Acentra HEALTH

Improving Prior Authorization Processing and Outcomes for Behavioral Health Inpatient Admissions and Concurrent Review

2026 IHCP Works Annual Seminar

Presented by Wendy Fields

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Agenda

- Setting the Stage: Improving Prior Authorization (PA) Processing & Outcomes
- Building a Strong Inpatient Behavioral Health Authorization
- Medical Necessity & The Clinical Story
- Admission & Concurrent Review Requirements
- Avoiding Pends, Denials and Common Submission Issues
- Post-denial Options & Provider Resources
- Questions

The Goal

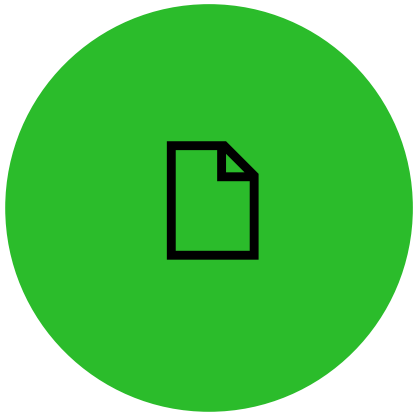
Timely decisions

Continuity of Care

Improved member experience

Where Requests Break Down

Most delays occur **before** clinical review begins



Documentation

- Forms
- Signatures
- Medical necessity

Submission

- Request submitted outside required timeframe

Missing information

- Incomplete requests lead to requests being pended for additional information

Before You Click Submit

Verify Eligibility

Ensure member is eligible for Fee for Service (FFS) coverage vs. Managed Care

Confirm PA is required

Check the fee schedule to ensure a PA is required

Gather Documents

Have all relevant clinical documentation with signatures ready to submit

Submit Review

Submit a **complete** request to Acentra Health

Build a Strong Authorization

Building a strong authorization starts with a strong foundation. That foundation begins with timely submission and includes complete documentation that clearly tells the patient's clinical story and demonstrates medical necessity. When those pieces are in place from the start, it helps reduce delays and allows us to make timely authorization decisions that support continuity of care.

Criteria for Psychiatric Inpatient Admissions

Members with **any** of the following presenting factors may meet medical necessity for psychiatric inpatient services:

Current or recent serious suicide ideation, with a plan and potential means with lethal intent

Current or recent serious, violent, impulsive an unpredictably dangerous homicidal ideation (with a plan and potential means)

Current or recent harm to self or others

Unable to care for self due to a psychiatric condition, such that imminent life-threatening deterioration occurred

Acute psychotic symptoms, severely bizarre thinking, and psychomotor agitation that cannot be safely treated at a less-restrictive level of care

Criteria for Substance Use Disorder (SUD) admissions

Inpatient stays for SUD treatment in all settings, including Institutions for Mental Diseases (IMD) will be based on the American Society of Addiction Medicine (ASAM) patient placement criteria, Level 4 (medically managed intensive inpatient services).

Providers must include all appropriate documentation demonstrating medical necessity for inpatient treatment with the PA request.

Prior Authorization for inpatient detoxification, rehabilitation & aftercare for chemical dependency reviewed on a case-by-case basis and must include consideration of the following:

- Treatment, evaluation, and detoxification are based on the stated medical condition and /or primary diagnosis for inpatient admission.
- Need for safe withdrawal from alcohol and or other drugs is indicated
- There is a history of recent convulsion or poorly controlled convulsive disorder.
- Reasonable evidence exists that detoxification and aftercare cannot be accomplished in an outpatient setting.

The Clinical Story

The clinical story should clearly explain:

- Why the inpatient treatment is medically necessary
- Why outpatient care is insufficient
- Current clinical risks
- Expected treatment goals

Plan of Care Requirements

The Plan of Care must demonstrate that:

- Community-based outpatient resources are not sufficient to meet the needs
- The condition requires inpatient services under the direction of a physician
- Inpatient treatment is reasonably expected to improve the member's condition or prevent regression

The Plan of Care must be based on a comprehensive diagnostic evaluation that considers:

- Medical and psychological needs
- Social and behavioral factors
- Presenting concerns
- Previous treatment interventions

Plan of Care Components

Each Plan of Care must include:

- Clearly defined treatment objectives and goals
- An integrated program of appropriate therapies, activities and treatment experiences
- A post-discharge plan developed at the appropriate time
- Coordination with partial hospitalization or community-based services to support continuity of care

Who develops the Plan of Care:

- Members age 22 and older: the attending or staff physician
- Members age 21 and younger: an Interdisciplinary team that includes qualified medical, behavioral health, and mental health professionals, along with the member and the parent, guardian, or caregiver involved in discharge planning.

Does your plan of care tell the story?

Why outpatient isn't enough

Current Clinical Risks

Chief Complaint "I don't feel safe. I've been thinking about ending my life."

History of Present Illness 34-year-old member with a history of Major Depressive Disorder presented to the Emergency Department after expressing suicidal ideation with a specific plan to overdose on prescription medication. Over the past two weeks, the member has experienced worsening depression, poor sleep, decreased appetite, medication noncompliance, and increasing social isolation.

Mental Status Examination

- Depressed mood
- Flat affect
- Impaired judgment
- Active suicidal ideation
- Unable to contract for safety

Risk Assessment Member is considered at HIGH RISK for self-harm due to active suicidal ideation with plan, medication noncompliance, and inability to maintain safety outside of a monitored setting.

Clinical Recommendation: Recommend acute inpatient psychiatric hospitalization for safety, stabilization, medication management, and intensive behavioral health treatment.

Initial Treatment Plan • Suicide precautions • Psychiatric medication evaluation • Individual and group therapy • Daily psychiatric assessment • Discharge planning with community follow-up

John Medical, M.D.

Why Inpatient treatment & expected treatment goals

Admission Request

Inpatient behavioral health admissions should be submitted within 48 hours of admission.

Retrospective reviews are considered under the following circumstances:

- Pending or retroactive member eligibility.
- Provider was unaware the member was eligible for services at the time services were rendered and can substantiate that reimbursement was continually pursued from the member until Indiana Health Coverage Program eligibility was discovered. The provider submitted the request for PA within 60 calendar days of the date that IHCP eligibility was discovered.

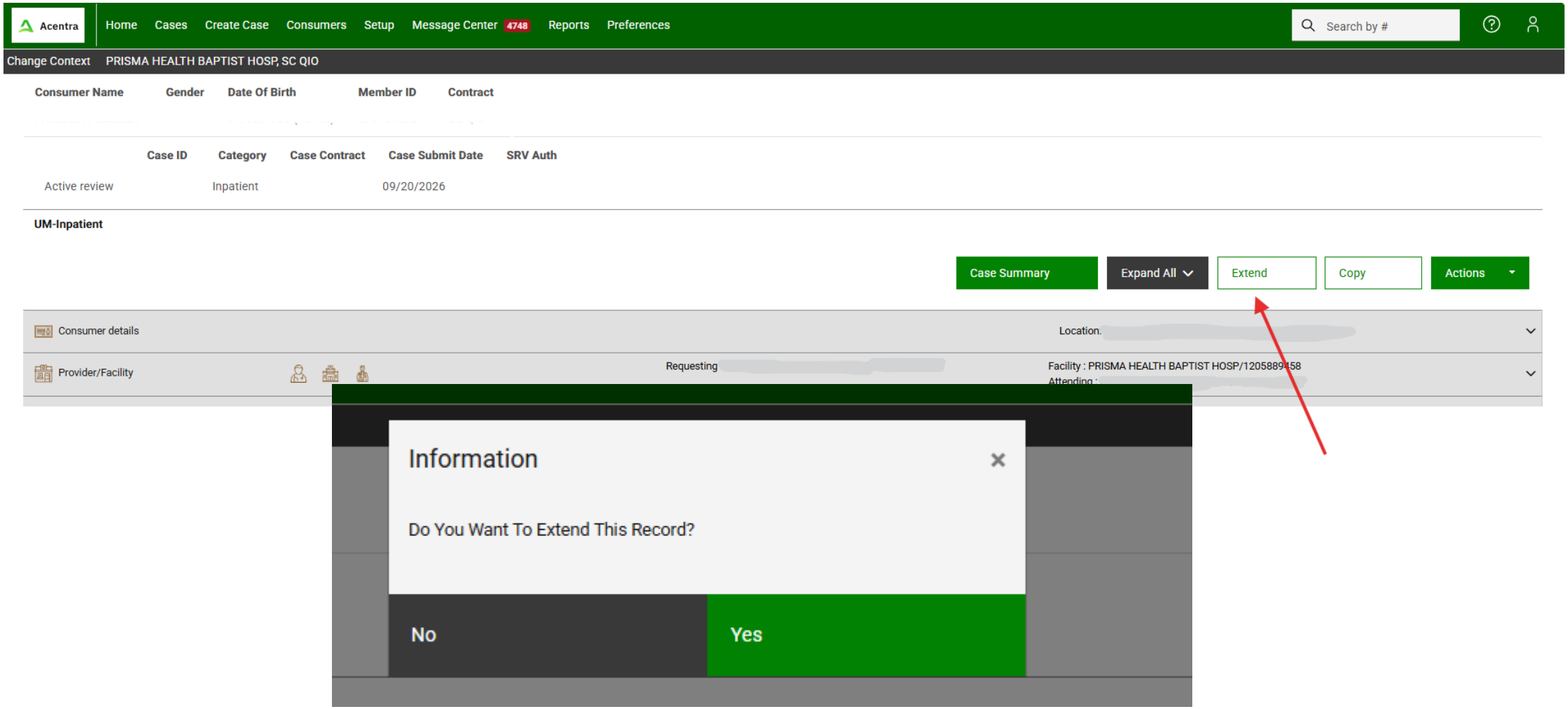
Concurrent Review Request

**Use the same case for both Admission and Concurrent Review Requests **

Concurrent review requests must be submitted no later than the last covered day; if the first con-covered day falls on a weekend, providers are strongly encouraged to submit the request before the weekend.

IMPORTANT*:* If the request is received untimely, then the certified start date of that concurrent request can only be authorized starting from the date it was received.

Concurrent Review Request



Think like a Reviewer

What has changed?

Is the treatment still working?

Medical necessity – is there a lower level of care available?

What is the discharge plan?

The clinical story should evolve with each review – documenting progress, remaining risks and discharge planning.

A Pended Request is an Opportunity

WHY REQUESTS ARE PENDED

- Missing or incomplete Plan of Care
- Missing signatures of qualified providers
- Goals not individualized
- Missing assessment
- Missing Medication Record
- Missing progress notes
- Missing the IHCP Initial Assessment Form for SUD
  - Forms can be found on the IHCP Forms webpage

HOW TO RESPOND

Gather ALL requested documentation

Upload everything together (in Atrezzo)

Respond within the required timeframe (7 calendar days)

General Reasons for Denials

ADMINISTRATIVE DENIALS:

- Response to pend request not received within 7 calendar days from request of additional information.
- Untimely notification of admission/concurrent requests.

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.

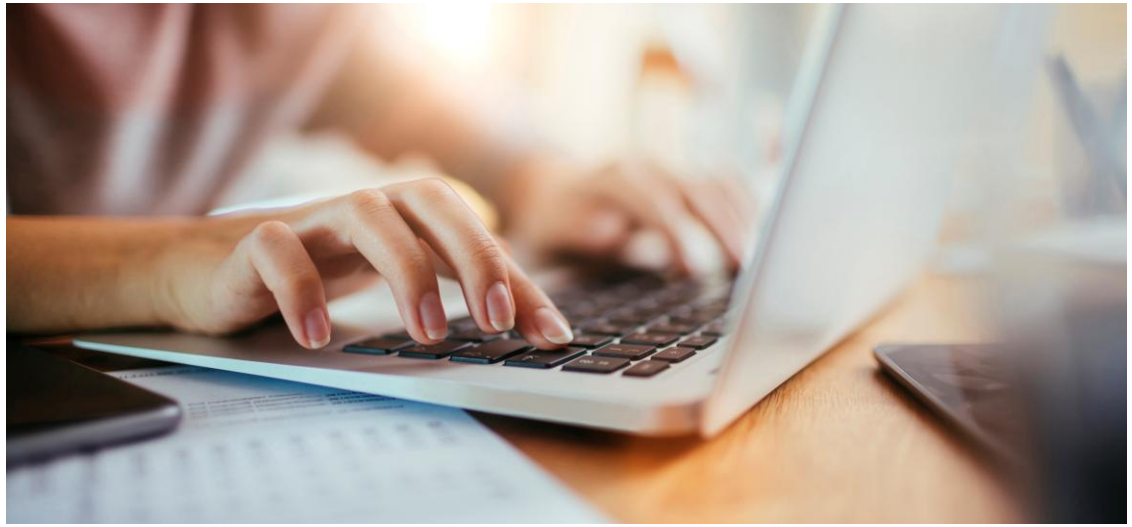
Example of a partial approval:

Provider requested PA for 7 days, but after review of the documentation submitted, the physician reviewer determines the member does not meet medical necessity for 7 days and only approves 5. This is a “partial approval.”

General Reasons for Voids

VOIDS:

- The request is a duplicate of another authorization submitted to Acentra Health.
- Member is with a managed care organization (not FFS)
- Provider requested

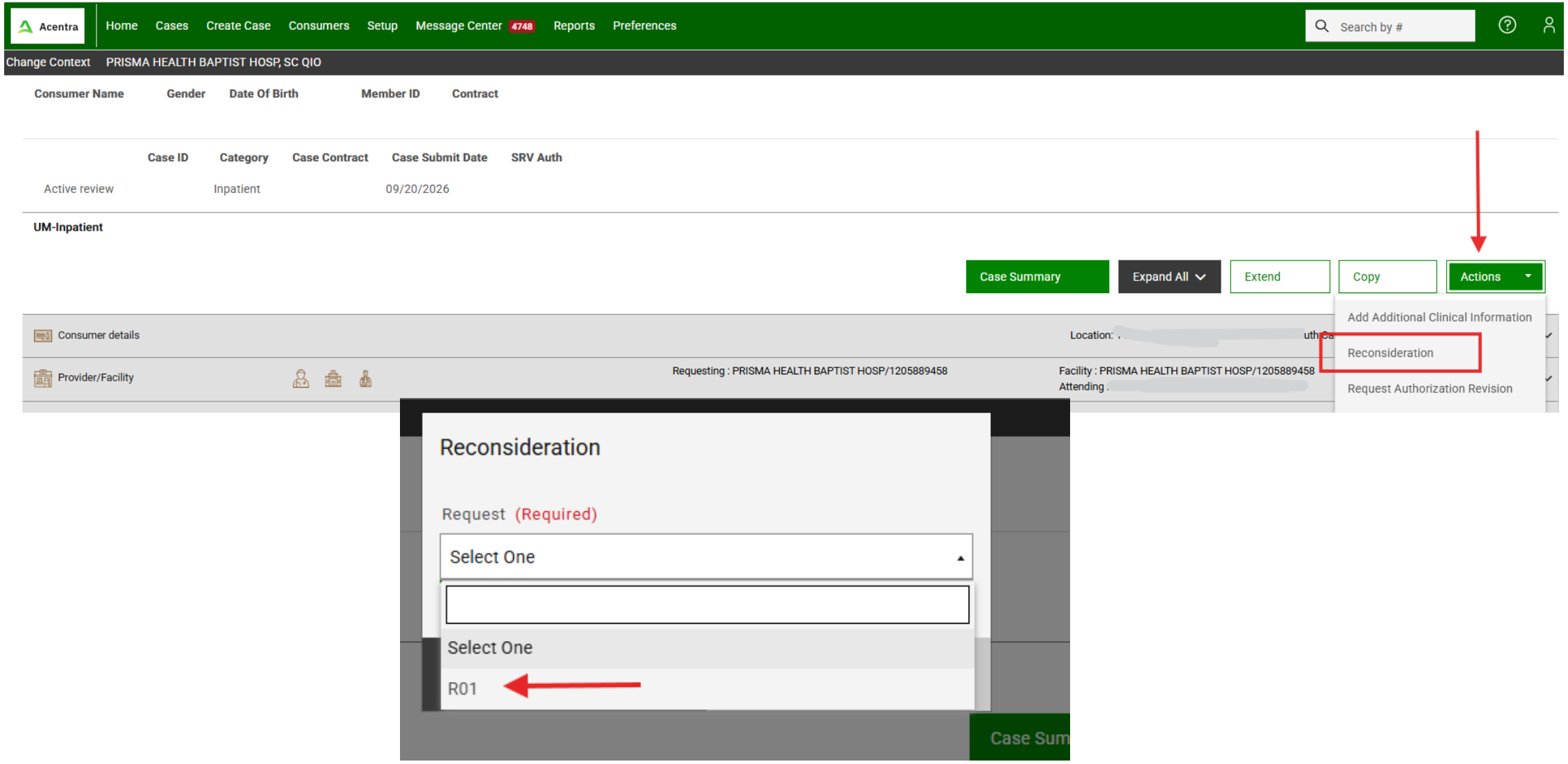


Post Denial Options – Administrative Review

If an administrative denial or medical necessity denial is issued, the provider can request an Administrative Review (also known as Reconsideration).

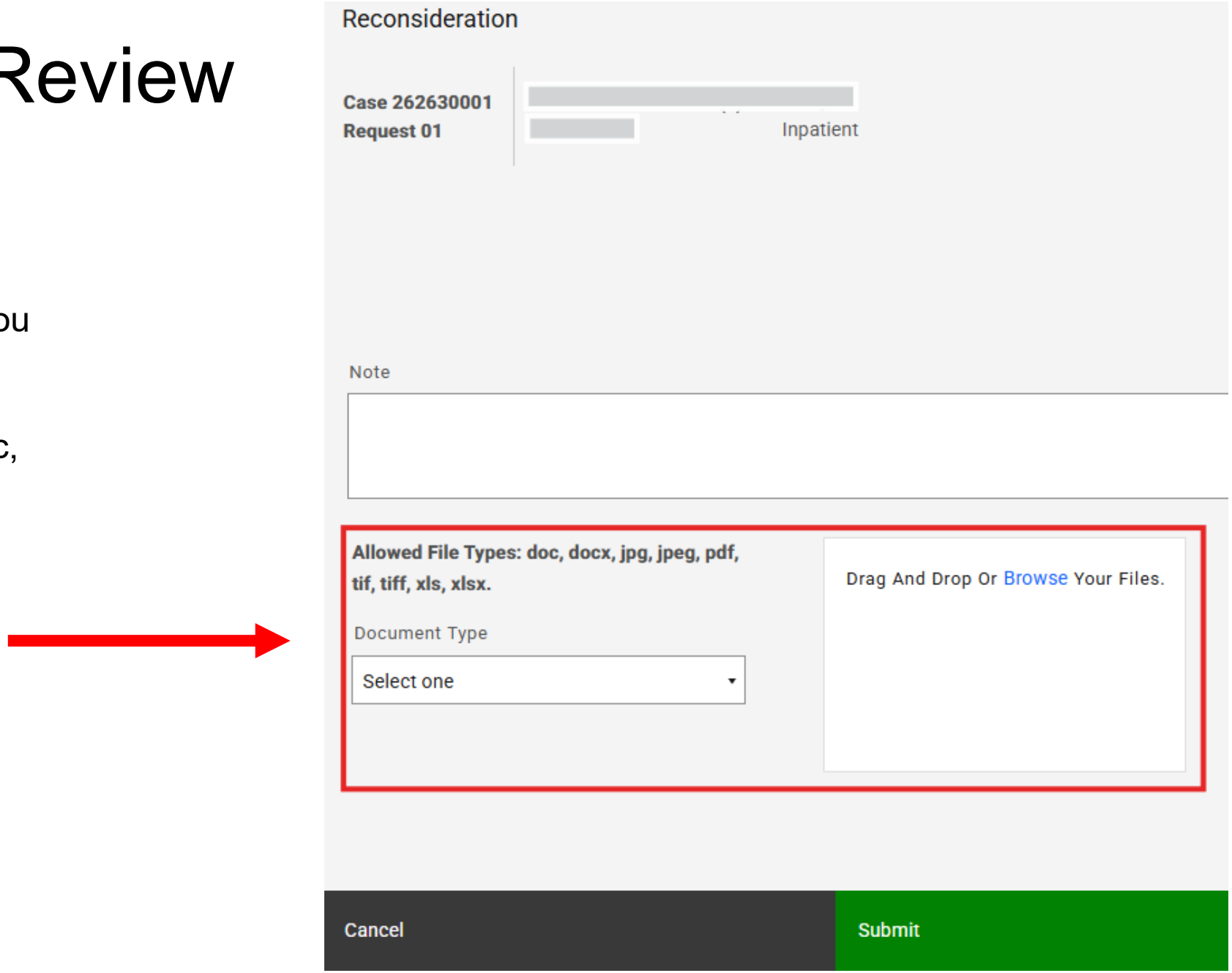
- The IHCP Prior Authorization Provider Reference Module contains details of what is required to initiate an administrative review and any required documents
- A provider requesting review of the modification (partial approval) or a denial of a PA must submit a written request for an administrative review within **seven business days** of the receipt of notification of modification (partial approval) or a denial.
- How to request an administrative review:
  - Select Reconsideration from the Actions drop down in the Atrezzo Provider Portal, or
  - Fax in the written request and include documents noted in the IHCP Prior Authorization Provider Reference Module – Section 4.

Administrative Review (Reconsideration)



Administrative Review

After selecting your Request number for reconsideration, you may upload or drag and drop your files. Atrezzo will allow several different file types: doc, docx, jpg, jpeg, pdf, tif, tiff and xlsx.



Success Starts Here

- ✓ Tell the clinical story
- ✓ Demonstrate medical necessity
- ✓ Complete the Plan of Care
- ✓ Monitor requests
- ✓ Respond promptly

Provider Resources

Indiana Medicaid for Providers

- IHCP Provider Bulletins
- Provider Reference Modules
- Provider Forms

Need assistance?

We are here to support you!

Provider Relations Assistance:
INPriorAuthIssues@acentra.com
**Please do not include protected information (PI)/protected health information (PHI) in emails

Provider Education Website:
https://inmedicaidffs.Acentra.com

Acentra Health Customer Service:
- Phone: 866-725-9991 M-F 8:00 am – 5:00 pm EST
(excludes holidays)
- Fax: 800-261-2774

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