PRIOR AUTHORIZATION

Next steps after submission

Presented by Wendy Sprigler RN, Provider and Member Liaison Coordinator

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Topics

- Authorization Review Process
- Pended PA
- Requests for Additional Units
- Transferring PAs Between Providers
- Hospice Member Disenrollment from Managed Care
- Retroactive PAs
- PA with Third-Party Liability
- Administrative Review (AR) and Appeal Process
- Common Denials
- Helpful Links
- Questions

Authorization Review Process

Turnaround Times

Standard Request	Expedited / Concurrent	Retrospective	Administrative Reviews
Five business days	Forty-eight hours	Thirty calendar days	Seven business days

Review Process Overview

- All documentation and criteria/requirements are reviewed.
- If any required documentation is required, clinical reviewer will pend to the provider. (This will be covered in depth later)
- Once all documentation is submitted, the reviewer determines if they can approve request against criteria.
- If the clinician cannot approve the PA based on criteria hierarchy the case is sent to a physician to review for medical necessity.
- All submitted documentation is reviewed and the medical director’s decision is returned to the clinical reviewer.
- The clinical reviewer enters the decision into the case in Atrezzo and completes the determination letters.

Letters

- Letters are generated at the time of completion.
- If submitted via portal, notice of case status change and letter creation is sent to the user who submitted the case.
- View/download authorization letter within case (under Attachments-Letters).
- Letters are then mailed to the following:
  - Member.
  - Requesting provider address on file.
  - Rendering provider address on file.
  - Attending physician (if entered in the case).
- Letters no longer contain PA numbers, but PA number will be available in Atrezzo.

Pended PA

Pended Cases

- If requested PA has insufficient information for utilization management (UM) team to review, request is pended.
- Turn around time clock is stopped.
- Clinical reviewer will send a letter and make a note indicating the information that is needed.
- Required clinical information must be submitted via portal or by fax within 30 calendar days for standard reviews.
- In portal: Upload documentation (Actions drop down/ Additional Clinical Information) or to fax: 800-261-2774.
- If requested information is not received within 30 calendar days, request is rejected.

Adding Documents to Case

- Select the ***ACTIONS*** drop down.
- The ***ACTIONS*** dropdown can be accessed from the main screen or from within the case.

Select One
MM/DD/YYYY
MM/DD/YYYY
Current
Copy
Extend
Discharge
Add Additional Clinical Information
Reconsideration
Request Authorization Revision
Request Peer To Peer Review

Request	Member	Status	Submit Date	Category	Discharge Date	Service Type	Service Dates	Procedures		
- Case: 232										
Request 01	300 AGRAND ATEST 01/01/1940	Submitted	10/24/2023	Inpatient	N/A	Inpatient Psychiatric	9/28/2023 - 1/13/2024	Approved: 3 View Procedures	No letters available	Actions

MEMBER NAME	GENDER	DATE OF BIRTH	MEMBER ID	CONTRACT
AGRAND ATEST	F	01/01/1940 (84 Yrs)	300054518099	Indiana FSSA

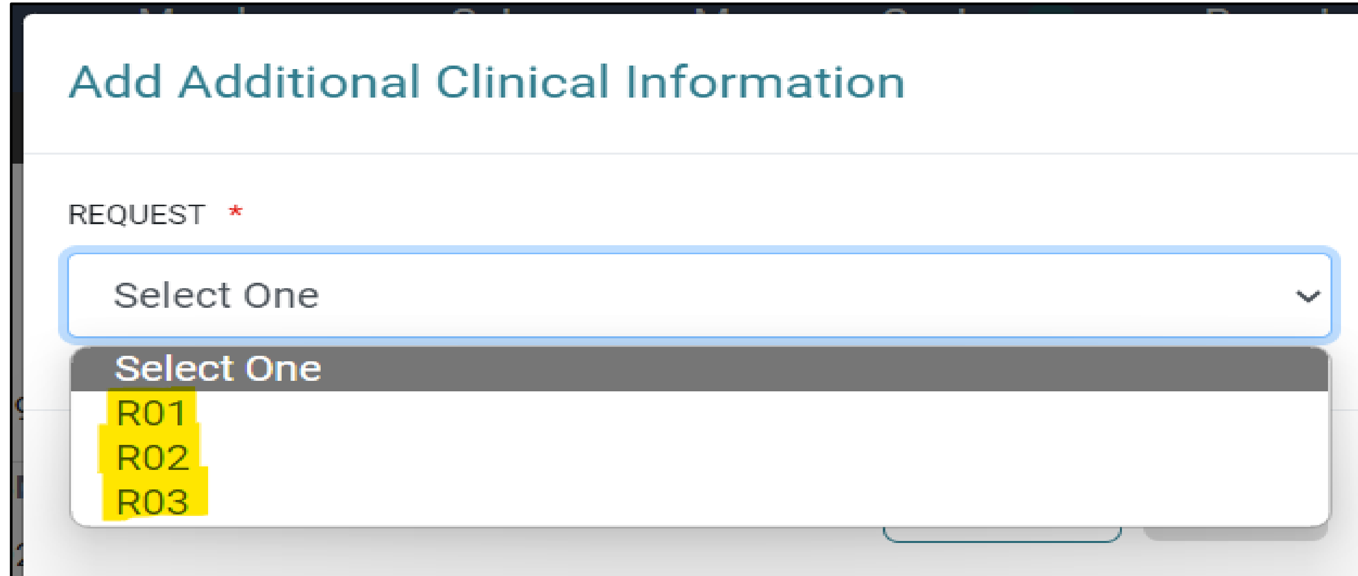
	CASE ID	CATEGORY	CASE CONTRACT	CASE SUBMIT DATE	SRV AUTH
INSUFFICIENT INFORMATION	23	Inpatient	Indiana FSSA	10/24/2023	

UM-INPATIENT
CASE SUMMARY
ACTIONS
Member Details
Provider/Facility
Requesting : Test Hospita
Clinical
Service Type
Request Type
Questionnaires
Add Additional Clinical Information
Reconsideration
Request Authorization Revision
Request Peer To Peer Review

- Select ***Add Additional Clinical Information.***

Selecting the Correct Request

- Select which request line (i.e., *R01, R02*), generally the most recent.



Screenshots for Uploading a File

- Select ***Document Type*** being uploaded.
- ***Browse*** or ***Drag and Drop*** files you want uploaded to the case.
- Provider may enter a note to the clinical reviewer under the ***Note*** section.
- Finish by selecting ***Submit***

Add Additional Clinical Information

Case 23
Request 01

YKID ATEST (M)
04/05/2003

Indiana FSSA
Outpatient

Note

Allowed File Types: doc, docx, jpg, jpeg, mdi, pdf, tif, tiff, xls, xlsx, xps.

Document Type

Select One

Augmentative Communication System Selection
Certificate of Medical Necessity for Oxygen
DME Information Form: Enteral and Parenteral Nutrition
Face to Face Encounter
Hospice Authorization Notice for Dually Eligible
Hospice Election

Drag And Drop Or Browse Your Files.

CANCEL
Submit

What Happens Next

- When the additional information is submitted, the clinical reviewer will receive a task to begin the medical necessity review.

- Upon receipt of the additional information, Acentra has an additional five business days for standard reviews and forty-eight hours for expedited or concurrent reviews, to complete the request.

Requests for Additional Units

Requesting Additional Units

- To request additional units, providers will need to extend the existing prior authorization (PA) by selecting the extend button within the case or from “actions” drop down for the case in the queue.
- The user will need to update the start date to reflect the date that the new units need to begin. (E.G. the current PA has an end date of 02/05/2024 but the units have been exhausted as of 01/20/2024, the provider will change the auto-populated start date from 02/06/2024 to 01/21/2024).
- The only exception to the date changes is for MRO packages. Providers will still use the extend feature but will keep the Dates of Service (DOS) the same as the existing request time.
- Provider can delete all additional codes that do not need to be extended.

Additional Unit Requests Process

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

CONSUMER NAME	GENDER	DATE OF BIRTH	MEMBER ID	CONTRACT
AGRAND ATEST	F	01/01/1940 (84 Yrs)	300054518099	Indiana FSSA

	CASE ID	CATEGORY	CASE CONTRACT	CASE SUBMIT DATE	SRV AUTH
COMPLETED	23	Outpatient	Indiana FSSA	11/02/2023	K24

UM-OUTPATIENT

CASE SUMMARY ACTIONS COPY EXTEND

- Case: 23

Request 01	300054518099 AGRAND ATEST 01/01/1940 Indiana Medicaid	Submitted 12/15/2023	Outpatient	N/A	Home Health	12/12/2023 - 6/8/2024	Approved: 1 View Procedures	No letters available	Actions

Copy

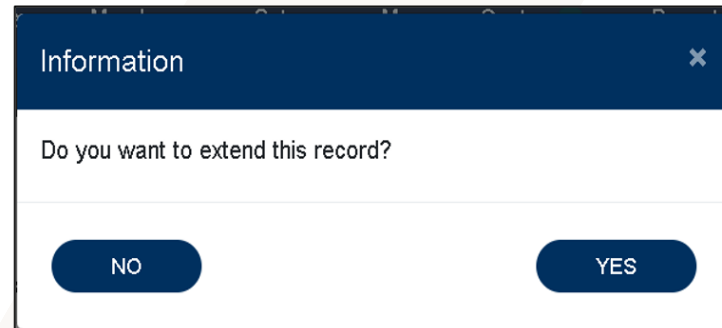
Extend

- Case: 233530003

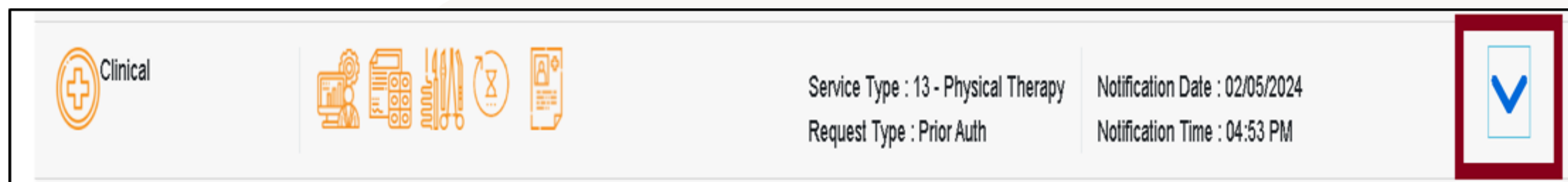
500911240999

Request Process

- 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.



Request Process Continued

- The user will then scroll to the new request line.

Request 02 | Un-Submitted

REQUEST TYPE * | FIPS CODE | NOTIFICATION DATE *
Prior Auth | | 02/06/2024

- The user will change the requested start date to the date the new units need to start.

97110 | THERAPEUTIC EXERCISES | Un-Submitted | Units / | 01/24/2024 - 04/22/2024

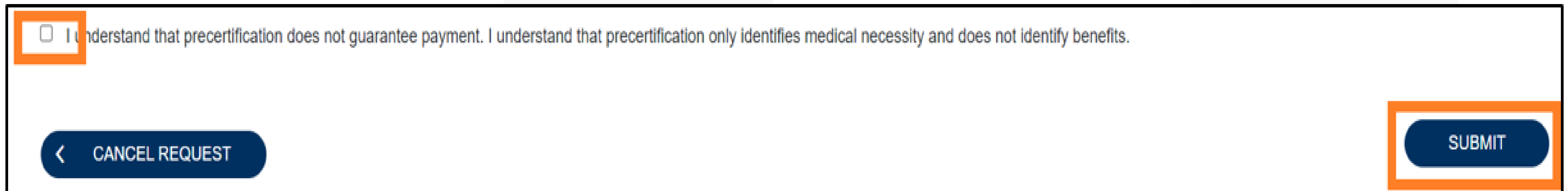
MODIFIER | UNIT QUALIFIER
GP | Select One

REQUESTED START DATE | REQUESTED END DATE * | REQUESTED DURATION * | REQUESTED QUANTITY * | REQUE
01/24/2024 | 04/22/2024 | 90 | 12 | $

***EXAMPLE: Original end date was 02/05/2024, this will populate as 02/06/2024 and will need to be changed.**

Acknowledgement Attestation

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.



Authorization Revisions

- Authorization Revision Request include:
  - Requests to move units between codes already approved.
  - If no additional units are needed but only the end date needs to be extended.

Transferring PAs Between Providers

Assuming a PA from Another Provider

- Fax a request on the IHCP Prior Authorization Revision Request Form to 800-261-2774 or call customer service at 866-725-9991.
- 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
- Hospice providers are required to submit completed Hospice Provider Request Between Hospice Providers Form.

Transferring Outstanding PA’s

- Providers should check eligibility before requesting or rendering service.
- With any change in a Member’s assignment to FFS, notify Acentra of any current PA; included supporting documentation to substantiate PA.
- Original PA letter must provide Acentra with the following:
  - ✓ Member ID (MID).
  - ✓ Provider’s National Provider Identifier (NPI).
  - ✓ Duration and frequency of authorization.

- Fax letter with explanation of request: 800-261-2774.
- When a member changes eligibility to Fee-For-Service (FFS) coverage from another vendor, Acentra honors existing PAs for specific durations, whichever comes first:
  - ✓ First 90 calendar days from member’s effective date in new plan.
  - ✓ Remainder of the PA dates of service.
  - ✓ Until approved units of service are exhausted.

***PA is not a guarantee of payment.**

Hoosier HealthWise Member Disenrollment from Managed Care

Hoosier Healthwise Disenrollments

- There is now a dedicated fax line for Hospice providers to send Hoosier Healthwise disenrollment requests.
- The new Hospice Disenrollment Fax number is 1-800-922-9805.
- The providers will still send the Medicaid Hospice Election form with a notation of Hospice Member Disenrollment from Managed Care in the subject line.
- A follow up phone call to verify receipt is still recommended before 4 PM Eastern Time to ensure timely notification to Maximus.
- Failure to follow these steps can result in a missed disenrollment.

Retrospective PAs

Retrospective Reviews

A retrospective review occurs when the entire date span of the request has past 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. ***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.
- When requesting a retrospective PA, detailed information and documentation to explain the retro request is required.

PA with Third-Party Liability

Third-Party Liability (TPL)

For members with TPL primary insurance, the provider will:	Members with Medicare or Medicare Advantage plan primary insurance:
• Follow the TPL authorization requirements • Obtain a PA from Acentra	• Covered Medicare services do not require a Acentra authorization. • Services not covered by Medicare subject to IHCP PA requirements - PA must be obtained from Acentra.

Administrative Review and Appeal Process

Administrative Review of PA Determinations

- Administrative Review (AR) for outpatient requests.
  - Must be received within 7 business days plus 3 calendar days of the date of the notification for an adverse determination.
- Peer-to-Peer reviews.
  - If Provider chooses to complete a Peer-to-Peer conversation first, the provider has the same time frame to submit an administrative review request following that determination.

- Inpatient hospitalizations a when member continues to be hospitalized:
  - Notification of intent to request review must be submitted within 7 business days plus 3 calendar days of the notification of modification or denial.
  - To continue with request, Acentra must receive entire medical record within 45 calendar days of discharge.

Initiating an Administrative Review

Provider must include the following information with the request:

- All Documentation to support medical necessity for the request of an administrative review.
- Summary letter to include:
  - Authorization number
  - Member’s Name
  - IHCP Member ID
  - Pertinent reasons the requested services are medically necessary.

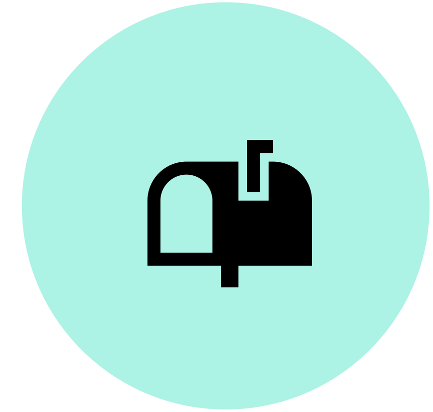
Submitting an Administrative Review

[Atrezzo Provider Portal]

- Select Reconsideration (from the actions drop down menu).
- Enter a note and add documents.

Fax

800-261-2774



Mail

Acentra
6802 Paragon Place, Ste. 440
Richmond, VA 23230

Administrative Hearing Appeal Process

- If Administrative Review decision is favorable: authorization effective on the originally requested date.

- If decision is to uphold authorization denial: provider may file an Administrative Hearing Appeal (AHA) within 33 calendar days of adverse decision.

- Members can appeal PA decision in writing:
  - ✓ Letter explaining why they think decision is wrong.
  - ✓ Letter must include member name and other important info (e.g., date of decision).

Additional Appeal Process Information

- As required by statute: if request for hearing is received before effective date of denial/modification, services continue at the authorized level of previous PA.

- If appellant is not the member: request must include documentation that appellant has legal right to act on behalf of member is required (e.g., Power of Attorney for Healthcare or legal guardianship papers).

Submitting an AHA

Mail

Family and Social Service Administration/Office of Administrative Law Proceedings – FSSA Hearings
402 W. Washington St, Rm E034
Indianapolis, IN 46204

Fax

317-232-4412

Email

fssa.appeals@oalp.in.gov

Common Denials

Common Reasons for Denials and Voids

ADMINISTRATIVE DENIALS:

- Missing mandatory form(s) that is not received within 30 calendar days of pending to provider.

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:

- The request is a duplicate of another authorization submitted to Acentra Health.

Helpful Links

FSSA Resources for Providers

Provider Fee Schedules

Accessible from the Family and Social Services Administration (FSSA) Provider web page. Guides providers regarding PA requirement.

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 request, they are located here.

Forms

Acentra Health’s Resources for Providers

- Atrezzo: 24-hour/365 days provider portal accessed at: Atrezzo Provider Portal

- Provider Education and Outreach, as well as system training materials (including Video recordings and FAQs) are located at: Acentra Provider training and education page

- Provider communication and support email: INPriorAuthIssues@Acentra.com

Conclusion and Q&A

Thank you for your time!

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**

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