Traditional Medicaid benefits, with the same PA requirements and procedures applying to those benefits as apply for other Traditional Medicaid members.

HCBS waiver program services are approved by the member's waiver program state administrator: the FSSA Division of Aging (DA) or Division of Disability and Rehabilitative Services (DDRS). The approved waiver services are recorded on a Notice of Action (NOA), and the approved dollars listed on the NOA are transmitted to the member's PA history table to be used during the claim adjudication process. Any discrepancies between approved dollars for waiver services on the NOA and dollars available on the member's PA history table need to be mediated through the member's case manager, who facilitates the resolution of any discrepancies.

Some services may be available through both State Plan (Traditional Medicaid) benefits and waiver program benefits. In this case, the State Plan service benefits, including any that may be available through PA, must be exhausted first before obtaining waiver program services, even if the waiver services are approved.

See the *Home- and Community-Based Services Billing Guidelines* module for more information.

## *1915(i) HCBS State Plan Authorizations*

The authorization process for HCBS 1915(i) services varies by program. For more information, see the following modules:

- *Division of Mental Health and Addiction: Adult Mental Health Habilitation Services*
- *Division of Mental Health and Addiction: Behavioral and Primary Healthcare Coordination Services*
- *Division of Mental Health and Addiction: Child Mental Health Wraparound Services*

### *Medicaid Rehabilitation Plan Authorizations*

For information about the MRO authorization process, see the *Medicaid Rehabilitation Option Services* module.

## Retroactive Prior Authorization

PA is given after services have begun or supplies have been delivered only under the following circumstances:

- Pending or retroactive member eligibility
  - The PA request must be submitted within 12 months of the date when the member's caseworker entered the eligibility information. The hospice authorization request must be submitted within one year of the date nursing facility level of care is approved by the office.
- Services rendered outside Indiana by a provider that had not yet enrolled as an IHCP provider
- Mechanical or administrative delays or errors by the contractor or county office of the FSSA Division of Family Resources (DFR)
- Transportation services to or from an out-of-state area or rendered by a provider located out of state or by an airline or air ambulance
  - The PA request must be submitted within 12 months of the date of service.
- Provider unaware that the member was eligible for services at the time services were rendered
  - PA is granted in this situation only if the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide the member's IHCP Member ID.
    - The provider can substantiate that reimbursement was continually pursued from the member until IHCP eligibility was discovered.
    - The provider submitted the request for PA within 60 calendar days of the date that IHCP eligibility was discovered.
- Any situation in which the provider cannot determine the exact procedure to be done until after the service has been performed

> *Note: If PA for a service is approved retroactively, the timely filing limit is extended to 180 days from the date the PA was approved. A copy of the approved PA stating "retroactive prior authorization" must be included as an attachment to the claim.*

## Prior Authorization and Third-Party Liability

If the IHCP requires PA for a service, and the member has additional insurance coverage that is primary, the provider must follow the primary insurer's requirements for obtaining PA and must *also* obtain PA from the appropriate IHCP PA contractor (based on the program assignment of the member) to receive payment from the IHCP for the balance of charges not paid by the primary insurance.

IHCP PA is not required for crossover claims – that is, claims for services covered under Medicare Part A or Part B, rendered to a dually eligible member, and paid (in whole or in part, including payments of zero due to copayment, coinsurance or deductible) by Medicare or a Medicare Advantage Plan. Services *not* covered by Medicare (including services denied by Medicare or a Medicare Advantage Plan) are subject to normal IHCP PA requirements.

See the *Third-Party Liability* module for more information.

# Section 3: Methods for Submitting Prior Authorization Requests

Indiana Health Coverage Programs (IHCP) providers have multiple options for submitting prior authorization (PA) requests:

- Providers can submit PA requests by fax or by mail using the appropriate PA request form as described in the *Submitting PA Requests by Mail or Fax* section.
- Providers can submit PA requests online using the portal of the applicable PA contractor. For a link to the portal that providers can use to submit FFS nonpharmacy PA requests, see the *Portal Links for Providers* page for links.
- Providers can submit PA requests electronically through the 278 transaction. Attachments to the 278 transaction must be submitted separately, via fax or mail. See the *Submitting PA requests by 278 Electronic Transaction* section.
- Providers can submit PA requests by telephone as described in the *Submitting PA Requests by Telephone* section.

Providers can also use these options to submit revisions to existing PA requests. See the *Revising PA Requests* section for more information.

Specific PA submission and documentation procedures may vary depending on the contractor, such as the IHCP FFS PA-UM contractor or the FFS pharmacy benefit manager (PBM), or (for services rendered under Healthy Indiana Plan [HIP], Hoosier Care Connect and Hoosier Healthwise managed care programs) the member's managed care entity (MCE).

## Submitting PA Requests by Mail or Fax

Providers can submit nonpharmacy prior authorization requests by mail or fax on the following forms (accessible from the *Forms* page at in.gov/medicaid/providers):

- *IHCP Prior Authorization Request Form* (universal prior authorization form)
- *IHCP Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form*
- *IHCP Dental Prior Authorization Request Form*

Providers should retain photocopies of the completed PA request forms for their records.

Completed request forms should be sent to the fax number or mailing address of the applicable PA contractor, as indicated in the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.

Each faxed submission must contain only one PA request or modification of an existing request, for one IHCP member, per provider. The IHCP will not accept multiple PA requests (batched) within the same faxed submission.

> *Note: Remember to write "Retro Request" and the reason for the retroactive request on any PA request for past dates of service. Otherwise, the PA request will be modified to the date the PA request is received. See the Retroactive Prior Authorization section for more information regarding retroactive PA.*

## Universal PA Request Form

The *IHCP Prior Authorization Request Form* is available on the *Forms* page at in.gov/medicaid/providers. Table 2 includes instructions for completing the form.

Table 2 – *IHCP Prior Authorization Request Form* Instructions

| Field | Description |
|---|---|
| Select the radio button of the entity that must authorize the service.<br>(For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].) | Select the appropriate radio button.<br>• If the service requested would be covered under a managed care program, select the radio button for the member's assigned managed care entity (MCE).<br>• If the service requested would be covered as fee-for-service (FFS) – including services carved out of managed care – select the radio button for the FFS prior authorization and utilization management (PA-UM) contractor. |
| Patient Information:<br>• IHCP Member ID<br>• Date of Birth<br>• Patient Name<br>• Address<br>• City/State/ZIP Code<br>• Patient/Guardian Phone | Enter the information requested for the member who is to receive the requested service. **Required.** |
| • PMP Name<br>• PMP NPI<br>• PMP Phone | Enter the information requested for the member's primary medical provider (PMP). **Required, if applicable.** |
| Requesting Provider Information:<br>• Requesting Provider NPI/ Provider ID<br>• Taxonomy<br>• Taxpayer Identification Number (TIN)<br>• Provider Name<br>• Provider Address | Enter the information requested for each field. **Required.**<br>Requesting medical providers should enter their National Provider Identifier (NPI). Atypical providers should enter their IHCP-issued Provider ID.<br>The requesting provider NPI/Provider ID must be the billing NPI/Provider ID used by the provider or entity requesting the authorization:<br>• For a group/corporate entity, the requesting provider NPI/Provider ID is different from the rendering provider NPI/Provider ID.<br>• For a sole proprietor, the requesting provider NPI/Provider ID and the rendering provider NPI/Provider ID will be the same.<br>• For a dual-status provider, the requesting provider NPI/Provider ID and the rendering provider NPI/ Provider ID may or may not be the same.<br>A valid NPI or Provider ID is required. If the requesting provider is not enrolled in the IHCP, the PA request will not be entered and the PA contractor will notify the preparer by telephone.<br>The provider's copy of the *Indiana Medicaid Prior Authorization Notification* (PA notification letter) is sent to the mail-to address on file for the requesting provider's NPI and Provider ID combination. |

| Field | Description |
|---|---|
| Rendering Provider Information:<br>• Rendering Provider NPI/ Provider ID<br>• TIN<br>• Name<br>• Address<br>• City/State/ZIP Code<br>• Phone<br>• Fax | Enter the information requested for each field, if the rendering provider is known at the time the request is completed. (The rendering provider is the physician or other IHCP-enrolled practitioner who will be delivering the service to the member.)<br>Enter the rendering provider's NPI or, for atypical providers that do not have an NPI, enter the rendering provider's IHCP Provider ID. |
| Ordering, Prescribing or Referring (OPR) Provider Information:<br>• OPR Provider NPI | Enter the NPI of the OPR provider. (The OPR provider is the practitioner that ordered, prescribed or referred the member for the requested service.) |
| Preparer's Information:<br>• Name<br>• Phone<br>• Fax | Enter the requested information about the person preparing the PA request. |
| Medical Diagnosis<br>• Dx1<br>• Dx2<br>• Dx3 | Enter the primary, secondary and tertiary International Classification of Diseases (ICD) diagnosis codes. |
| Assignment Category | Check the assignment category for the service you are requesting. |
| Dates of Service, Start | Enter the requested start date for the service. (For continued services, the start date must be the day after the previous end date.) |
| Dates of Service, Stop | Enter the requested stop date of service. |
| Procedure/Service Codes | Enter the requested service codes, such as Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), revenue code, National Drug Code (NDC) and so forth. |
| Modifiers | Enter any applicable service code modifiers. |
| Service Description | Enter a short description (or include an attachment) of the requested services and like services provided by other payers. |
| Taxonomy | Enter any applicable taxonomy codes. |
| Place of Service (POS) | Enter the requested place of service. |
| Units | Enter the requested number of units. Units are equal to days, months or items, whichever is applicable. |
| Dollars | Enter the estimated or known IHCP cost of the service. **Required for home health services and durable medical equipment (DME) requests.** |
| Notes | Enter clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan-of-treatment dates.<br>Your request MUST include medical documentation to be reviewed for medical necessity. |

| Field | Description |
|---|---|
| Mandatory Additional Documentation Checklist | *Note: This field is only on the Residential/Inpatient SUD Treatment PA Request Form.*<br>Check each box to indicate that the required documentation is included with request. **Required.** |
| Signature of Qualified Practitioner<br>Date | Authorized provider, as listed in the *Providers Allowed to Submit PA Requests* section, must sign and date the form. Signature stamps can be used. **Required.** |

Before submitting the *IHCP Prior Authorization Request Form* by fax or mail, complete the following:

- Make sure the form has a signature and date from a qualified practitioner. The signature prevents the PA from being suspended and delaying services.
- Confirm that the Member ID (also known as RID) is correct.
- Confirm that the NPI or Provider ID is correct.
  - For FFS PA, the *requesting provider* is the billing entity, and the *rendering provider* is the individual provider performing the service.
    - Sole proprietors and group or corporate business entities, such as a DME supplier or hospital, must place their billing NPI or IHCP Provider ID in the **Requesting Provider NPI/Provider ID** field. The PA notification letter is mailed to the requesting provider's mail-to address.
    - The **Rendering Provider NPI/Provider ID** field should contain the NPI or Provider ID of the physician or other IHCP-enrolled practitioner within the group or corporate business entity that ordered the services, equipment or supplies.

> *Note: For sole proprietors or dual-status providers, the requesting provider and the rendering provider may be one and the same.*

  - For managed care PA, the IHCP recommends that providers contact the appropriate MCE (Anthem, CareSource, MHS MDwise or UnitedHealthcare) to determine how to complete the Requesting Provider and Rendering Provider fields on the *IHCP Prior Authorization Request Form*.

> *Note: Effective Jan. 1, 2026, MDwise is no longer participating as an IHCP MCE.*

- Confirm that all other information on the form is correct and complete. Remember that the ICD diagnosis code must be listed and procedure codes must be valid, including modifiers.
- To ensure that response letters are mailed to the appropriate location, verify that the requesting provider's mail-to address is correct in *Core*MMIS. Providers may verify the accuracy of their mail-to address on file by using the Provider Maintenance link on the IHCP Provider Healthcare Portal (IHCP Portal) or by calling Customer Assistance at 800-457-4584 (select option 2).

## *Residential/Inpatient SUD Treatment PA Request Form*

The *IHCP Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form* is available on the *Forms* page at in.gov/medicaid/providers. This form must be used instead of the standard universal PA request form to request PA for inpatient and residential SUD treatment services.

This form contains the same fields as the universal PA request form, plus a checklist for additional documentation that is mandatory for residential and inpatient SUD treatment requests. The instructions for completing the universal PA request form (in Table 2) are also applicable to this form. That table includes instructions for the additional field that is specific to this form.

## IHCP Dental Prior Authorization Request Form

Table 3 contains instructions for the *IHCP Dental Prior Authorization Request Form*. The form as well as the instructions are available on the *Forms* page at in.gov/medicaid/providers.

Table 3 – *IHCP Dental Prior Authorization Request Form* Instructions

| Field | Description |
|---|---|
| Requesting provider NPI (or IHCP Provider ID)<br>Name<br>Telephone<br>Taxonomy<br>Service location ZIP Code+4<br><br><br>Mail-to provider NPI (or IHCP Provider ID)<br>Name<br>Telephone<br>Taxonomy<br>Service location ZIP Code+4 | Enter the requesting or rendering provider's NPI (for atypical providers, enter the IHCP Provider ID), name, telephone number, taxonomy and service location ZIP Code +4. The taxonomy is used to establish a one-to-one match with the NPI entered. If the requesting provider is not enrolled, the PA request form will be returned to the provider. **A valid NPI or Provider ID is required.**<br><br>The provider's copy of the *Indiana Medicaid Prior Authorization Notification* (PA notification letter) is sent to the address that corresponds to the requesting provider NPI/Provider ID in this field, unless a separate mail-to provider is identified on the form.<br><br>If the requesting provider does not have a valid service location on file, a PA notification letter will not be generated.<br><br>If the mail-to provider fields are completed in conjunction with the requesting provider information that has a valid service location, the address on file for the mail-to provider NPI/Provider ID will be selected as the mailing address for the PA notification letter, instead of the address on file for the requesting provider NPI/Provider ID. |
| Member name<br>Member address<br>IHCP Member ID<br>Member date of birth | Enter the name, address, IHCP Member ID and date of birth for the member who is to receive the requested service. |
| Dates of service, Start | Enter the requested start date for the service. (For continued services, the start date must be the day after the previous authorization end date.) |
| Dates of service, Stop | Enter the requested stop date for the service. |
| Requested service, Procedure code | Enter the requested service code, such as CPT, Current Dental Terminology (CDT), HCPCS, revenue code or NDC. |
| Requested service, Description | Enter a short description (or include an attachment) of the requested service and like services provided by other payers. |
| Place of service | Enter the requested place of service. |
| Units | Enter the number of units desired. Units are equal to days, months or items, whichever is applicable. |
| Dollars | Enter the estimated or known IHCP cost of the service. **Required for home health services, DME and pharmacy requests.** |
| Caseworker<br>Telephone | Enter the caseworker's name and telephone number. |

| Field | Description |
|---|---|
| MCE/590/FFS | Select the appropriate member plan, if applicable:<br>• For managed care, select **MCE**.<br>• For the 590 program, select **590**.<br>• For fee-for-service plans, select **FFS**. |
| Is member employed? | Select **YES** or **NO**. |
| Circumstances (place/type) | Enter employment information, if applicable. |
| Is member in job training? | Select **YES** or **NO**. |
| Type of job training | Enter training information, if applicable. |

**Dental Treatment Plan**

| Field | Description |
|---|---|
| 1. Endodontics | On the chart, indicate with a checkmark (✓) the tooth or teeth (1–32) to be treated by root-canal therapy. |
| 2. Periodontics | Briefly summarize the periodontal condition. |
| 3. Does the member have missing teeth? | Select **YES** or **NO**. If yes, indicate which teeth are missing with a checkmark (✓) on the diagram provided. |
| 4. Partial dentures | Answer questions A through E as indicated.<br>A. Date or dates of extractions of missing teeth.<br>B. Which teeth are to be extracted? (List tooth numbers.)<br>C. Which teeth are to be replaced? (List tooth numbers.)<br>D. Brief description of materials and design of partial.<br>E. Is member wearing partials now? (**YES** or **NO**)<br>Age of present partials. |
| 5. Dentures | Check one or both: Full upper denture, Full lower denture.<br>Answer questions A through D as indicated:<br>A. How long edentulous?<br>B. Is member wearing dentures now? (**YES** or **NO**)<br>Age of present dentures.<br>C. Is the member physically and psychologically able to wear and maintain the prostheses? (**YES** or **NO**)<br>D. Can the member's existing dentures be relined or repaired to extend their useful life? (**YES** or **NO**) |
| 6. Describe treatment if different from above | Describe any treatment to be provided that was not listed previously on this form. |
| 7. Is the member on parenteral/enteral nutritional supplements? | Check **YES** or **NO**. If Yes, a plan of care to wean the member from the nutritional supplements must be attached. If the plan of care is not provided, dentures, partials, relines and repairs will be denied. |
| 8. Brief dental/medical history | Enter pertinent information known to the provider about the member's dental and medical history. |
| Signature of requesting dentist | The authorized provider, as listed in the *Providers Allowed to Submit PA Requests* section, must sign the form. Signature stamps can be used. |
| Date of submission | Enter the date the form was actually submitted. |

# Submitting PA Requests Through the Provider Portal

> *Note: Effective July 1, 2023, PA requests for FFS nonpharmacy services can no longer be submitted through the IHCP Portal, but instead must be submitted to the current IHCP FFS PA-UM contractor, which has its own provider portal. For PA requests submitted **prior to** July 1, 2023, the authorization status will continue to be viewable on the IHCP Portal for a limited time. PA requests submitted prior to July 1, 2023, that have end-dates after July 1, 2023, will be viewable in **both** the IHCP Portal and the provider portal of the new FFS PA-UM contractor.*

The IHCP FFS PA-UM contractor allows providers to submit FFS, nonpharmacy PA requests online using its provider portal. For information about registering for and using the portal, see the *Portal Links for Providers* page at in.gov/medicaid/providers.

> *Note: FFS **pharmacy** prior authorizations are handled by the IHCP FFS pharmacy benefit manager (PBM). MCEs handle PA for the members of their **managed care** health plan.*

Prior authorization can be requested directly by the providers listed in the *Providers Allowed to Submit PA Requests* section, within their scope of practice. All other providers must include an attachment documenting that the service or supply is ordered by a qualifying attending practitioner as described in that section.

# Submitting PA Requests by 278 Electronic Transaction

The 278 electronic transaction provides standard data requirements and content for all users who request and respond to prior authorization (PA) or certification requests. The 278 transaction supports the following information:

- Submission of initial electronic requests
- Submission of updated or revised electronic requests
- Submission of paper attachments for electronic requests
- Submission of retroactive electronic requests
- Submission of out-of-state electronic requests
- Submission of electronic administrative reviews
- Response with approval
- Response with modified approval
- Response with denial of a previous request
- Response with follow-up action code
- Response with action code

> *Note: Requests for administrative review and appeals of PA decisions must be submitted in writing, even if the PA request itself was submitted electronically. See the Section 4: Prior Authorization Administrative Review and Appeal Procedures section for instructions.*

Providers wanting information about the 278 transaction for submitting electronic PA requests should contact the applicable PA contractor. Contact information can be found in the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.

*Health Insurance Portability and Accountability Act* (HIPAA) legislation mandates that many of the major healthcare electronic data exchanges, such as electronic submission of PA requests and the electronic responses, are standardized national formats for all payers, providers and clearinghouses. All providers that submit affected data electronically to the IHCP must use the mandated HIPAA formats. HIPAA specifically names several electronic standards that must be followed when certain healthcare information is exchanged. These standards are published as *National Electronic Data Interchange Transaction Set Implementation Guides* – commonly called implementation guides (IGs). An addendum to each IG was also published and must be used with the IG to properly implement each transaction. IGs and addenda are available for purchase and download from the Washington Publishing Company website at wpc-edi.com.

The IHCP developed technical companion guides to help users understand the IHCP requirements for each electronic transaction. The information contained in the IHCP companion guides is intended only to supplement the adopted IGs and provide guidance and clarification as they apply to the IHCP. The IHCP companion guides are never intended to modify, contradict or reinterpret the rules established by the IGs. For IHCP-specific guidelines related to the 278 transaction, see the *278 Prior Authorization Request and Response* companion guide, available on the *Key Links* page, accessible from the IHCP FFS PA-UM contractor's website.

All healthcare organizations exchanging HIPAA transaction data electronically with the IHCP are required to establish an electronic data interchange (EDI) relationship. Entities with this EDI relationship are referred to as trading partners..

# Submitting PA Requests by Telephone

> *Note: The information in this section is specific to FFS nonpharmacy PA requests. For policies and procedures related to telephone PA requests for FFS pharmacy services, contact IHCP FFS pharmacy benefit manager (PBM); for managed care services, contact the member's MCE.*

Portal submission is the preferred method for all authorization requests; however, the IHCP FFS PA-UM contractor will accept authorization requests and notifications of discharge submitted by telephone. Verbal notification of the Case ID number will be provided at the time of call. A clinical reviewer will review the case for medical necessity and provide written notification of the PA-UM decision. PA telephone requests may help facilitate hospital admission or discharge, to maintain the health and well-being of the member, or when emergency services are required

An *IHCP Prior Authorization Request Form* is not necessary for telephone PA services. However, additional written substantiation and documentation may be required.

The *IHCP Quick Reference Guide* at in.gov/medicaid/providers is the primary source for prior authorization contact information, including for managed care PA contractors.

# Section 4: Prior Authorization Administrative Review and Appeal Procedures

Prior authorization (PA) administrative review and appeal procedures are outlined in the *Indiana Administrative Code* (IAC) sections *405 IAC 5-7* and *405 IAC 1.1.* Appeals on Indiana Health Coverage Programs (IHCP) PA issues are conducted in accordance with *405 IAC 1.1*. For all PA decisions, a *Notice of Appeal Rights* is sent with the PA notification letter, outlining the procedures to be used.

Administrative reviews are completed by the PA contractor that denied the request. If the administrative review is submitted to the incorrect PA contractor, the request will be returned to the provider for submission to the appropriate organization for review. If the member has been assigned to a different health plan or program since the request for PA was denied, providers can either appeal to the PA contractor that denied the request *or* submit a new PA request for review to the correct PA contractor.

The information in this section pertains to fee-for-service (FFS), nonpharmacy PA requests submitted to the IHCP FFS prior authorization and utilization management (PA-UM) contractor.

> *Note: For **managed care** PA requests, the Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise member or provider should contact the member's managed care entity (MCE) Member Services or Provider Services toll-free number for information about how to submit a grievance or appeal. See contact information in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*
>
> *For information about FFS **pharmacy**-related PA appeals, see the Pharmacy Services module.*

## Administrative Review of PA Decisions

A provider requesting review of the modification or denial of a PA must submit a written request for an administrative review within **seven business days** of the receipt of notification of modification or denial. Requests submitted by telephone will not be accepted. Failure to submit a timely request for administrative review as outlined in *405 IAC 5-7-2(b)* results in the loss of the right to request an appeal administrative hearing.

In situations of inpatient hospitalization, when administrative review is desired but the member continues to be hospitalized, a notification of *intent to request an administrative review* must be submitted (by mail, fax or phone) to the IHCP FFS PA-UM contractor within seven business days of the receipt of notification of PA modification or denial. If the provider wants to continue with the administrative review, the IHCP FFS PA-UM contractor must receive the entire medical record within 45 calendar days after discharge.

To initiate an administrative review, providers must include the following information with the request:

- Copy of the original *Indiana Prior Review and Authorization Request* form

  OR

  Summary letter, including the following:
  - Authorization number
  - Member's name
  - IHCP Member ID
  - Pertinent reasons the requested services are medically necessary
- All documentation regarding the need for the service or equipment, including medical records, equipment consultations, progress notes, case histories and therapy evaluations
  - Documentation should be pertinent to the case and support the medical necessity of the requested service.
  - For authorization review requests for inpatient hospitalizations, the entire medical record must be included.
- Name, telephone number and address of the provider submitting the request

This information should be faxed or mailed to the IHCP FFS PA-UM contractor or submitted through the Atrezzo Provider Portal For the appropriate address, fax number and portal link, see contact information in the *IHCP Quick Reference Guide* at in.gov/medicaid/providers).

The IHCP FFS PA-UM medical director or designee renders the administrative review decision within seven business days of receipt of all necessary documentation. The requesting provider and member receive written notification of the decision containing the following information:

- The IHCP contractor determination and the rationale for the decision
- The *Notice of Appeal Rights* through the Indiana Family and Social Services Administration (FSSA)

# Administrative Hearing Appeal Process for PA Decisions

The following subsections address the PA administrative hearing appeal process for IHCP providers and members.

## *Provider Appeals of Prior Authorization Decisions*

Any provider that has submitted a request for prior authorization can appeal a denial or modification of the request by requesting an administrative hearing with the FSSA, after exhausting the administrative review process. The appeal request must be in writing and must be signed by the requesting provider or designee. Provider appeals of PA decisions are conducted in accordance with the member appeals regulation, *405 IAC 1.1*.

Provider requests for administrative hearings must be submitted within 33 calendar days of the administrative review decision to the following address:

**Office of Administrative Law Proceedings**
**FSSA Hearings and Appeals**
**402 W. Washington St., Room E034**
**Indianapolis, IN 46204**

**Fax: 317-232-4412**
**Email: fssa.appeals@oalp.in.gov**

> *Note: There is a limit of 25MB for emails. The email should be encrypted, but the appeal documents attached should be unprotected, as the OALP may later be required to turn them over to the courts for judicial review.*

## *Member Appeals of Prior Authorization Decisions*

If a member disagrees with a denial or modification of a PA request, the member can ask for a hearing (pursuant to *Code of Federal Regulations 42 CFR 431.200 et seq*. and *405 IAC 1.1*) by filing an appeal as described in this section. An administrative review by the FFS PA-UM contractor is **not** required before a member files a request for a hearing with the FSSA.

> *Note: For services covered under the managed care delivery system, HIP, Hoosier Care Connect and Hoosier Healthwise members must first exhaust their MCE's appeal process before submitting an appeal to the FSSA.*

Members can appeal a PA decision by writing a letter explaining why they think the decision is wrong. The letter must be signed and must include the member's name and other important information, such as the date of the decision. Requests for administrative hearings should be sent to the following address:

**Family and Social Services Administration**
**Office of Administrative Law Proceedings – FSSA Hearings**
**402 W. Washington St., Room E034**
**Indianapolis, IN 46204**

**Fax: 317-232-4412**
**Email: fssa.appeals@oalp.in.gov**

> *Note: There is a limit of 25MB for emails. The email may be encrypted, but the appeal documents attached should be unprotected, as the OALP may later be required to turn them over to the courts for judicial review.*

If the appellant is not the member, documentation that the appellant has the legal right to act on behalf of the member, such as power of attorney for healthcare or legal guardianship papers, must accompany the request.

The filing must be within 33 calendar days of the date the adverse decision was received or takes effect, whichever is later.

As required by statute, if the request for a hearing is received before the effective date of the denial or modification of continuing services, services are continued at the authorized level of the previous PA.

For additional information regarding the member appeals process, see the *Member Appeals* section of the *Member Eligibility and Benefit Coverage* module.