Prior Authorization of FFS Physician Administered Drugs

On behalf of Indiana Medicaid

Acentra HEALTH

Agenda

General Authorization Requirements

Prior Auth Submission Requirements and Provider Responsibilities

Prior Authorization for PAD

- **Non-Specific Codes, Carve Out Codes, and Weight Loss Drug Update**

Tips for Reducing Administrative Denials

Post Submission Actions for Authorization Revisions, Admin Review and Peer to Peer

General Prior Authorization Requirements

Acentra Health performs all prior authorization (PA) requests for medications covered under the medical benefit.

Optum Rx performs all reviews for medications covered under the pharmacy benefit

Prior Authorization Submission Requirements

Submitting via Portal

Submitting requests through the portal is the preferred PA method

- The portal Case Wizard provides step-by-step guidance through the case submission process and prompts you if there are any issues.
- Communicate with clinical reviewers using case Notes.
- Allows you to have multiple accounts assigned under your login.

Submitting via Fax

- Prior Authorization Request Form:
  - Member Identification number
  - Provider NPI both “Requesting” and “Rendering” (if different)
  - HCPCS; along with dates of service (DOS)
  - Diagnosis code
  - Form must be signed
- Submit all relevant documentation at the time of submission

Submitting via Phone

- Provider must provide all the information from the Prior Authorization Request Form. Then submit all relevant documentation either via portal, fax or mail.

*__Abbreviations__ National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) and Dates of service (DOS).

Provider Responsibilities

Providers are responsible for completing required forms and referencing the IHCP Prior Authorization (PA) provider modules to ensure requests are submitted correctly:

- Certain PA requests (as well as the PA request forms themselves for mailed or faxed submissions) are available on the IHCP website Forms page
- For detailed instructions regarding the FFS nonpharmacy PA procedures, refer to both the *Prior Authorization* provider reference module and the IHCP's *Best Practices: Nonpharmacy Prior Authorization*

Provider Responsibilities (cont.)

- ✓ Verify the Member's eligibility with Indiana Medicaid FFS via the IHCP provider portal
- ✓ Routinely check IHCP Provider Bulletins to maintain awareness of Provider bulletins for any updates related to the PAD service area
- ✓ Check the IHCP Fee Schedule and Outpatient Fee Schedule prior to submission to ensure a prior authorization is required for the HCPCS code.
- ✓ Complete all required forms and submit documentation with the request for authorization.
- ✓ Ensure that the request is not a duplicate request.

Provider Responsibilities for Retrospective Review

Retrospective review occurs when the entire date span of the request is in the past, prior to the date of submission. This is considered under the following circumstances:

- Pending or retroactive member eligibility.
- Provider unaware that the member was eligible for services at the time services were rendered. A Prior Authorization (PA) is granted in this situation only when certain conditions are met.

PRIOR AUTHORIZATION FOR

Physician Administered Drugs

Nonspecific CPT or HCPCS Drug Codes

- When a provider cannot use an existing CPT or HCPCS code to bill for new IHCP covered drugs because they have not assigned a specific code, the provider should bill using an appropriate nonspecific CPT or HCPCS code, such as the following:
  - J3490 – Unclassified drugs
  - J3590 – Unclassified biologics
  - 90749 – Unlisted vaccine/toxoid

- Providers can use a nonspecific CPT or HCPCS code when billing, but only when no code is available.
  - Providers must include a narrative that accurately describes the drug being administered or the drug's route of administration.

Carve Out Codes

- The IHCP designates certain drugs as “carved-out” of the managed care delivery system. These drugs are reimbursed as FFS for all IHCP members, including those enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise.

- Physician-Administered Drugs Carved Out of Managed Care and Separately Reimbursed

*These physician-administered drugs must be billed to Gainwell using the professional claim for all members.

EPSDT Weight Loss Drug Update

- Most frequently requested EPSDT weight loss medications reviewed under CPT code **J3490** are Wegovy, Imcivree, and Saxenda
- The Questionnaire must be completed for all EPSDT requests for CPT codes J3490, as well as J3590 and C9399.
- Drugs to treat obesity are not a covered benefit outside EPSDT (21 years or older)
- Acentra Health only reviews the initial request, all subsequent requests for the SAME weight loss drug must go to Optum Rx.

Medical Necessity Documentation:

- Must include a diagnosis of morbid obesity with comorbid conditions
- Documentation of nutritional counseling and/or weight-loss programs
- Any pharmacological agents or interventions that have been used by the member

IHCP PAD Update – BT2025154

The IHCP posted a new provider bulletin to announce additional procedure codes that will require Prior Authorization:

For dates of service (DOS) on or after Dec. 1, 2025, a prior authorization will be required for procedure codes (HCPCS) J1602 (golimumab [Simponi; Simponi Aria]) and J3262 (tocilizumab [Actemra]) when these drugs are provided under the fee-for-service (FFS) medical benefit.

Additionally, for DOS on or after Dec. 1, 2025, FFS PA criteria for procedure code J2357 (omalizumab [Xolair]) will be revised to align with current criteria for this drug under the FFS pharmacy benefit.

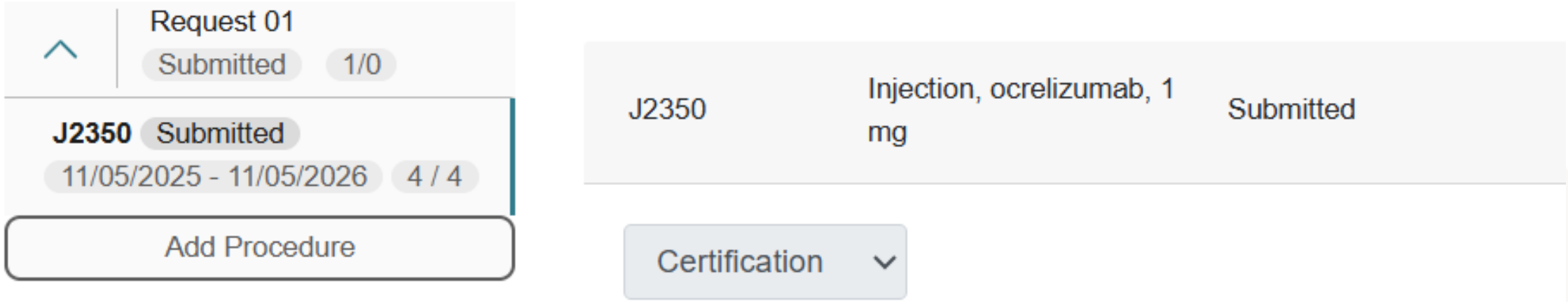
Sign up to receive email alerts ***

Tips to Reduce Denials

- Upload or provide all required documentation at the time of submission.
- Ensure the requested units/dosage is correct for member prior to submission-we do not calculate units for the providers.
- For nonspecific CPT or HCPCS Drug Codes, providers must include a narrative that accurately describes the drug being administered or the drug's route of administration.
- Routinely check IHCP Provider Bulletins to maintain awareness of Provider bulletins for any updates related to the PAD service area as this may reference medical necessity criteria.

Additional Tips to Reduce Denials

- Ensure requested PA units align with the billing units for the entire PA period. You can look on the HCPCS line description in Atrezzo and you will see the MG associated with the drug being requested.



Common Reasons for Denials and Voids

ADMINISTRATIVE DENIALS:

- All documentation is not received at the time of submission

MEDICAL NECESSITY DENIALS:

- Does not meet medical necessity

PARTIAL APPROVALS:

- Dates/units may be modified according to date of submission.
- Medical necessity has not been met for the entire requested service.

COMMON REASONS FOR VOIDS:

- The request is a duplicate of another authorization submitted to Acentra Health.
- The requested service(s) does not require a Prior Authorization per IHCP Fee Schedule.
- Prior authorization incorrectly submitted to Acentra Health.
  - Member eligibility can be updated anytime, be sure to check on IHCP Provider Portal prior to submitting any PA request.

POST REQUEST DETERMINATION

ACTIONS

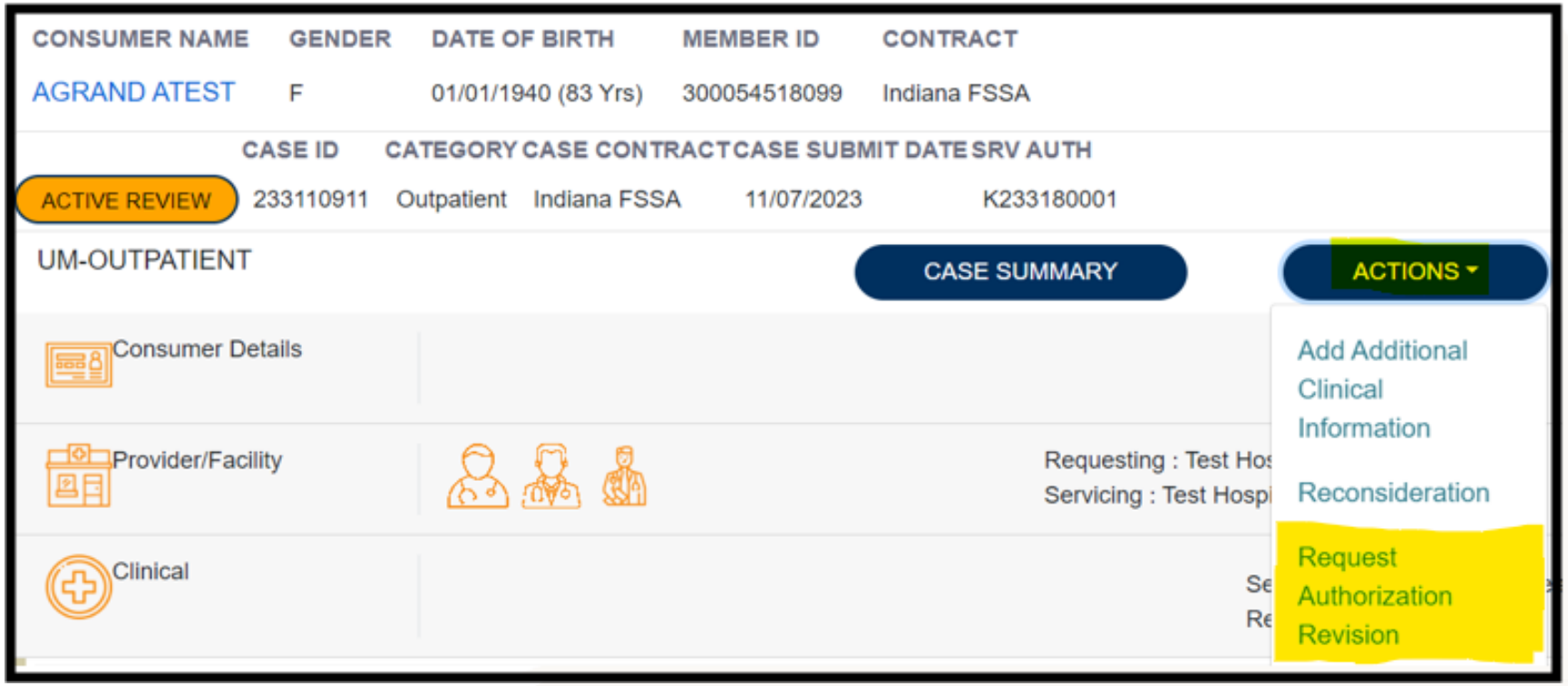
Authorization Revision Requests

An authorization revision must be submitted for the following types of requests:

- Correction in units requested and there needs to be a system update.
- Additional dosage is required, and more units need to be added.
- If no additional units are needed but the end date needs to be extended, this would also be an Authorization Revision Request.

If you are submitting a revison request by fax, you must complete the correct form located on IHCP website: IHCP Prior Authorization Revision Request Form

Authorization Revision Requests Online



Assuming a PA From Another Provider

- Complete the **Authorization Revision Request form** and fax it to 800-261-2774 or call customer service at 866-725-9991 for assistance.

- Provide all relevant information including but not limited to:
  - Member information
  - Originating provider information
  - Authorization number
  - Procedures on the PA request
  - Date PA will be assumed

Administrative Review/Reconsideration

- The provider MUST submit a request for administrative review to Acentra Health within ***7 business days plus 3 calendar days*** of the date provided on the initial adverse determination letter.

- To request an administrative review:
  - Request from the “actions” drop down in Atrezzo Provider Portal.
  - Fax in a written request
  - It is important to reference the IHCP Prior Authorization reference module for details of what is required to initiate an administrative review: https://www.in.gov/medicaid/providers/files/modules/prior-authorization.pdf

Peer to Peer

- Requests for peer to peer must be completed within 7 business days plus 3 calendar days of the date provided on the initial adverse determination letter.

- To request a Peer to Peer review:
  - Use the “Actions” drop down in the Atrezzo portal to select Peer to Peer. Enter the ordering provider’s full name, phone number, and three dates and times for your availability, OR
  - Call our Customer Service team at 866-725-9991 to assist you over the phone.

- Once an agreeable date and time have been identified, a representative will contact the provider by phone with the confirmed date and time. A note will also be placed in the case that is visible to the provider.

FSSA Resources for Providers

Provider Fee Schedules

Fee Schedules

Accessible from the Indiana Medicaid Provider web page. Guides providers regarding PA requirement.

Provider Modules

Provider Modules

Found in the providers references section. Guides providers on requirements.

- PAD specific Module

Injections Vaccines and Other PADs

Forms

Forms

If prior authorization request requires forms to be submitted with request, they are located here.

Bulletins

Bulletins

Important Indiana Health Coverage Programs (IHCP) announcements are made in IHCP bulletins

Conclusion and Q&A

Thank you for your time and participation!

Provider Relations Assistance	**INPriorAuthIssues@acentra.com**
Provider education website	**Training & Education - Indiana Medicaid FFS (acentra.com)**
Acentra Health Customer Service:	**Phone: 866-725-9991** **Fax: 800-261-2774**