Prior Authorization Process of FFS I/P and O/P Surgery Services

Acentra HEALTH

On behalf of Indiana Medicaid

Agenda

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General Prior Authorization Requirements

Submitting via Portal

Atrezzo Provider Portal

- Case Wizard provides step-by-step guidance through the case submission process.
- Upload all required forms and relevant documentation at the time of submission.

Submitting via Fax

- Prior Authorization Request Form:
  - Member Identification number
  - Provider NPI both “Requesting” and “Rendering” (if different)
  - CPT; CDT; REV; HCPCS; along with dates of service
  - 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, mail, or fax.

*__Abbreviations__: Dates of service (DOS), National Provider Identifier (NPI), Current Procedural Terminology (CPT), Current Dental Terminology (CDT), Revenue code (REV), & Healthcare Common Procedure Coding System (HCPCS)

Provider Responsibilities

- Methods for Prior Authorization Submission:
  - Atrezzo Provider Portal
  - Fax: 800-261-2774
  - Phone: 866-725-9991
- Please check the FSSA's Provider Fee Schedules prior to submission to ensure a prior authorization is required for the service being rendered.
- Always verify the Member's eligibility with Indiana Medicaid FFS via the IHCP provider portal.
- Ensure that the request is not a duplication of services.
- A request is considered timely when it is submitted prior to the start of services (unless submitted late due to retrospective Medicaid eligibility).

****Prior authorization does not guarantee payment.**

Retrospective Reviews

A retrospective review occurs when the entire date span of the request has passed prior to 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.

Important: When requesting a retrospective PA, submit all required information and documentation to explain why it is required. Retrospective requests will not be pended.

Timely Submissions for Retrospective Review

- If the PA request is received untimely and does not qualify as a retrospective review, then the certified start date of the request can only be authorized from the date received.

- If all dates of service have passed from the date received, and the request does not qualify for retrospective review (IHCP conditions), then the full request for the retrospective review will receive an Administrative Denial.

- All required documentation must be received at the time of submission for your retrospective review as these reviews are not to be pended.

Inpatient Surgery

I/P Surgery Prior Authorization

Located in the Surgical Services module, the Indiana Health Coverage Programs (IHCP) defines surgical services for a member requiring or seeking medically necessary perioperative care. The IHCP provides coverage for inpatient and outpatient surgical services and associated implantable medical equipment within the guidelines described in this document.

- Non-emergency inpatient hospital admissions – including all elective or planned admissions and admissions for which the patient's condition permitted adequate time to schedule suitable accommodation, require prior authorization. This requirement applies to medical and surgical inpatient admissions.

- Check member eligibility prior to any Prior Authorization (PA) submissions.
  - If the member does not have FFS, but is enrolled in a managed care program, ensure the service is prior authorized by the managed care entity (MCE).

I/P Surgery Prior Authorization

Any surgical procedure usually performed on an outpatient basis, *when scheduled as an inpatient procedure must be prior authorized.* The length of stay for the inpatient admission is determined by the appropriate diagnosis-related group (DRG) but is subject to retrospective review for medical necessity.

Criteria for determining medical necessity for inpatient admission include the following:

- Technical or medical difficulty during the O/P procedure, as documented in the medical record
- Presence of physical or mental conditions that make prolonged preoperative or postoperative observations by a nurse or other skilled medical personnel a necessity
- Simultaneous performance of another procedure, which itself requires hospitalization
- Likelihood of another procedure that would require hospitalization following the initial procedure prior authorization for surgical services for IHCP fee-for-service (FFS) members must then be requested from the FFS PA contractor.

I/P Surgery Covered Services (Example)

- Plastic or reconstructive surgery
  - Panniculectomy, and breast, genitourinary and facial plastic and reconstructive.
- Maxillofacial surgery
  - Orthognathic and temporomandibular joint surgery
- Cleft lip and cleft palate
- Cardiac pacemakers - Please note the IHCP does not cover implantation of the dual-chamber pacemaker for the following clinical conditions:
  - Ineffective atrial contractions
  - Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of the tachycardia
  - A clinical condition in which pacing takes place only intermittently and briefly and is not associated with a reasonable likelihood that pacing needs will become prolonged

I/P Surgical Services

- For a list of noncovered surgical services, see the Outpatient Fee Schedule and Professional Fee Schedule, which is accessible from the IHCP Fee Schedules page at Indiana Medicaid: Providers: IHCP Fee Schedules

- There are non-covered codes that will require a prior authorization due to special circumstances (such as maxed limit of a service, or when a member requires additional services or new or replacement equipment).

  - EPSDT is an example for requests that are non-covered codes, where the member is under 21 and need a prior authorization for medical necessity.

I/P Surgery Non-Covered Services (Example)

Noncovered Breast Reconstruction Services

- IHCP reimbursement is not available for breast reconstruction in the following cases:
  - To reshape a normal structure to improve appearance or self-esteem
  - For conditions not related to congenital defects, developmental anomalies, trauma, infection, tumors or disease.
- IHCP reimbursement is not available for procedures performed to address cosmetic symptoms, including ptosis, poorly fitting clothing, unacceptable appearance or nipple-areolar distortion.
- The use of liposuction to perform breast reduction is considered investigational and is noncovered.
- For Provider Preventable Conditions (PPC) codes, see Surgical Services Codes, accessible from the Code Sets page on the IHCP Website. Surgical Services Codes

I/P Surgery Documentation Requirements

- The IHCP Provider Reference Modules should be your go-to resource for information regarding Surgical Services. For each service type it shows any required documents that are needed or directs you to the correct reference module for that information.

- Examples of this include the following service types that are frequently pended for additional information as the PA request does not include required documentation for review:
  - Bariatric Surgery
  - Cochlear Implants

Example Documentation Requirements Bariatric Surgery

Per the IHCP **Surgical Services** provider reference module, the request for PA for bariatric surgery must be accompanied by all the following documentation:

- A signed statement from the member acknowledging an understanding of preoperative and postoperative expectations
- Documentation that member failed to maintain weight loss or achieve a BMI below the thresholds indicated Bariatric Surgery section, despite a committed attempt at conservative medical therapy including participation in a nonsurgical weight loss program.
- Documentation that reflects a psychiatric evaluation for possible behavioral health conditions that are contraindications to the surgery performed by a licensed practitioner (see list in module
- Consultation reports from other practitioners outlining their history or conditions (i.e. substance use disorders, etc).
- For members under 21 years of age, documentation by two physicians who have determined bariatric surgery is necessary.

Example: Documentation Requirements Cochlear Implants

The IHCP requires specific medical documentation for medically necessary procedures or surgeries, including Cochlear Implants. A prior authorization requires medical documentation of certain medical conditions that include, but not limited to:

- Diagnosis of bilateral moderate-to-profound sensorinerual hearing impairment with limited benefit from appropriate hearing aids

- Cognitive ability to sue auditory clues and willingness to undergo and extended program or rehabilitation

For information about maintenance, repair and replacement of the cochlear implant see the Hearing and Services module.

Outpatient Surgery

O/P Surgical Services

- Outpatient Surgical services is a surgical procedure that can be performed in a healthcare setting where the member is registered as a patient with the facility but not admitted as inpatient.

- This service allows the members to remain in the hospital for up to 72 hours under observation status.

O/P Surgical Non-Covered Services

- In the Outpatient Facility Services provider module, note that the IHCP does not cover surgical or other invasive procedures to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously. The IHCP also does not cover services related to these noncovered procedures. All services provided in the operating room when an error occurs, and all related services provided during the same hospitalization in which the error occurred, are not covered.

- See the Provider Preventable Conditions section in the Surgical Services module for more information.

O/P Surgical Non-Covered Services

- For a list of noncovered surgical services, see the Outpatient Fee Schedule and Professional Fee Schedule, which is accessible from the IHCP Fee Schedules page at Indiana Medicaid: Providers: IHCP Fee Schedules
- There are non-covered codes that will require a prior authorization due to special circumstances (such as maxed limit of a service, or when a member requires additional services or new or replacement equipment).
  - EPSDT is an example for requests that are non-covered codes, where the member is under 21 and need a prior authorization for medical necessity.

O/P Non-Reimbursed Services

Certain implantable DME items are reimbursable separately from the implantation procedure when it is performed in an outpatient surgical setting, including certain implantable contraception devices, as described in the Family Planning Service reference module. As well as the following devices described in the Surgical Services module:

- Cardiac pacemakers • Cochlear implants • Implantable cardioverter defibrillator
- Implantable infusion pump • Osteogenic bone growth stimulator (implantable)
- Patient-activated event recorder – implantable loop recorder • Phrenic nerve stimulator
- Spinal cord stimulator • Vagus nerve stimulator

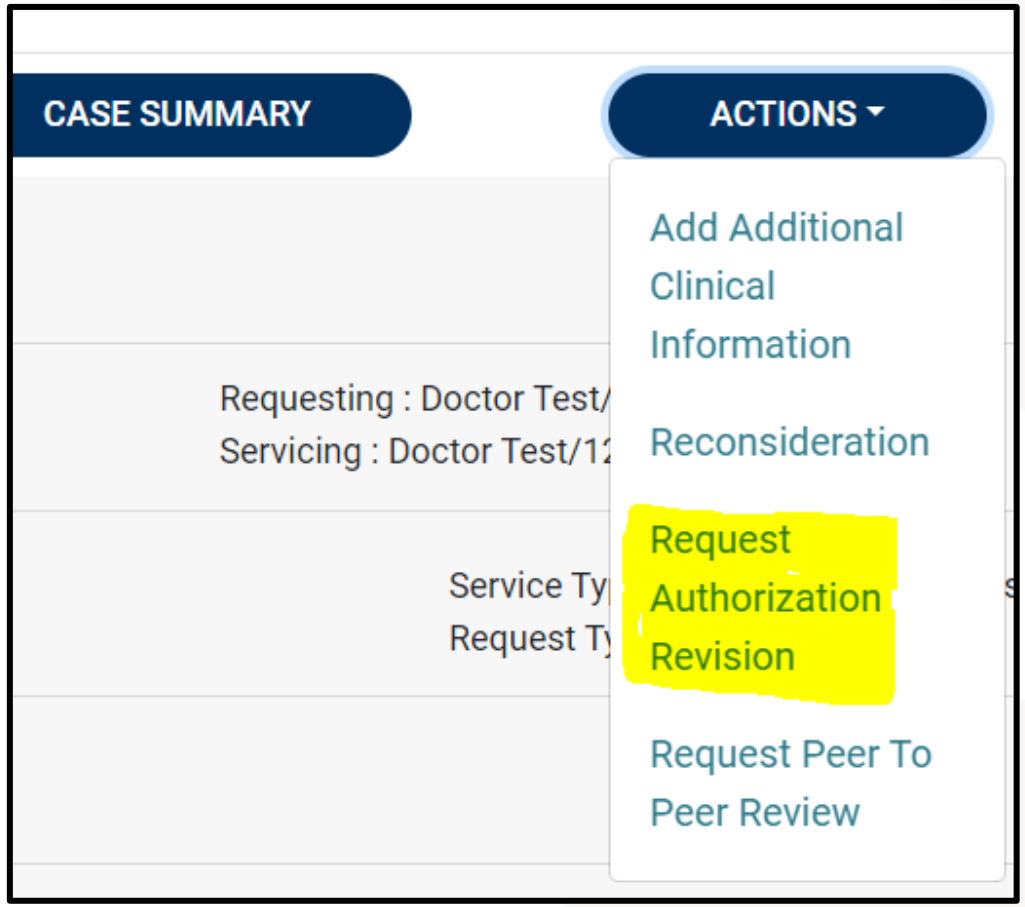
For a list of items that are *separately reimbursable for the outpatient surgery*, see the Implantable DME Separately Reimbursable in the Outpatient Setting table in Surgical Services Codes section. This is accessible from the *Code Sets* webpage at in.gov/medicaid/providers.

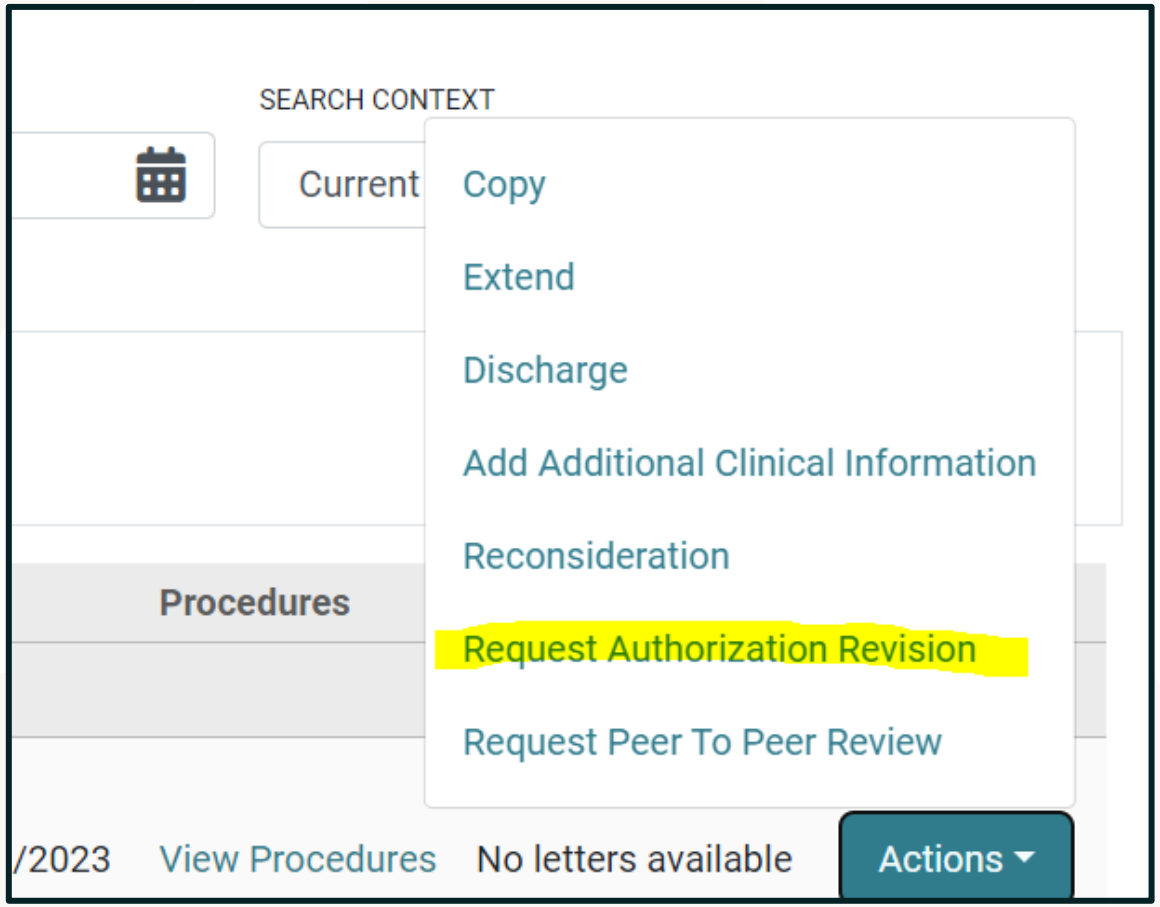
Post Determination Actions

Prior Authorization Revision Request

- When you have an approved prior authorization (PA) and rescheduling is necessary, please submit an Authorization Revision Request.
  - If you have a PA for surgery scheduled for March 3rd and it needs to be changed, the provider has until the end of the day March 3rd to request to extend the dates on that approved surgery.
    - If your PA has expired, we cannot adjust the dates on the existing PA and a new request must be submitted to Acentra Health.
- If no additional units are needed but the end date needs to be extended, this would also be an Authorization Revision Request.

Authorization Revision Request Screenshot





Prior Auth Review Process and Tips to Reduce Pends and Denials

Prior Authorization Review Process

After submission of a request, one of the following actions will occur:

1. **Approval**: Request met criteria either at nurse review level or medical director review.
2. **Pended request for additional information**: Required documentation is requested when not included with the original submission.

Prior Authorization Review Process Continued

3. **<u>Administrative Denial</u>**:

- Denial of services due to:
  - Untimely Request
  - Requested information not received

3. **<u>Medical Necessity Denial</u>**:

- Physician has determined that medical necessity has not been met.
- The physician may partially approve or fully deny a request.

Common Reasons for Denials and Voids

ADMINISTRATIVE DENIALS:

- Missing required documentation that is not received:
  - within 7 days of receipt of the initial PA request
- No clarification of units – number requested is not matching the date of service (DOS)
- If member is retro-eligible and not all information is submitted, it will be administratively denied.
  - Everything must be submitted at time of request

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

VOIDS:

- Member is not FFS or the PA submitted to the incorrect Vendor
- Per fee schedule the CPT does not require a Prior Authorization
- If a request is a duplicate of another authorization submitted to Acentra Health

Tips to Reduce Pends and Denials

- Ensure to obtain a PA prior to rendering services
- Upload all required documentation at the time of submission
- Include all required forms and service specific documentation when submitting the request. Verify:
  - Any required forms are filled out completely and properly signed as required
  - Signed physician order has been included in request
  - The request has not been previously submitted
  - The member is not receiving services from a different provider
- Provide any missing documentation within 7 days of the date the case was pended for Additional Information

Post Denial Actions

Administrative Review/Reconsideration

- If an administrative denial or medical necessity denial is issued, the provider can request an Administrative Review (also known as a Reconsideration).
- For I/P hospitalizations 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 portal, fax or mail) to Acentra Health within seven business days of the receipt of notification of PA modification or denial. If the provider wants to continue with the administrative review, Acentra Health must receive the entire medical record within 45 calendar days after discharge.
- How to request a formal administrative review:
  - Request from the “actions” drop down in the Provider Portal.
  - Fax in a written request to 800-261-2774
  - Provider module contains details of what is required to initiate an administrative review: Prior Authorization Module

Peer-to-Peer

- Providers may request a Peer-to-Peer
- Requests for a peer to peer must be made within ***7 business days plus 3 calendar days*** of the date provided on the initial determination letter.
- To request a peer to peer:
  - Request from the “actions” drop down in the Provider Portal. Provide the ordering provider’s full name, phone number, and three dates and times of availability.
  - Call Customer Service at 866-725-9991.
  - Once an agreeable date and time have been identified, a representative will contact (via telephone) the provider with the confirmed date and time. A note will also be placed in the case that is visible to the provider.

Assuming a PA From Another Provider

- Complete and fax a request using the Authorization Revision Request form 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

FSSA Resources for Providers

Provider Fee Schedules

Accessible from the Family and Social Services Administration (FSSA) Provider web page.

Guides providers regarding PA requirement.

Provider Fee Schedules

Provider Modules

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

Provider Modules

Forms

If prior authorization request requires forms to be submitted with the request, they can be found on the forms page.

Forms

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 Health Customer Service:	**Phone: 866-725-9991** **Fax: 800-261-2774**

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