Acentra HEALTH

Prior Authorization of Inpatient Rehab and LTAC Services

Indiana FFS Provider Training

Agenda

General Authorization Requirements

Provider Responsibilities

Inpatient Rehab Requirements

LTAC Requirements

Tips to Reduce Pends and Administrative Denials

Post Denial Options

Atrezzo Process for Authorization Revisions

Provider Resources

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)

General Prior Authorization Requirements (Cont.)

- Ensure to check member eligibility prior to any PA submissions.

- A request is considered timely when the request is submitted prior to the start of services (unless submitted late due to retrospective Medicaid eligibility).
  - A request is considered untimely if any of the dates of service are in the past from the service start date.

- View the IHCP PA Provider Reference Module prior to submitting your requests: Prior Authorization

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.
- Complete all required forms in its entirety and submit all documentation with request for authorization.

****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:

- If there is pending or retroactive member eligibility
- When a Provider was unaware the member was eligible at the time services were rendered and meets IHCP prior auth conditions

Important: When requesting a retrospective PA, detailed information and documentation will need to given to explain why the retrospective request is required.

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 concurrent 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 Rehab

I/P Rehab Medical Necessity Documentation

The IHCP provides reimbursement for inpatient rehabilitation services when such services are prior authorized and determined to be medically necessary.

- Prior authorization is required for all inpatient rehabilitation admissions.
- Revenue Codes are Length Of Stay (LOS) and 0128
- Before admission to a physical rehabilitation unit, an assessment of the patient's total rehabilitative potential must be completed and documented in the medical record.
- A written plan of care, cooperatively developed by the therapist or psychologist and the attending physician, is required for all rehabilitation services.
- Documentation in the medical record must include the member's condition, IHCP criteria and level of care necessary in the rehabilitation unit.

I/P Rehab Admissions

- **The following conditions must be met for physical rehabilitation admission:**
  - The patient is medically stable and is responsive to verbal or visual stimuli
  - The patient has sufficient mental alertness to participate in the program
  - The patient's premorbid condition indicates a potential for rehabilitation
  - The required documentation to include the criteria listed in Indiana Administrative Rules and Policy - 405 IAC 5-32 are met, which includes severity of illness, intensity of service and discharge criteria.

I/P Rehab Severity of Illness Criteria

- **The following criteria must demonstrate the inability to function independently with demonstrated impairment:**
  - Cognitive function (attention span, memory or intelligence
  - Communication (aphasia with major receptive or expressive dysfunction)
  - Continence (bladder or bowel)
  - Mobility (transfer, walk, climb stairs or wheelchair)
  - Pain management (pain behavior limits functional performance)
  - Perceptual motor function (special orientation or depth of distance perception)
  - Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis)

I/P Rehab Intensity of Service Criteria

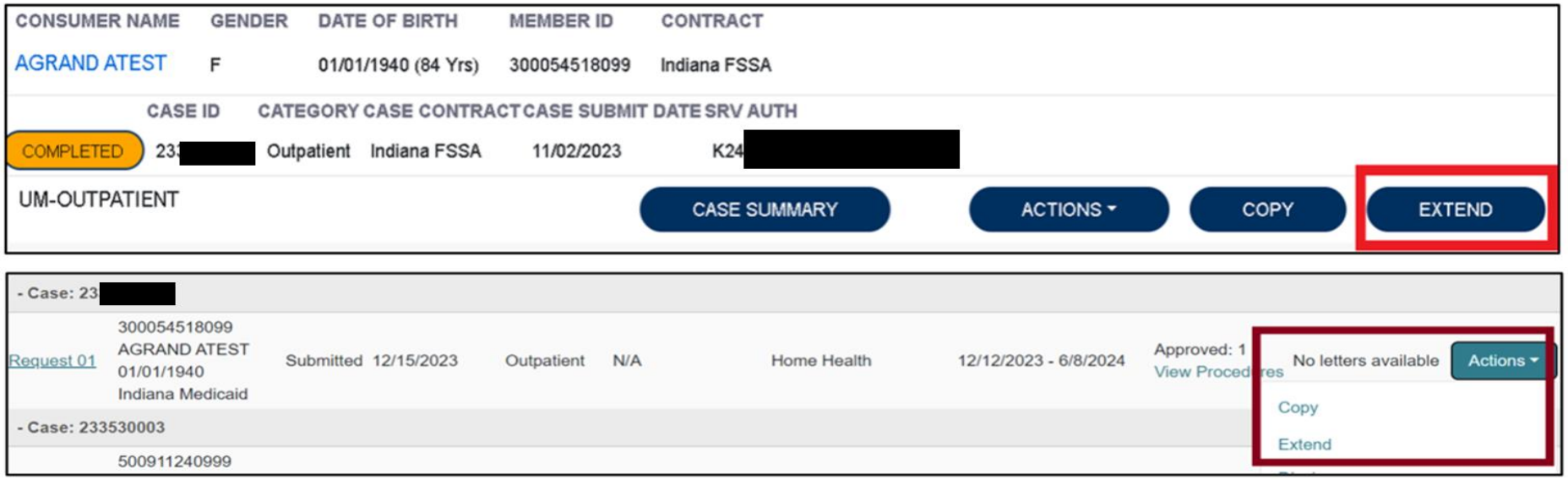
- **Intensity-of-service criteria for inpatient rehabilitation are as follows:**
  - Multidisciplinary team evaluation at least every two weeks
  - Physical therapy and at least one of the following therapies (totaling a minimum of three hours daily):
    - Occupational therapy
    - Speech therapy
  - Participation in a rehabilitation program under the direction of a qualified physician
  - Skilled rehabilitative nursing care or supervision required at least daily

Inpatient Hospital Services

Continued Stay/Extension

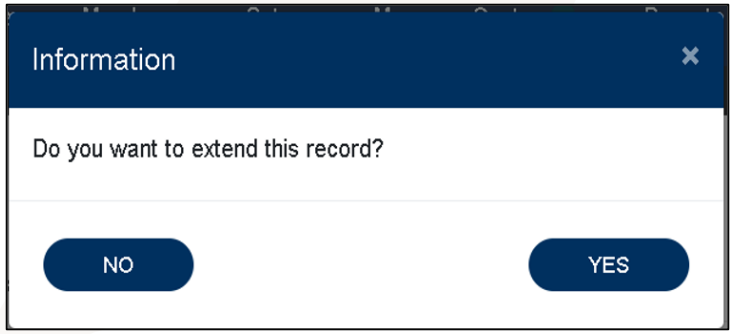
- For an I/P Rehab continued/concurrent request, the PA request should be received on or prior to the last covered day of the previous request.

To begin, the user will choose to extend the existing PA. This can be done from the work queue view or within the case itself.



Continued Stay/Extension

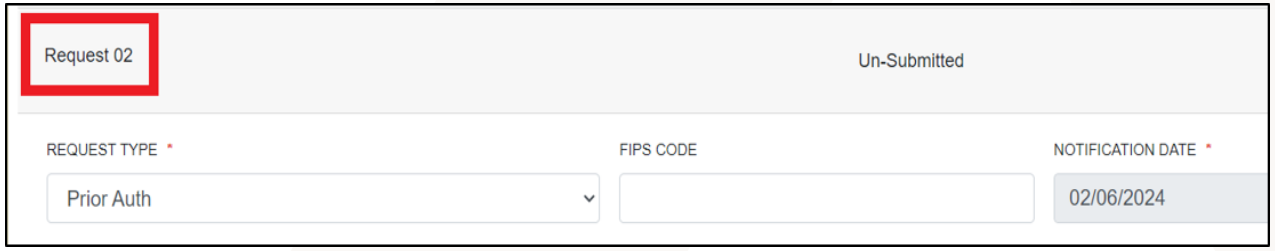
The system will ask the user to verify the action by clicking YES.



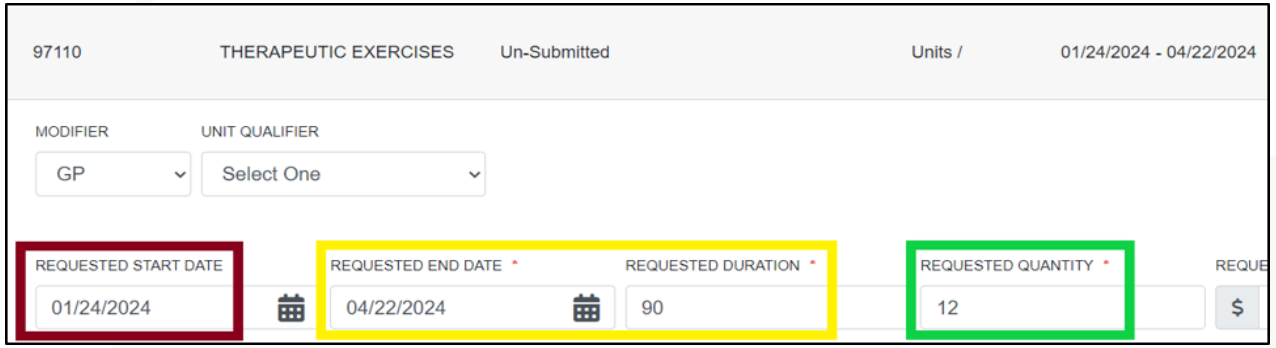
Next, the system will populate the case summary. Here the user will scroll to the Clinical section and select the down caret to expand the section.

Continued Stay/Extension (Cont.)

The user will then scroll to the new request line.



The user will enter the continued stay start date and the end date. The requested quantity should correlate with the requested duration.

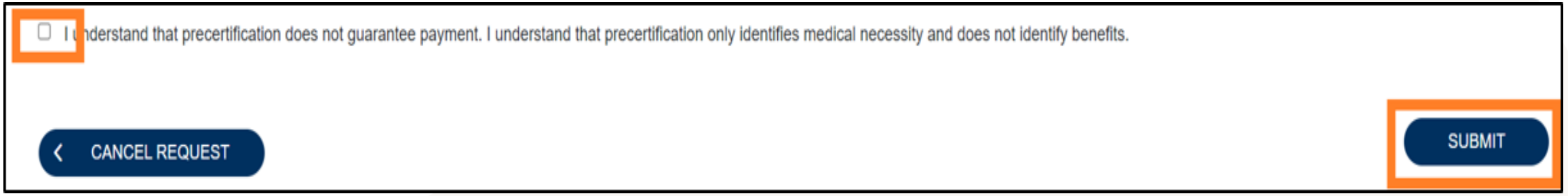


***EXAMPLE: Original end date was 02/05/2024, then the concurrent request would begin on 02/06/2024.**

Continued Stay/Extension (Cont.)

- Once the request line has been updated to reflect the new start date and requested units, the user will scroll to the bottom of the screen and check the box acknowledging that the PA is not a guarantee of payment and only identifies medical necessity, not benefits.

- The user will then click the submit button.



LTAC Services

I/P LTAC Services

Long term acute care (LTAC) facilities are utilized to treat members with complex medical issues, have chronic conditions or are recovering from a critical illness, but are not medically stable enough to be discharged home, or for a skilled nursing facility (SNF).

LTAC Admissions

The following documentation must be completed and included with requests for admission to an LTAC hospital:

- Prior to the admission to an LTAC hospital, assessment of the patient's current medical status and discharge goals must be documented.

- Revenue Code 0101

- The member must be admitted to the LTAC hospital directly from an acute care facility or they must be re-admitted to the LTAC hospital from a nursing facility or a rehab facility.

LTAC Admissions

All of the following situations will apply to the patient's status and current requirements before admission to the LTAC hospital:

- Patient is medically stable, and an initial diagnostic workup is completed.
- There are no major surgical procedures planned.
- Patient has a prognosis requiring a prolonged stay in an acute setting, and there is a reasonable expectation for improved status of the patient's medical condition.
- Patient requires interactive physician direction with daily on-site assessment.
- The patient requires significant ancillary services dictated by complex, acute medical needs.

Requesting Facility Documentation

The following information must accompany a request for approval and an evaluation by the requesting facility:

- Diagnosis and premorbid conditions.
- Information about where the patient is being admitted from, if not hospitalized.
- Neurological assessment.
- Complete listing of long- and short-term goals.
- Discharge plan with two options, depending on the member's condition.
- History of any previous rehabilitation therapies.
- Prognosis and documentation that there is a reasonable expectation the member's functional and medical status will improve.
- History, physical, and discharge or case summary, if the member is currently hospitalized.
- *The admission assessment must be received*.

I/P LTAC Services Review

During the prior authorization review process, the medical director may assist with determination:

- Admissions requested for specific medical conditions such as respiratory, cardiac or impaired skin integrity should follow national clinical guidelines (such as InterQual, MCG, etc).

- These admissions will be reviewed for medical necessity and intensity of service on a case-by-case basis.

Inpatient Hospital Services

LTAC Continued Stays

When reviewing requests for a continued stay in the LTAC hospital, the IHCP follows national clinical guidelines. For continued stay, the request must be received by the PA department 48 hours before the last approved day and is to include the following:

- Completed IHCP Prior Authorization Revision Request Form (not required if the PA update is requested online via the PA contractor's provider portal).
- A summary of the current discharge plans and documentation of family or friend participation in the discharge planning process.
- A neurological assessment update, if appropriate.
- Documentation of the member's cooperation, participation or progress.

Prior Auth Review Process and Tips to Reduce Pends and Denials

Prior Authorization Review Process

After your 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
  - within 14 days of receipt of the continued stay/concurrent 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 and 14 days from receipt of the continued stay, concurrent request.

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

Provider Resources

- **Provider Education and Training materials** (Videos, Handbooks, Quick Guides and FAQs) are located at: https://inmedicaidffs.acentra.com/training-and-education/

- **Provider Communication and Support email**: INPriorAuthIssues@Acentra.com

  Provider registration assistance. Prior Auth submission issues. Assistance with account.

- **Dedicated Customer Support Line Call us at 866-725-9991**

  Request a clinical call back. Check case status. Reset Log In. Submit prior auth requests.

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**

Acentra HEALTH

Accelerating Better Outcomes