Chapter 6: Prior Authorization
## Chapter 6: Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revisions</th>
<th>Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>September 1999</td>
<td>Policies and procedures are current as of March 1, 1999</td>
<td>New Manual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EDS Document Management Unit</td>
</tr>
<tr>
<td>2.0</td>
<td>June 2001</td>
<td>Policies and procedures are current as of June 1, 2000</td>
<td>Chapters 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, and Appendix A</td>
</tr>
<tr>
<td>3.0</td>
<td>April 2002</td>
<td>Policies and procedures are current as of August 1, 2001</td>
<td>All Chapters</td>
</tr>
<tr>
<td>4.0</td>
<td>April 2003</td>
<td>Policies and procedures are current as of April 1, 2002</td>
<td>All Chapters</td>
</tr>
<tr>
<td>5.0</td>
<td>July 2004</td>
<td>Policies and procedure are current as of January 1, 2004</td>
<td>All Chapters</td>
</tr>
<tr>
<td>5.1</td>
<td>March 2005</td>
<td>Policies and procedure are current as of January 1, 2005</td>
<td>Quarterly Update</td>
</tr>
<tr>
<td>6.0</td>
<td>December 2006</td>
<td>Policies and procedures current as of April 1, 2006</td>
<td>Quarterly Update</td>
</tr>
<tr>
<td>7.1</td>
<td>February 2008</td>
<td>Policies and procedures as of October 1, 2007</td>
<td>Semiannual Update</td>
</tr>
<tr>
<td>8.1</td>
<td>January 2009</td>
<td>Policies and procedures as of October 1, 2008</td>
<td>Semiannual Update</td>
</tr>
<tr>
<td>9.0</td>
<td>April 2009</td>
<td>Policies and procedures as of April 1, 2009</td>
<td>Semiannual Update</td>
</tr>
<tr>
<td>Version</td>
<td>Date</td>
<td>Reason for Revisions</td>
<td>Completed By</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
<td>----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>9.1</td>
<td>November 2009 Policies and procedures as of October 1, 2009</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>10.0</td>
<td>June 22, 2010 Policies and procedures as of April 1, 2010</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>10.1</td>
<td>November 30, 2010 Policies and procedures as of October 1, 2010</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>11.0</td>
<td>May 19, 2011 Policies and procedures as of April 1, 2011</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>11.1</td>
<td>Policies and procedures as of October 1, 2011 Published: January 31, 2012</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>12.0</td>
<td>Policies and procedures as of May 1, 2012 Published: June 19, 2012</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>12.1</td>
<td>Policies and procedures as of November 1, 2012 Published: March 19, 2013</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>13.0</td>
<td>Policies and procedures as of May 24, 2013 Published: July 23, 2013</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>13.0</td>
<td>Policies and procedures as of May 24, 2013 Published: August 8, 2013</td>
<td>Corrected telephone and fax numbers</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>13.1</td>
<td>Policies and procedures as of November 1, 2013 Published: January 21, 2014</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>14.0</td>
<td>Policies and procedures as of April 1, 2014 Published: June 20, 2014</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>14.1</td>
<td>Policies and procedures as of October 1, 2014 Published: February 5, 2015</td>
<td>Semiannual Update</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
<tr>
<td>15.0</td>
<td>Policies and procedures as of January 1, 2015 Published: May 26, 2015</td>
<td>Semiannual Update • Updated Limitations section • Updated Criteria for Healthy Indiana Plan (HIP) Prior Authorization heading • Updated PA Inquiry section</td>
<td>HP Provider Relations and Publications Units</td>
</tr>
</tbody>
</table>
### Table of Contents

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revisions</th>
<th>Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Units</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Retroactive Prior Authorization</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>278 Response</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Evaluation and Management Services</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Neuropsychological and Psychological Testing</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Automatic External Defibrillators and Wearable Cardioverter Defibrillators</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Prior Authorization Criteria for Accessories K0607 – K0609</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Additional Attendant</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Provider Appeals</strong> section</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated <strong>Notification Procedures</strong> section</td>
<td></td>
</tr>
</tbody>
</table>
# Chapter 6: Table of Contents

Chapter 6: Revision History ................................................................. 6-2  
Chapter 6: Table of Contents ................................................................. 6-5  
Section 1: Introduction to Prior Authorization ....................................... 6-8  
  General Information ........................................................................... 6-8  
  Limitations ....................................................................................... 6-9  
  Providers Allowed to Submit PA and Electronic 278 Requests ................. 6-10  
  Submit Prior Authorization Requests through Web interChange ............ 6-10  
  Physician Signature Stamps ............................................................... 6-10  
  Outstanding Prior Authorizations for Nonpharmacy Services ................ 6-11  
Section 2: Prior Authorization Procedures ........................................... 6-13  
  Prior Authorization Criteria .................................................................. 6-13  
  Criteria for Risk-Based Managed Care Prior Authorization ................. 6-13  
  Criteria for Healthy Indiana Plan (HIP) Prior Authorization ................. 6-13  
  Fee-for-Service Care Select ................................................................ 6-13  
  Member Eligibility ............................................................................ 6-13  
  Automation of Pharmacy Prior Authorization for Fee-for-Service Claims 6-14  
  Home Health Nursing Services ........................................................... 6-14  
  Suspension for Requests of Additional Information ............................... 6-14  
  Rejected PA Requests ........................................................................ 6-14  
  Telephone Authorizations .................................................................... 6-15  
  Telephone Numbers and Staffing ....................................................... 6-15  
  Automated Attendant ......................................................................... 6-16  
  Prior Authorization Request Form ...................................................... 6-16  
  Helpful Hints for Nonpharmacy PA ..................................................... 6-18  
  Time Parameters .............................................................................. 6-19  
  PA Inquiry ........................................................................................ 6-20  
  Indiana Prior Review and Authorization Dental Request Form ............... 6-20  
  Medicaid Second Opinion Form .......................................................... 6-23  
  Medical Clearance Forms .................................................................... 6-23  
  Procedures ...................................................................................... 6-23  
  Fax Authorizations .......................................................................... 6-24  
  Prior Authorization Decision Letter ................................................... 6-24  
  Telephone Requests for Prior Authorization ........................................ 6-25  
  Prior Authorization (PA) Update Requests .......................................... 6-25  
  Examples of PA Update Requests ....................................................... 6-25  
  PA Update Decision Letter .................................................................. 6-26  
  Decision Description ........................................................................... 6-26  
  Non-Indiana Health Coverage Programs Prior Authorizations ............... 6-27  
  590 Program Authorizations .............................................................. 6-27  
  Home and Community-Based Waiver Services Authorizations ............ 6-27  
  Non-Indiana Health Coverage Programs Provider Procedures ............. 6-27  
  Retroactive Prior Authorization .......................................................... 6-28  
  Prior Authorization and Third Party .................................................... 6-28  
Section 3: 278 Electronic Transaction .................................................... 6-29  
  Purpose of the 278 Transaction ............................................................ 6-29  
  278 Request .................................................................................... 6-29  
  Data Elements .................................................................................. 6-30  
  Certification Type Codes .................................................................... 6-30  
  Service Type Codes .......................................................................... 6-30
## Table of Contents

Facility Type Codes ................................................................. 6-31  
Level-of-Service Codes .......................................................... 6-31  
Release of Information Codes .................................................. 6-31  
Segments .................................................................................. 6-32  
  Diagnosis Segment ............................................................... 6-32  
  Previous Certification Identification Segment ....................... 6-32  
  Procedures Segment ............................................................ 6-32  
  Message Segment .............................................................. 6-33  
Reasons for Rejection of Request .............................................. 6-33  
  Duplicate Requests or Approval of Nonspecific Codes .......... 6-33  
Paper Attachments and Electronic PA Requests ....................... 6-34  
  Retroactive Prior Authorization Requests ........................... 6-35  
  Request for Transportation Services .................................. 6-36  
  278 Response .................................................................... 6-36  
  Action Codes ...................................................................... 6-36  
  Reject Reason Codes .......................................................... 6-37  

### Section 4: Institutional Prior Authorization Policy Requirements .......... 6-38

#### General Information ............................................................ 6-38  
Diagnosis-Related Group Inpatient Hospital Admission Prior Authorization  
  Policy Requirements ............................................................. 6-38  
  Prior Authorization for Psychiatric Admission 6-39  
  Admission Criteria .............................................................. 6-42  
  Policy Parameters for Hospice Prior Authorization ............... 6-44  
  IHCP Managed Care Members Electing the Hospice Benefit .... 6-45  
  Medicaid Hospice Authorization ......................................... 6-47  
  Emergency Admission .......................................................... 6-48  
  PA Not Required for Emergency Admissions for Burn Cases... 6-48  
  Emergency Admission Prior Authorization Policy Requirements – Hoosier Healthwise and Care Select Considerations  
  Care Select ......................................................................... 6-48  
  Risk-Based Managed Care ..................................................... 6-49  
  General Information ............................................................. 6-51  
  Practitioner Prior Authorization Policy Requirements .......... 6-51  
  Physician Services ............................................................. 6-51  
  Podiatry Services ............................................................... 6-52  
  Chiropractic Services .......................................................... 6-53  
  Dental Services .................................................................... 6-53  
  Spinal Cord Stimulation ....................................................... 6-55  
  Genetic Testing .................................................................... 6-55  
  Practitioner Prior Authorization Policy Parameters – Managed Care Considerations ................................................. 6-57  
  Care Select .......................................................................... 6-57  
  Risk-Based Managed Care ..................................................... 6-57  
  Home Health Prior Authorization Policy Requirements .......... 6-57  
  Home Health Nursing Services ........................................... 6-58  
  Therapy Prior Authorization Policy Requirements .................. 6-60  
  Home Health/Nursing/Therapy Prior Authorization Policy Requirements – Hoosier Healthwise Considerations .................. 6-61  
  Risk-Based Managed Care ..................................................... 6-62  
  Outpatient Mental Health Prior Authorization Policy Requirements .......... 6-62

Library Reference Number: PRPR10004
Published: May 26, 2015
Policies and Procedures as of January 1, 2015
Version: 15.0
# Table of Contents

Neuropsychological and Psychological Testing .......................... 6-62  
Psychiatric Diagnostic Interviews .............................................. 6-62  
Medicaid Rehabilitation Option Services ................................. 6-62  
Care Select .............................................................................. 6-63  
Risk-Based Managed Care ...................................................... 6-63  

Medical Supplies and Equipment Prior Authorization Policy Requirements  
Medical Supplies ...................................................................... 6-64  
Monthly Maximum and Annual Allowance for Incontinence Supplies Per Member ...................................................... 6-65  
Durable Medical Equipment and Home Medical Equipment .......... 6-65  
Automatic External Defibrillators and Wearable Cardioverter Defibrillators .................................................. 6-67  
Prior Authorization Criteria .................................................... 6-67  
Prior Authorization Criteria for Accessories K0607 – K0609 .......... 6-68  
Medical Supplies and Equipment Prior Authorization Policy Requirements – Managed Care Considerations .................................................................................. 6-69  
Care Select .............................................................................. 6-69  
Risk-Based Managed Care ...................................................... 6-69  
Transportation Prior Authorization Policy Requirements .............. 6-69  
Twenty One-Way Trip Limitation and Exemptions ....................... 6-70  
Transportation Prior Authorization Policy Requirements – Managed Care Considerations .................................................. 6-71  
Care Select .............................................................................. 6-71  
Risk-Based Managed Care ...................................................... 6-71  
Prior Authorization Criteria for Food Supplements, Nutritional Supplements, and Infant Formulas .......................................................... 6-72  

## Section 6: Out-of-State Prior Authorization Policy Parameters ........... 6-73  
Service Coverage ........................................................................ 6-73  
Prior Authorization Requirements for Out-of-State Services .......... 6-73  
Designated Out-of-State Areas .......................................................... 6-73  
Out-of-State Primary Medical Providers and Auto-assignment ....... 6-74  
Service Restrictions ..................................................................... 6-74  
Out-of-State Suppliers of Medical Equipment .................................. 6-74  

## Section 7: Prior Authorization Administrative Review and Appeal Procedures .......................................................... 6-75  
General Information ..................................................................... 6-75  
Administrative Review ............................................................... 6-75  
Administrative Hearing ............................................................... 6-76  
Provider Appeals ........................................................................ 6-76  
Member Appeals ......................................................................... 6-77  
Notification Procedures ............................................................... 6-77  

Index .......................................................................................... 6-78
Section 1: Introduction to Prior Authorization

General Information

The Indiana Administrative Code (IAC) contains the rules and regulations that govern the Indiana Health Coverage Programs (IHCP). The IAC serves as a comprehensive reference for covered services and prior authorization (PA) procedures and parameters. The IHCP providers are responsible for reading the portions of the IAC that apply to their areas of service. Specific PA criteria are found in 405 IAC 5-3 and 407 IAC.

The ADVANTAGE Health Solutions, Inc.℠ Fee-for-Service (FFS) PA Department reviews all nonpharmacy PA requests for IHCP members—except those enrolled in a managed care entity (MCE)—on an individual, case-by-case basis. ADVANTAGE Health Solutions-Care Select (CS) reviews all nonpharmacy PA requests for Care Select-enrolled members on an individual, case-by-case basis. The department’s decisions to authorize, modify, or deny a given request are based on medical reasonableness, necessity, and other criteria in the IAC. The PA departments use the Family and Social Services Administration (FSSA)-approved internal criteria in addition to the IAC, PA guidelines, bulletins, and banner pages. The Hoosier Healthwise and Healthy Indiana Plan (HIP) managed care insurers are responsible for processing medical service PA requests and notifying members about PA decisions. The MCEs may develop their own internal criteria for 405 and 407 IAC rule compliance.

Providers can obtain applicable sections of the non-MCE internal criteria by emailing PolicyConsideration@fssa.in.gov or writing to the following address:

Policy Consideration
Family & Social Services Administration
Office of Medicaid Policy and Planning
402 W. Washington Street MS07
Room W374
Indianapolis, IN 46204

The FSSA is responsible for the administration of the Hoosier Healthwise MCEs and HIP pharmacy benefits for claims. This responsibility includes processing all outpatient pharmacy claims and managing pharmaceutical services for drugs and some drug-related medical supplies and medical devices provided by enrolled IHCP pharmacy or durable medical equipment providers as fee-for-service (FFS). All pharmacy point of sale (POS) prior authorization requests are handled through Catamaran.

All other capitated services remain the responsibility of the Hoosier Healthwise and HIP health plans. These services include:

• Procedure-coded drugs billed by entities other than IHCP-enrolled pharmacy providers
• Most medical supplies and medical devices (that is, those not referenced in the Drug-Related Medical Supplies and Medical Devices Table in Chapter 8: Billing Instructions of this manual)
• Durable medical equipment (DME)
• Enteral or oral nutritional supplements

The prior authorization requests for the drug-related medical supplies and medical devices (identified in the Drug-Related Medical Supplies and Medical Devices Table) are the responsibility of the ADVANTAGE Health Solutions, Inc.℠ Fee-for-Service (FFS) PA Department when provided by a pharmacy or DME provider for all IHCP members.
The CFR, IC, IAC, FSSA Medical Policy Manual, and IHCP Provider Manual, along with bulletins and banner pages published on the web, provide a complete resource for PA policy and procedures. All necessary PA forms for FFS and Care Select requests are included in this chapter or can be found on the Forms page at indianamedicaid.com. Providers should contact the appropriate MCE to obtain information on PA documentation procedures for services rendered under the risk-based managed care (RBMC) programs – HIP and Hoosier Healthwise. For pharmacy-related PA for all IHCP members, providers should contact Catamaran. Providers are responsible for using these tools to ensure accurate, timely PA review and claims processing. Submissions of any unapproved forms are returned to the provider.

Limitations

The IHCP does not reimburse providers for any IHCP service requiring PA unless PA is obtained first. If a PA request qualifies for retroactive eligibility as defined in this chapter, a determination must be made prior to submitting a claim. PA is monitored by concurrent or post-payment review. Exceptions to this policy are noted later in this chapter.

Any authorization of a service by ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS is limited to authorization for payment of IHCP-allowable charges. It is not an authorization of the provider’s estimated fees.

PA is not a guarantee of payment. Notwithstanding any PA by the provider’s office, the provision of all services and supplies must comply with the following resources:

- IHCP Provider Agreement
- IHCP Provider Manual
- IHCP Bulletins
- Remittance Advice (RA) statements or 835 transactions
- IHCP Banner Pages
- PA criteria requested and issued to providers
- Any applicable state or federal statute or regulation

Providers can request PA on behalf of the IHCP member. After PA is obtained, the member can choose the provider that will render the authorized service, as long as the member is not restricted to a specific provider of service, such as members enrolled in the Right Choices Program (RCP) and members assigned to a specific primary care provider (PCP). It is important to note that the member may have a prior-authorized service performed by a physician other than the one that requested the PA; the approved PA belongs to the member, not to the provider.

PA for RBMC members must be requested from the member’s MCE, unless the service is carved out of the RBMC program. For additional information on services that are carved out of the RBMC program, see Chapter 1: General Information in this manual.

PA requests for HIP members must be requested from the member’s HIP insurer unless the service is carved out of the HIP program. For additional information on services that are carved out of the HIP program, see Chapter 1: General Information in this manual.

**Note:** If a member has other health insurance, and a service that is covered by Medicaid requires PA from both payer sources, the provider must obtain PA from both sources before rendering services.
**Providers Allowed to Submit PA and Electronic 278 Requests**

In accordance with 405 IAC 5-3-10, PA requests can be submitted and signed by the following provider types:

- Doctor of medicine (MD)
- Doctor of osteopathy (DO)
- Dentist
- Optometrist
- Podiatrist
- Chiropractor
- Psychologist endorsed as a health service provider in psychology (HSPP)
- Home health agency (authorized agent)
- Hospitals (authorized agent)
- Transportation providers (authorized agent)

The provider must approve the request by personal signature or providers and their designees may use signature stamps. Providers that are agencies, corporations, or business entities may authorize one or more representatives to sign requests for PA.

If a provider, other than those listed previously, submits an electronic 278 request transaction (electronic PA request), the requester must submit additional documentation indicating the service or supply is physician-ordered. The additional documentation is sent in the form of an attachment and must be received on paper, by mail, or fax. The original 278 request transaction is suspended for documentation of the physician’s order. Failure to submit additional documentation within 30 calendar days of the request results in denial of the request. If a provider does not fall into one of the groups listed previously, the PA is suspended for proof of physician signature.

**Submit Prior Authorization Requests through Web interChange**

Web interChange, accessible at indianaicaid.com, allows providers to submit nonpharmacy PA requests and to view their status online. Providers can also submit PA requests on paper, by telephone, or by fax, and should continue to follow existing policies when submitting PA requests.

*Note: To inquire about existing PAs via Web interChange, providers must have a PA number, or be the requesting or service provider of the PA.*

The provider types listed previously may access Web interChange to submit PA requests. Detailed information about using the web application is available on Web interChange > Help > Frequently Asked Questions > FAQs for Transaction.

**Physician Signature Stamps**

The Centers for Medicare & Medicaid Services (CMS) Transmittal 59 allows for the acceptance of a physician’s rubber-stamp signature for clinical record documentation, provided it is permitted by federal, state, and local law, and authorized by the home health agency’s or hospice agency’s policy. Pursuant to 405 IAC 5-3-5(c)(2), it is permissible for the agency to use a signature stamp for the
Indiana Health Coverage Programs Prior Authorization Request Form, which is accessible from the Forms page at indianamedicaid.com.

The following state regulations apply to Medicaid PA requests for home health services and can be viewed on the Internet at in.gov/legislative/iac.

- 405 IAC 5-16-3.1 Home health agency services; limitations does not address physician signature stamps for physician orders or written care plans.
- 405 IAC 5-22-2 Nursing services; prior authorization requirements does not address physician signature stamps for prior authorization of nursing services.

Therefore, physician signature stamps may be used on the Indiana Health Coverage Programs Prior Authorization Request Form when requesting Medicaid PA. However, any physician order or plan of treatment that is attached to the Indiana Health Coverage Programs Prior Authorization Request Form must include an original signature by the physician.

State regulations for the Medicaid hospice benefit, which can be viewed at in.gov/legislative/iac, do not specifically provide for physician signature stamps. The following regulations do apply to Medicaid PA requests for hospice services with regard to the hospice physician certification and the hospice plan of care:

- 405 IAC 5-34-5 Physician certification
- 405 IAC 5-34-7 Plan of care

To ensure that the medical director or physician member of the hospice reviewed the plan of care, an original signature is required. Based on these regulations, physician signature stamps may be used on the Indiana Health Coverage Programs Prior Authorization Request Form when requesting Medicaid PA for hospice services. However, any Medicaid Hospice Physician Certification form or Medicaid Hospice Plan of Care form that is attached to the Indiana Health Coverage Programs Prior Authorization Request Form must include an original signature by the physician. The IHCP states that electronic signatures are not acceptable on plans of care submitted to the ADVANTAGE Health Solutions-FFS PA Department.

Home health and hospice providers should contact the Acute Care Division of the Indiana State Department of Health (ISDH) at (317) 233-7474 concerning ISDH home health and hospice survey rules.

The Medicaid Hospice Physician Certification and Medicaid Hospice Plan of Care forms are available in the State Forms Online Catalog on the FSSA website at in.gov/fssa.

Outstanding Prior Authorizations for Nonpharmacy Services

If a member changes programs between Traditional Medicaid (FFS) or Care Select, PAs are available in IndianaAIM for claims processing by HP Enterprise Services and will not necessitate a new request.

If a member changes from a managed care program, such as Hoosier Healthwise or HIP, to Traditional Medicaid (FFS) or Care Select, all existing PAs are honored for 30 calendar days or for the remainder of the PA dates of service, whichever comes first. The PAs may be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home health care. Requiring a duplicate authorization from the new plan places an additional burden on the provider and can result in delayed or inappropriately denied treatments or services to the member. Providers should check eligibility before rendering services. On checking eligibility, providers should notify the new plan of any outstanding PAs and supply documentation to substantiate the PAs.
Plans participating in Hoosier Healthwise, HIP, or Care Select must honor outstanding PAs given within the program for services for the first 30 days of a member’s effective date in the new plan. This authorization extends to any service or procedure previously authorized within the Hoosier Healthwise or Care Select program, including but not limited to surgeries, therapies, pharmacy, home health care, and physician services. MCEs may be required to reimburse out-of-network providers during the 30-day transition period.

When a provider requests a PA from a Hoosier Healthwise or HIP MCE and receives approval from that MCE, and the member becomes eligible for Care Select, it is important for the provider to fax a copy of the PA approval notification to the Care Select health plan the member is enrolled with on that date of service, so the PA can be entered into IndianaAIM, and the provider can be reimbursed for the service.

The entity that issued the original PA is required to provide the new entity assignment with the following information:

- Member identification number (RID) for members
- Provider’s National Provider Identifier (NPI)
- Procedure codes
- Duration and frequency of authorization
- Other information pertinent to the determination of services provided

The request for PA should be submitted on the Indiana Health Coverage Programs Authorization Request Form.

The reverse is also true. If a member is eligible for Care Select and the provider receives approval from one of the Care Select health plans, and the member becomes eligible for Hoosier Healthwise or HIP, it is important for the provider to fax a copy of the PA approval notification to the MCE the member is enrolled with on that date of service, so the PA can be entered.
Section 2: Prior Authorization Procedures

Prior Authorization Criteria

Criteria for Risk-Based Managed Care Prior Authorization

Managed care entities (MCEs) are responsible for determining what services require prior authorization (PA) for their members, excluding carved-out fee-for-service (FFS)-covered services. Pharmacy PA requests must be requested from Catamaran. However, for self-referral services, the MCEs must follow the guidelines for PA in the Indiana Administrative Code (IAC) and outlined within this manual. PA requests for services carved out of risk-based managed care (RBMC) are processed through ADVANTAGE Health Solutions-FFS and are subject to the same criteria as FFS requests. See the RBMC section in Chapter 1: General Information of this manual for a list of self-referral and carved-out services.

Additional information about MCE authorization procedures can be requested from the MCE at the telephone numbers provided by the Indiana Health Coverage Programs (IHCP) Web interChange Eligibility or Automated Voice Response (AVR) systems. Other resources include Chapter 1: General Information of this manual or indianamedicaid.com.

Criteria for Healthy Indiana Plan (HIP) Prior Authorization

Healthy Indiana Plan (HIP) insurers are responsible for determining what services require PA for their members, excluding carved-out FFS-covered services. HIP pharmacy PA requests must be requested from Catamaran.

Additional information about HIP authorization procedures can be requested from the insurers at the telephone numbers provided by the IHCP Web interChange or AVR systems.

Fee-for-Service Care Select

The Indiana Family and Social Services Administration (FSSA) contracted with ADVANTAGE Health Solutions-FFS for review of most requests for PA on behalf of IHCP members enrolled under Traditional Medicaid. With regard to the Care Select program, ADVANTAGE Health Solutions-Care Select (CS) reviews PA requests for its members as well as MDwise-CS members. The decision to approve or deny a PA request is based on criteria that, in part, is included in 405 IAC 5-3-1 through 405 IAC 5-13-14 and reflects the current standards of practice in the provider community. Carefully reading the rules provides valuable information about coverage and prior approval policies. For example, PA is required for all services or items provided under the 590 Program for which the provider charge is $500 or greater.

Member Eligibility

Granting PA confirms medical necessity but is valid only if a member is eligible on the date services are rendered.
Note: It is not the responsibility of the Prior Authorization Department in the IHCP to ensure the eligibility status of a member. Providers should also determine whether the member has third-party liability (TPL) coverage and whether PA from the third-party carrier is necessary. PA is not a guarantee of payment, and member eligibility should be verified by the provider before services are rendered. Because the IHCP is the payer of last resort, claims must be submitted to the third-party carrier before they are submitted to the IHCP. The third-party carrier, as well as the IHCP, might require PA.

Automation of Pharmacy Prior Authorization for Fee-for-Service Claims

For information related to automated pharmacy authorization, see Chapter 9, IHCP Pharmacy Services Benefit.

Home Health Nursing Services

PAs submitted to request nursing services must reflect the appropriate home visit nursing code. PAs for nursing requests do not need to indicate whether a registered nurse (RN) or a licensed practical nurse (LPN) is to perform the service, because that level of detail is reported on the UB-04 paper claim or the electronic 837 institutional transaction.

The IHCP issues PA for home health nursing based on procedure code 99600 TD – Unlisted home visit, service, or procedure – registered nurse.

Home health providers can bill 99600 TE – Unlisted home visit or service – LPN/LVN or 99600 TD – Unlisted home visit, service, or procedure – registered nurse, and IndianaAIM uses the approved PA units for the RN service 99600 TD.

Suspension for Requests of Additional Information

Note: The information in this section does not apply to pharmacy services.

For the PA reviewer to determine if a service or procedure is medically reasonable and necessary, the PA vendor may request more information from the member and provider. The PA vendor must receive this information within 30 calendar days of the request, or the PA request is systematically denied. If the PA vendor determines medical necessity, the dates authorized are those on the originally suspended PA request.

Rejected PA Requests

PA requests that are submitted via paper or by fax to the incorrect PA vendor for Traditional Medicaid or Care Select are rejected. Providers receive a PA decision letter documenting the rejected status of the PA, noting that the PA was submitted to the wrong PA vendor based on the assignment of the member to a specific IHCP program. When providers receive notification that the submitted PA request has been rejected, a new PA request must be submitted to the member’s correct MCE or to ADVANTAGE Health Solutions. It is important to note that providers must verify member eligibility to determine which IHCP program the member is associated with and, therefore, determine the correct PA address for submission of the PA request.
For PA requests that are submitted via Web interChange, the system automatically delivers the request to ADVANTAGE Health Solutions.

**Telephone Authorizations**

Note: The information in this section does not apply to pharmacy services.

An Indiana Health Coverage Programs Prior Authorization Request Form is not necessary for telephone PA services. However, additional written substantiation and documentation may be required.

PA telephone requests are appropriate to facilitate hospital discharge, to maintain the health and well-being of the member, or when emergency services are required. Examples of services prior authorized by telephone include, but are not limited to, nutritional feedings, extended stays for burn therapy and rehabilitation, and out-of-state requests.

Verbal notification of approval, modification, or denial, with written notification to follow, is given when the call is made for the following services:

- Inpatient hospital admission and concurrent review, when required
- Continuation of retroactive PA for emergency treatment on an inpatient basis
- Surgeries or other treatments that approach or exceed the cost limits or utilization review parameters found in the IAC
- Medically necessary services or supplies that facilitate discharge from a hospital or prevent admission to a hospital
- Equipment repairs necessary for the life support or safe mobility of the patient
- Medical services when a delay in beginning the services could reasonably be expected to result in a serious deterioration of the patient’s medical condition

Telephone PAs are not approved for services that can otherwise be authorized in writing, such as routine office visits; trend events, such as specialized therapies and continued home health care services; elective surgeries; retroactive requests for nonemergency services; and extension of existing PAs.

Section 2: Telephone and Address Directory in Chapter 1: General Information of this manual provides additional information.

**Telephone Numbers and Staffing**

The PA department telephone numbers are as follows:

**Medical PA:**

ADVANTAGE Health Solutions-FFS  
1-800-269-5720

ADVANTAGE Health Solutions-CS  
1-800-784-3981

The toll-free numbers are available throughout Indiana and to providers located in designated or contiguous areas of Michigan, Ohio, Kentucky, and Illinois.
Telephone lines are staffed from 8 a.m. to 5 p.m. Eastern Time, Monday through Friday, excluding six holidays: New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Automated Attendant

ADVANTAGE Health Solutions-FFS handles Traditional Medicaid FFS calls. The PA telephone lines have an automated attendant to direct calls to the appropriate area. When a call is answered, the automated attendant offers the following options:

- Option 1 – Behavioral Health Precertification
- Option 2 – Durable Medical Equipment Precertification
- Option 3 – Home Health and Hospice Precertification
- Option 4 – MRO Precertification
- Option 5 – Dental and Transportation Precertification
- Option 8 – Elective, Urgent, and Surgical Admission Precertification

Providers should access the appropriate option for the PA question; otherwise, if nothing is pressed, the call is transferred to the PA “Other” line. For Care Select PA questions, providers can also access the ADVANTAGE Health Solutions-FFS website at advantageplan.com for more information.

Prior Authorization Request Form

Note: The information in this section does not apply to pharmacy services.

All PA requests not listed in the preceding subsection must be submitted in writing using a universal prior authorization form, the Indiana Health Coverage Programs Prior Authorization Request Form. The Indiana Health Coverage Programs Prior Authorization Request Form and the Prior Authorization System Update Request Form are Health Insurance Portability and Accountability Act (HIPAA)-compliant. Copies of these forms and the Indiana Prior Review and Authorization Dental Request form are available on the Forms page at indianamedicaid.com.

Written requests for PA must be submitted to one of the following addresses based on the member’s program enrollment. Providers must verify member eligibility to determine in which IHCP program the member is enrolled.

Prior Authorization Department
ADVANTAGE Health Solutions-FFS
P.O. Box 40789
Indianapolis, IN 46240

Prior Authorization Department
ADVANTAGE Health Solutions-CS
P.O. Box 80068
Indianapolis, IN 46280

The Indiana Health Coverage Programs Prior Authorization Request Form and instructions for completing the form are available on the Forms page at indianamedicaid.com. The instructions for using the form are also presented in Table 6.1.
Providers should retain photocopies of the Indiana Health Coverage Programs Prior Authorization Request Forms for their records. The PA contractor prefers to receive the completed PA forms by fax. However, the original form will be accepted and must be submitted to the appropriate PA department listed previously.

### Table 6.1 – Indiana Health Coverage Programs Prior Authorization Request Form Instructions

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Information:</strong> Medicaid ID/RID#</td>
<td>Enter the information requested for the member who is to receive the requested service. Required.</td>
</tr>
<tr>
<td>DOB</td>
<td>Enter the information requested for the member’s primary medical provider (PMP). Required, if applicable.</td>
</tr>
<tr>
<td>Name/Address/City/State/ZIP/Phone</td>
<td></td>
</tr>
<tr>
<td>PMP Name/NPI/Phone</td>
<td></td>
</tr>
<tr>
<td><strong>Requesting Provider Information:</strong> Requesting Provider NPI#</td>
<td>Enter the information requested for each field. Required.</td>
</tr>
<tr>
<td>Tax ID#</td>
<td>Enter the requesting provider’s National Provider Identifier (NPI). Enter the Legacy Provider Identifier (LPI) for atypical providers that do not have an NPI.</td>
</tr>
<tr>
<td>Service Location Code</td>
<td>The requesting provider NPI must be the billing NPI used by the provider/entity requesting the authorization. For a group/corporate entity, the requesting provider NPI is different from the rendering provider NPI. For a sole proprietor or a dual-status provider, the requesting provider NPI and the rendering provider NPI may be the same.</td>
</tr>
<tr>
<td>Provider Name</td>
<td>A valid NPI or LPI is required. If the requesting provider is not enrolled, the PA form will be returned to the provider.</td>
</tr>
<tr>
<td><strong>Rendering Provider Information:</strong> Rendering Provider NPI#</td>
<td>The provider’s copy of the Indiana Prior Review and Authorization Request Decision letter is sent to the “Mail To” address on file for the requesting provider’s NPI and service location code combination.</td>
</tr>
<tr>
<td>Tax ID#</td>
<td></td>
</tr>
<tr>
<td>Name/Address/City/State/ZIP/Fax</td>
<td></td>
</tr>
<tr>
<td><strong>Ordering, Prescribing, or Referring (OPR) Provider Information:</strong> OPR Physician NPI#</td>
<td>Enter the NPI of the OPR provider.</td>
</tr>
<tr>
<td></td>
<td>The OPR provider is the practitioner that ordered, prescribed, or referred the member for the requested service.</td>
</tr>
<tr>
<td><strong>Preparer’s Information:</strong> Name</td>
<td>Enter the requested information about the person preparing the PA request.</td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Diagnosis</strong></td>
<td>Enter the primary, secondary, and tertiary ICD diagnosis codes.</td>
</tr>
<tr>
<td><strong>Assignment Category</strong></td>
<td>Check the assignment category for the service you are requesting.</td>
</tr>
</tbody>
</table>
### Field | Description
--- | ---
Dates of Service, Start | Enter the requested start date of service (for continued services, the start date must be the day after the previous end date).
Dates of Service, Stop | Enter the requested stop date of service.
Procedure/Service Codes | Enter the service codes, (such as Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), revenue code, National Drug Code (NDC), and so forth).
Modifier(s) | Enter any applicable service code modifiers.
Requested Service | Enter a short description (or include an attachment) of the requested services and like services provided by other payers.
Taxonomy | Enter any applicable taxonomy codes.
POS | Enter the requested place of service (POS) code.
Units | Enter the requested number of units. Units are equal to days, months, or items, whichever is applicable.
Dollars | Enter the estimated or known IHCP cost of the service. This field is required for home health services and DME equipment requests.
Notes | Enter clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan of treatment dates.
Signature of Qualified Practitioner | Authorized provider, as listed in Section 1 of this chapter and 405 IAC 5-3-10, must sign and date the form. Signature stamps can be used.

### Helpful Hints for Nonpharmacy PA

When submitting nonpharmacy PA requests, complete the following:

- Write the PA number on all system updates.
- Make sure the PA form has a physician’s signature and date. The signature prevents the PA from being suspended and delaying services.
- Ensure that the NPI or provider number, member ID number, and other information are correct on PA forms. Remember the diagnosis International Classification of Diseases (ICD) code must be listed. Service codes must be valid, including modifiers.
- Verify through HP that the provider’s Mail To address is correct in IndianaAIM to ensure letters are mailed to the appropriate location. Providers with multiple sites should append the appropriate alpha location code to the end of their Legacy Provider Identifier (LPI) for each site. Providers may verify the accuracy of their Mail To address via the Provider Profile feature of Web interChange – go to indianamedicaid.com and click Web interChange under “Quick Links.”
- For Traditional Medicaid and Care Select, the requesting provider is the billing entity, and the rendering provider is the individual provider performing the service. If you are a sole proprietor, or a group or corporate business entity, such as a DME supplier or hospital, you must place your billing NPI or Medicaid LPI in the “requesting” provider field on the Indiana Health Coverage Programs Prior Authorization Request Form. This action generates a PA decision letter in IndianaAIM that is mailed to the billing or requesting provider’s “mail to” address. The “rendering”
provider field should contain the NPI or LPI of the physician or other IHCP-enrolled practitioner within the group or corporate business entity that ordered the services, equipment, or supplies. For sole proprietors or dual-status providers, the requesting provider and the rendering provider may be one and the same.

- Hoosier Healthwise and Healthy Indiana Plan MCEs use claims processing systems other than IndianaAIM. For this reason, the IHCP recommends that providers contact the appropriate MCE (MDwise, Anthem, or MHS) to determine how to use the “requesting” and “rendering” provider fields on the Indiana Health Coverage Programs Prior Authorization Request Form.

**Time Parameters**

The provider is responsible for submitting new PA requests for ongoing services at least 30 calendar days before the current authorization period expires to ensure that services are not interrupted.

The decision about PA is made as quickly as possible. If a decision is not made within seven calendar days for FFS and CS members – weekends and State holidays excluded – after receipt of all required documentation, authorization is deemed to be granted within the coverage and limitations specified (405 IAC 5-3-14). The provider must wait until the approved PA decision letter or the 278 response is returned before billing for the service, or until verification can be made that ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS received the form or the 278 request and did not render a decision on the request within the time parameters listed previously. Verification is accomplished using Web interChange PA inquiry or the AVR system. When additional information is requested, the time parameters as described previously begin on receipt of the information by the ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS PA department. The established mechanism to allow time for the provider to supply this information is achieved by suspending the first request form and having the provider submit another request form with the additional information.

**Note:** Suspending the request does not mean the request is denied; it gives the provider additional time to provide clinical information that facilitates a more accurate and appropriate determination.

If documentation is not received within 30 days, the request is denied. Examples of reasons for suspending requests include lack of complete medical history, missing medical clearance forms, or missing plan of treatment. If the determination involves a denial or modification of a continuing service, such as home health care, at least 10 days’ notice plus three days’ additional mailing time must be given before the effective date of the change begins.

Additional clinical information to justify medical necessity or additional information needed for clarification, including, but not limited to, X-rays, ultrasound, lab, and biopsy reports, may be required. Photographs may be necessary in some instances, such as breast reduction surgery or wound management.
Send the completed *Indiana Health Coverage Programs Prior Authorization Request Form* to the following address as appropriate:

**Prior Authorization Department**  
ADVANTAGE Health Solutions-FFS  
P.O. Box 40789  
Indianapolis, IN 46240

**Prior Authorization Department**  
ADVANTAGE Health Solutions-CS  
P.O. Box 80068  
Indianapolis, IN 46280

Providers should retain photocopies of the *Indiana Health Coverage Programs Prior Authorization Request Forms* for their records. The PA vendors prefer to receive the completed PA forms by fax. However, the original form is accepted by mail and must be submitted to the appropriate PA department listed in this section.

**PA Inquiry**

The IHCP requires PA for certain services for medical necessity. Certain services also require submitting requests for additional units through PA when normal limits are exhausted. Providers must monitor the number of units of each prior-authorized service and must verify eligibility before delivery of a service. Providers can verify eligibility by contacting the AVR system or Web interChange. The PA department determines if a service requires PA, based on medical necessity.

By determining a member’s delivery system, the provider knows which entity to contact based on the program assignment of the member. The eligibility verification identifies whether a member is one of the following:

- Traditional Medicaid member enrolled as an FFS
- Hoosier Healthwise member enrolled in an RBMC
- *Care Select* member enrolled with a care management organization (CMO) and whose care is managed by a CMO
- Healthy Indiana Plan member enrolled with HIP insurers

Providers should contact Catamaran to obtain information about PA requests involving drug and biological services.

**Indiana Prior Review and Authorization Dental Request Form**

Form instructions for the *Indiana Prior Review and Authorization Dental Request* are contained in Table 6.2.
Table 6.2 – Indiana Prior Review and Authorization Dental Request Form Instructions

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Provider NPI #</td>
<td>Requesting provider information. Type the data requested. The requesting or rendering provider’s NPI or LPI is required. If the requesting provider is not enrolled, the PA form will be returned to the provider. A valid NPI or LPI is required. The provider’s copy of the <em>Indiana Prior Review and Authorization Dental Request Decision</em> letter is sent to the address that corresponds to the provider information entered in this field, if a separate mailing provider ID and service location are not identified on the form. If the requesting provider information does not have a valid service location, a PA decision letter will not be generated. Therefore, providers should complete the mailing provider ID and service location fields to ensure that the PA decision letter is mailed to the correct address. If the mailing provider ID and service location fields are completed in conjunction with the requesting provider information that has a valid service location, the mailing provider ID and service location information will be selected as the mailing address for the PA decision letter, instead of the requesting provider number and service location information.</td>
</tr>
<tr>
<td>Name/Address/City/State/ZIP/Phone Mailing Provider ID and Service Location</td>
<td></td>
</tr>
<tr>
<td>RID NO.</td>
<td>Member information. Type the data requested for the member who is to receive the requested service.</td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Name/Address/City/State/ZIP</td>
<td></td>
</tr>
<tr>
<td>Dates of Service, Start</td>
<td>Requested start date for the service; for continued services, the start date must be the day after the previous end date.</td>
</tr>
<tr>
<td>Dates of Service, Stop</td>
<td>Requested stop date for the service.</td>
</tr>
<tr>
<td>Service Code</td>
<td>Type the requested service code such as CPT, ADA, HCPCS, revenue, or NDC.</td>
</tr>
<tr>
<td>Requested Service</td>
<td>Type a short narrative or include attachment of the requested service and like services provided by other payers.</td>
</tr>
<tr>
<td>Place of Service</td>
<td>Type the requested place of service.</td>
</tr>
<tr>
<td>Units</td>
<td>Type the number of units desired. Units are equal to days, months, or items, whichever is applicable.</td>
</tr>
<tr>
<td>Dollars</td>
<td>Type the estimated or known IHCP cost of the service. Optional, except for home health services, DME equipment, and pharmacy requests.</td>
</tr>
<tr>
<td>Caseworker/Phone</td>
<td>Type the caseworker name and telephone number.</td>
</tr>
<tr>
<td>MCO/590/FFS/CS/MS</td>
<td>Check, if applicable.</td>
</tr>
<tr>
<td>Is Member Employed?</td>
<td>Check YES or NO.</td>
</tr>
<tr>
<td>Circumstances (Place/Type)</td>
<td>Type employment information, if applicable.</td>
</tr>
<tr>
<td>Is Member in Job Training?</td>
<td>Check YES or NO.</td>
</tr>
</tbody>
</table>
### Field Description

#### Type of Job Training
Type training information, if applicable.

#### Dental Treatment Plan

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the Member have missing teeth?</td>
<td>Check YES or NO. If Yes, indicate missing teeth with an X on the diagram provided.</td>
</tr>
<tr>
<td>1. Endodontics</td>
<td>Indicate on the number graph the tooth or teeth to be treated by root canal therapy (1-32).</td>
</tr>
<tr>
<td>2. Periodontics</td>
<td>Briefly summarize the periodontal condition.</td>
</tr>
<tr>
<td>3. Partial dentures</td>
<td>Use the diagram to indicate the teeth involved. Date or dates of extractions of missing teeth. Which teeth are to be extracted (tooth #)? Which teeth are to be replaced (tooth #)? Brief description of materials and design of partial. Is member wearing partials now? Age of present partials.</td>
</tr>
<tr>
<td>4. Dentures</td>
<td>Full upper denture, full lower denture. Check one or both. How long endentulous? Is the patient physically and psychologically able to wear and maintain the prosthesis? Is member wearing dentures now? Age of present dentures.</td>
</tr>
<tr>
<td>5. Describe treatment if different from above</td>
<td>Type description of any treatment to be provided that was not listed previously on this form.</td>
</tr>
<tr>
<td>6. Is the member on parenteral or enteral nutritional supplements?</td>
<td>Check YES or NO. If Yes, a plan of care to wean the member from the nutritional supplements must be attached. If the plan of care is not provided, dentures, partials, relines, and repairs will be denied.</td>
</tr>
</tbody>
</table>

#### Brief Dental/Medical History
Type pertinent information known to the provider about the member’s dental and medical history.

#### Signature of Requesting Dentist
The authorized provider, as listed in Section 1 of this chapter, must sign and date the form. Signature stamps can be used.

#### Date of Submission
Type the date the form was actually submitted.

Send the completed Indiana Prior Review and Authorization Dental Request form to the following address as appropriate:

**Prior Authorization Department**
ADVANTAGE Health Solutions-FFS
P.O. Box 40789
Indianapolis, IN 46240

**Prior Authorization Department**
ADVANTAGE Health Solutions-CS
P.O. Box 80068
Indianapolis, IN 46280

This form is available on the [Forms] page at indianamedicaid.com.

Providers should retain photocopies of the Indiana Prior Review and Authorization Dental Request forms for their records. The PA vendors prefer to receive the completed PA forms by fax. However,
the original form will be accepted by mail and must be submitted to the appropriate PA department listed in this section.

**Medicaid Second Opinion Form**

Providers may be required to submit a second or third opinion to substantiate the medical necessity of certain services. If required, the *Medicaid Second Opinion Form* should be completed as directed in the form’s narrative and returned to the appropriate PA department based on the program assignment of the member. This form is available on the [Forms](http://www.indianamedicaid.com) page at indianamedicaid.com.

**Medical Clearance Forms**

Providers must submit medical clearance forms to justify the medical necessity of designated DME or medical supplies when requesting PA. DME or medical supplies that require medical clearance forms when requesting PA include, but are not limited to, the following services:

- **Augmentative** – *Augmentative Communication System Selection* form
- **Certificate of Medical Necessity (CMN) for home oxygen therapy** – *Certificate of Medical Necessity: Oxygen* form
- **CMN parenteral or enteral nutrition** – *Certificate of Medical Necessity: Parenteral or Enteral Nutrition* form
- **Hospital beds** – *Medical Clearance Form: Hospital and Specialty Beds* form
- **Motorized wheelchairs or other power-operated vehicles** – *Indiana Health Coverage Programs Medical Clearance for Motorized Wheelchair Purchase* form
- **Negative pressure wound therapy** – *Indiana Health Coverage Programs Medical Clearance Form – Negative Pressure Wound Therapy* form
- **Non-motorized wheelchairs** – *Indiana Health Coverage Programs Medical Clearance for Non-Motorized Wheelchair Purchase* form
- **Standing equipment** – *Medical Clearance Form: Physical Assessment for Standing Equipment* form
- **Transcutaneous electrical nerve stimulator (TENS) units** – *Medical Clearance for TENS Unit (Transcutaneous Electrical Nerve Stimulator)* form

Copies of these forms are available for downloading on the [Forms](http://www.indianamedicaid.com) page at indianamedicaid.com.

**Procedures**

When requesting PA for the DME or medical supplies named previously, providers must complete the appropriate clearance form and attach it to a completed *Indiana Health Coverage Programs Prior Authorization Request Form*. Failing to provide appropriate medical clearance forms with PA request forms results in suspension, not denial, of PA requests. Forms should be completed in sufficient detail to enable a decision about medical reasonableness and necessity.

Providers should retain photocopies of the *Indiana Health Coverage Programs Prior Authorization Request Forms* and any medical clearance forms included with their submissions for their records. The PA vendors prefer to receive the completed PA forms and any medical clearance forms by fax. However, the original forms will be accepted by mail and must be submitted to the appropriate PA department listed in this section.
Fax Authorizations

Note: The information in this section does not apply to pharmacy services.

ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS PA department accepts PA requests by fax. It is preferred that each PA request be faxed separately. However, if providers must batch PA requests into one fax, they can clearly indicate that the fax contains multiple requests and clearly indicate each separate PA request by adding a separate cover letter between each PA request.

The same procedures are used for PA requests sent by fax transmission as for telephone PA requests. See the Telephone Authorizations section of this chapter for these procedures.

The PA department fax numbers are as follows:

Medical PA:
ADVANTAGE Health Solutions-FFS
Fax: 1-800-689-2759
ADVANTAGE Health Solutions-CS
Fax: 1-800-689-2759

Prior Authorization Decision Letter

Note: This information does not apply to pharmacy services.

After a decision is reached about a PA request, IndianaAIM automatically generates an Indiana Prior Review and Authorization Request Decision letter. If the PA request is not approved, additional information is included with the decision letter to explain the decision. For example, IAC references and administrative review and appeal rights are included for modified and denied decisions. A suspension is not a denial; rather, it is a request for additional information. Providers must return the additional information within 30 calendar days, or the request is denied. If the PA request is rejected, providers will receive a PA decision letter documenting the rejected status of the PA request, noting that the PA was submitted to the wrong PA vendor based on the assignment of the member to a specific IHCP program.

PA decisions are mailed to the member and the requesting provider. The rendering provider, if not also the requesting provider, must contact either the requesting provider or the member to secure a copy of the PA decision.

An explanation of the Indiana Prior Review and Authorization Request Decision letter content follows:

• The top-left area of the form provides requesting provider and member information.
• Specific information about the requested service is provided below the provider and member information.
• Space for narrative about the decision is provided below the service information.

Instead of submitting another PA request, certain authorization information can be updated by telephone or letter.
Telephone Requests for Prior Authorization

The traditional Medicaid FFS and Care Select PA department telephone numbers are as follows:

Medical PA:

ADVANTAGE Health Solutions-FFS
1-800-269-5720

ADVANTAGE Health Solutions-CS
1-800-784-3981

The toll-free numbers are available throughout Indiana and to providers located in designated or contiguous areas of Michigan, Ohio, Kentucky, and Illinois.

Prior Authorization (PA) Update Requests

Submit PA update requests on the Prior Authorization – System Update Request Form. Written PA update requests can also be submitted on the provider’s letterhead, with PRIOR AUTHORIZATION UPDATE written boldly across the top. Include pertinent information, such as member identification number (RID); PA number; and information to be corrected, changed, or updated. Attach a copy of the original PA request and system-generated letter to verify the item to be updated.

Mail or fax the request to the following address as appropriate based on the program assignment of the member:

Prior Authorization Department
ADVANTAGE Health Solutions-FFS
P.O. Box 40789
Indianapolis, IN 46240
Fax: 1-800-689-2759

Prior Authorization Department
ADVANTAGE Health Solutions-CS
P.O. Box 80068
Indianapolis, IN 46280
Fax: 1-800-689-2759

The Prior Authorization – System Update Request Form is available on the Forms page at indianamedicaid.com.

Examples of PA Update Requests

The following are examples of appropriate PA update requests:

• A provider that discovers a clerical error in entering PA data may call or write to request the correction of the system, depending on the complexity of the situation. If the error does not require research or review of the original PA request, the correction can be updated over the telephone. However, some items may be too complicated to resolve with a telephone call and may require additional medical documentation to support the request. Providers may need to send the original request and system-generated letter for review. An explanatory letter is helpful.

• A request to increase home health services, except in the case of urgent or emergency services, requires a written request with supporting documentation of medical necessity.

• Extending the dates on an approved surgery because rescheduling was necessary is appropriate for a telephone update.
When a PA number is updated, a system-generated Indiana Prior Review and Authorization PA Update Decision letter is sent automatically to the requesting provider and the member. Any request for a new service must be submitted as a new PA request.

**PA Update Decision Letter**

When an existing PA is updated, IndianaAIM automatically generates an Indiana Prior Review and Authorization Update Decision letter. This letter highlights the information that was changed in a narrative at the bottom of the letter.

The *Indiana Prior Review and Authorization Update Decision* letter includes the following information:

- Requesting provider information
- Member information
- Specific information about the requested service provided

**Decision Description**

A decision is included on the *Indiana Prior Review and Authorization Update Decision* letter that describes the decision and includes the following information:

- Approved
- Administrative approval
- Decision overturned by administrative law judge (ALJ)
- Denied
- Rejected
- Evaluation; awaiting final decision; normal cycle
- Approved for continuation of service
- Modified for continuation of service
- Denied for continuation of service
- Noncovered code, denied
- Restored to previous level, awaiting appeal result
- Modified
- No PA required
- No PA required when requested by a PMP
- Pending receipt of required information
- Incorrect PMP
- Suspended
- Appeal dismissed, no hearing, request approved
- Appeal dismissed, no hearing, request modified
- Appeal dismissed, no hearing, request denied
• Decision modified through court action
• Decision upheld by ALJ
• Modified through administrative review
• Approved through administrative review
• Automatically approved after 10 days

Non-Indiana Health Coverage Programs Prior Authorizations

590 Program Authorizations

PA for the 590 Program mirrors the IHCP PA system. However, transportation is not a covered service for the 590 Program; therefore, PA cannot be granted for 590 Program transportation requests.

PA is required for any service that the provider estimates is $500 or more, regardless of whether the service requires PA in the Traditional Medicaid Program.

PA is not required, unless provided by an out-of-state provider, for any service that the provider estimates is less than $500, regardless of whether the service requires PA in the Traditional Medicaid Program.

PA requests for pharmacy expenses of more than $500 must be directed to Catamaran.

Services for 590 Program members may be prior authorized retroactively. 590 Program services can also be requested using the electronic 278 transaction.

Home and Community-Based Waiver Services Authorizations

Home and Community-Based Services (HCBS) waiver members receive Traditional Medicaid Program benefits; therefore, the same policy that stipulates which IHCP State Plan services require PA also applies to waiver member program benefits. This PA can be requested using the electronic 278 transaction. HCBS waiver program services are approved by the member’s Level of Care (LOC) waiver program State administrator, which is either the FSSA Division of Aging or the FSSA Division of Disability and Rehabilitative Services. The approved waiver services are recorded on a Notice of Action (NOA), and the approved dollars listed on the NOA are transmitted to the member’s PA history table to be used during the claim adjudication process. Any discrepancies between approved dollars for waiver services on the NOA and dollars available on the member’s PA history table need to be mediated through the member’s case manager, who facilitates the resolution of any discrepancies. Some services may be available through both State plan benefits and waiver program benefits. In this case, the State plan service benefits, including any that may be available through PA, must be exhausted first before obtaining waiver program services, even if the waiver services are approved.

Non-Indiana Health Coverage Programs Provider Procedures

For PA consideration, the requester must have a valid NPI or, if an atypical provider, an LPI, which has been registered with Indiana Medicaid.

The rendering provider must be enrolled in the IHCP to receive reimbursement for providing services to an IHCP member, ensuring that all service requirements are met.
Retroactive Prior Authorization

PA is given after services have begun or supplies have been delivered only under the following circumstances:

• Pending or retroactive member eligibility
  – The PA request must be submitted within 12 months of the date when the member’s caseworker entered the eligibility information. The hospice authorization request must be submitted within one year of the date nursing facility Level of Care is approved by the office.

• Mechanical or administrative delays or errors by the contractor or county office of the FSSA Division of Family Resources (DFR)

• Services rendered outside Indiana by a provider that had not yet enrolled as an IHCP provider

• Transportation services authorized under 405 IAC 5-30
  – The PA request must be submitted within 12 months of the date of service.

• The provider was 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 RID.
  – 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.

• Any situation in which the physician cannot determine the exact procedure to be done until after the service has been performed

Providers should submit FFS and CS requests to ADVANTAGE Health Solutions. Providers should submit requests for RBMC members to the correct MCE based on the date of service.

Prior Authorization and Third Party

If PA is required for a service, and the member has additional insurance coverage that is primary, PA must be obtained from the appropriate PA vendor, based on the program assignment of the member, to receive payment from the IHCP for the balance of charges not paid by the primary insurance. In addition, if the primary payer requires PA, the provider must follow that plan’s requirements for obtaining PA. The provider must also obtain a PA from ADVANTAGE if the code requires a PA for Indiana Medicaid claim processing.

PA and Medicare PA are not required for members with Medicare Part A and Part B coverage if the services are covered (in whole or in part) by Medicare. Services not covered by Medicare are subject to normal PA requirements.
Section 3: 278 Electronic Transaction

Purpose of the 278 Transaction

The 278 transaction provides standard data requirements and content for all users who request and respond to authorization or certification requests. The 278 transaction supports the following information:

- Submission of initial electronic requests
- Submission of updated or revised electronic requests
- Submission of paper attachments for electronic requests
- Submission of retroactive submission of electronic requests
- Submission of out-of-state electronic requests
- Submission of electronic administrative reviews
- Response with approval
- Response with modified approval
- Response with denial of a previous request
- Response with follow-up action code
- Response with action code

Continue sending all requests for administrative hearings to the following address:

Attention: Hearings and Appeals  
Division of Family Resources  
Indiana Family and Social Service Administration  
402 West Washington Street, Room E034  
Indianapolis, IN 46204

Requests for administrative hearings can also be sent directly to the local county office.

278 Request

Health Insurance Portability and Accountability Act (HIPAA) legislation mandates that many of the major healthcare electronic data exchanges, such as electronic submission of prior authorization (PA) requests and the electronic responses, are standardized national formats for all payers, providers, and clearinghouses. All providers who submit affected data electronically to the Indiana Health Coverage Programs (IHCP) must use the mandated HIPAA formats. HIPAA specifically names several electronic standards that must be followed when certain healthcare information is exchanged. These standards are published as National Electronic Data Interchange Transaction Set Implementation Guides – commonly called Implementation Guides (IGs). An addendum to each IG was also published and must be used with the IG to properly implement each transaction.

The IHCP has developed technical companion guides to help users understand the IHCP requirements for each new electronic transaction and to assist during the implementation process. In most cases, the existing data exchange format has changed, such as electronic claim submission. In other cases, a new transaction is available, such as the PA request and response transaction. The information contained in
the IHCP Companion Guide is only intended to supplement the adopted IGs and provide guidance and clarification as it applies to the IHCP. The IHCP Companion Guide is never intended to modify, contradict, or reinterpret the rules established by the IGs.

Providers wanting information about the 278 transaction for submitting electronic PA request should contact the EDI Solutions Unit at INXIXElectronicSolution@hp.com.

All healthcare organizations exchanging HIPAA transaction data electronically with the IHCP are required to establish an EDI relationship. Entities with this EDI relationship are referred to as trading partners. The IHCP has prepared information to assist entities with becoming IHCP trading partners. Trading partner information is available on the EDI Solutions page at indianamedicaid.com. In addition, providers wanting to submit electronic PA requests must follow the testing requirements as outlined by the IHCP. For additional information about the testing process or to obtain copies of testing instructions, see the EDI Solutions page at indianamedicaid.com. Providers may also contact the Electronic Solutions Help Desk by email at INXIXtradingpartner@hp.com or by telephone at 1-877-877-5182.

Data Elements

The IHCP Companion Guide provides detailed information about data elements that are required, situational, or not used by the IHCP for submitting a 278 transaction for PA. Data elements that could require more detailed explanations are discussed in the following sections.

Certification Type Codes

Certification type codes are required data elements used in the 278 transaction to indicate the kind of certification requested. These codes are also found in the 278 IG. When submitting an electronic request for PA, the requester must use one of the certification type codes listed in Table 6.3 to specify the type of request needed.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Appeal – Intermediate</td>
<td>Informs the IHCP the request is for an administrative review</td>
</tr>
<tr>
<td>2</td>
<td>Appeal – Standard</td>
<td>Informs the IHCP the request is for an administrative review</td>
</tr>
<tr>
<td>3</td>
<td>Cancel</td>
<td>Indicates the request was previously submitted but is being canceled by the requester</td>
</tr>
<tr>
<td>4</td>
<td>Extension</td>
<td>Indicates the request is for an update to a previously approved PA</td>
</tr>
<tr>
<td>I</td>
<td>Initial</td>
<td>Indicates a new request</td>
</tr>
<tr>
<td>R</td>
<td>Renewal</td>
<td>Indicates an update to a previously approved PA</td>
</tr>
<tr>
<td>S</td>
<td>Revised</td>
<td>Indicates a request for a change or update to a previously approved PA</td>
</tr>
</tbody>
</table>

Service Type Codes

Service type codes are used in the 278 transaction to identify the classification of service for the PA request. This data element is required if known by the submitting provider. A complete list of service type codes is provided in the 278 IG.
Examples of service type codes are as follows:
- 12 – Durable medical equipment (DME)
- 45 – Hospice
- 54 – Long-term care

**Facility Type Codes**

Facility type codes identify the type of facility where services were performed. This data element is required. The two categories of facility type codes follow:
- Uniform Billing Claim Form Bill Type
- Place of service (POS)

A list of the Uniform Billing Claim Form Bill Type Codes is found through the named code sources listed in the 278 transaction IG for the specific facility type code. See the NUBC website at nubc.org for a current list of Type of Bill codes. The provider is responsible for using current codes maintained by the named entity responsible for the code set.

**Level-of-Service Codes**

Level-of-service codes are used to indicate the request is for an emergency service and is a situational data element. Emergency admissions that require PA must be reported to ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS PA department within 48 hours of admission, as indicated in Chapter 8: Billing Instructions of this manual. Providers must continue to follow the guidelines for submission of emergency requests as outlined in Chapter 8: Billing Instructions of this manual. Providers must use one of the codes from Table 6.4 to indicate an emergency request.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>Emergency</td>
</tr>
<tr>
<td>U</td>
<td>Urgent</td>
</tr>
</tbody>
</table>

**Release of Information Codes**

Release of information codes are used to indicate that the provider has a statement on file, signed by the member, which authorizes the release of the member’s medical information. Providers must use one of the current codes listed in Table 6.5.
Table 6.5 – Release of Information Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Appropriate release of information on file at healthcare service provider or utilization review organization</td>
</tr>
<tr>
<td>I</td>
<td>Informed consent to release medical information for conditions or diagnoses regulated by federal statutes</td>
</tr>
<tr>
<td>M</td>
<td>Provider has limited or restricted ability to release data related to a claim</td>
</tr>
<tr>
<td>O</td>
<td>On file at payer or at plan sponsor</td>
</tr>
<tr>
<td>Y</td>
<td>Yes, provider has a signed statement permitting release of medical billing data related to a claim</td>
</tr>
</tbody>
</table>

Segments

A segment is a unit of information in the transaction. The IHCP Companion Guide provides detailed information about segments that are required, situational, or not used by the IHCP for submitting a 278 transaction requesting PA. Segments requiring more explanation are discussed in the following sections.

Diagnosis Segment

This segment of the 278 transaction allows providers to submit up to 12 ICD codes for a single patient event. A patient event is defined as: The service or group of services associated with a single episode of care. The ICD code is a required data element and must be submitted after the appropriate diagnosis type code.

Previous Certification Identification Segment

This segment is required when a provider submits an additional request associated with a previously approved PA, and the provider knows the previous PA request number.

Procedures Segment

This segment is used to request specific services and procedures and is required for all IHCP PA requests. There are various procedures on the Code List Qualifier listed in the 278 IG used to designate the specific procedure code. However, the IHCP processes only procedure codes defined under the ABR – Assigned by Reviewer and BO – Health Care Common Procedure Coding System (HCPCS) code sets. Revenue Codes are reported under ABR. The American Medical Association (AMA) Current Procedural Terminology (CPT) codes are reported under BO. The American Dental Association (ADA) Current Dental Terminology® (CDT) codes are considered level II HCPCS codes and are reported under BO.

The IHCP is currently reviewing the Logical Observation Identifiers Names and Codes (LOINC) for future use. The LOINC identify specific information concerning the patient or services that the Utilization Management Organization (UMO) requires from the provider to complete the medical review. The LOINC are addressed in the 278 4010 addenda. The LOINC are not to be used with the 278 transaction for processing the IHCP PA requests at this time.
Units

Providers can submit PA requests for service units or for specific dollar amounts. For example, procedure code E8000 – *Gait trainer, pediatric size, posterior support, includes all accessories and components* is used to identify the device. The Message segment of the 278 request is used to identify the specific type of device for the PA request. HCPCS code E8000 includes the accessories associated with the device. Providers cannot submit separate codes for the accessories.

Message Segment

The 278 transaction allows providers to submit a free-form text message about the request. The Message (MSG) segment allows a free-form text field of up to 264 characters.

Modifiers

When submitting a PA request that contains a CPT or HCPCS modifier, providers must use the MSG segment in the 278 transaction. This format accommodates reporting modifiers for up to 12 procedure codes. The procedure for the reported modifier is identified in the MSG segment by the corresponding HI element where the procedure is located. The IHCP Companion Guide: 278 Prior Authorization Review Request and Response Transaction provides detailed instructions about billing modifiers. The companion guide also provides information about submitting a request that contains both a modifier and a text message in the MSG segment.

Reasons for Rejection of Request

Providers receive a 278 response for requests that cannot be processed at a system or application level, based on the information submitted. The IHCP Companion Guide: 278 Prior Authorization Review Request and Response Transaction or the 278 IG provides a list of Reject Reason Codes. Some examples of rejection are as follows:

- Subscriber/Insured not in Group/Plan Identified
- Invalid diagnosis or dates
- Missing service codes and dates
- Exact duplicate of another request

PA requests submitted to the incorrect care management organization (CMO) via the 278 PA Request and Response transaction are rejected regardless of the certification type with reason code 78 – *Subscriber/Insured not in Group/Plan Identified*, and a PA decision letter will not be generated. When providers receive notification that the submitted PA request has been rejected, a new PA request must be submitted to the correct PA contractor.

Duplicate Requests or Approval of Nonspecific Codes

IndianaAIM rejects duplicate 278 requests for the exact date of service, exact procedure, and exact requesting provider for the same member. Duplicate requests submitted for unspecified procedure or service codes are manually reviewed. Providers must use the Message segment of the 278 transaction to identify the specific procedure or service submitted for the unspecified code to avoid rejection.

For example, when submitting HCPCS code E1399 – *Durable medical equipment, miscellaneous*, providers must indicate in the Message segment the specific equipment requested.
To avoid rejection as a duplicate of another request, procedures or services that are repeated for the same date of service must be submitted with one of the modifiers in Table 6.6. These modifiers must be documented in the Message segment corresponding to the appropriate procedure code in the corresponding HI segment. This does not refer to requests submitted for multiple units for the same procedure or service on the same date of service on the PA service line.

### Table 6.6 – Repeated Services Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76</td>
<td>Repeat procedure by same physician</td>
</tr>
<tr>
<td>77</td>
<td>Repeat procedure by another physician</td>
</tr>
<tr>
<td>91</td>
<td>Repeat clinical diagnostic laboratory test</td>
</tr>
</tbody>
</table>

### Paper Attachments and Electronic PA Requests

The IHCP accepts paper attachments with an electronic PA request. The 278 transaction does not support electronic attachments at this time.

When a 278 request transaction requires submission of additional documentation, the documentation must be submitted as a paper attachment. When a provider elects to send a paper attachment with a 278 transaction, the following information must be included on the 278 transaction in the Additional Patient Information segment:

- **Attachment Transmission Code** – Indicates an electronic request has paper documentation to support the requested services. This code defines the timing and transmission method or format of the reports and the method of submission. This value is provided in Attachment Transmission Code, Data Element 756, on the 278 transaction. All valid Attachment Transmission Codes are accepted for the 278 transactions; however, the IHCP accepts only paper attachments for electronic or paper PA requests by mail and fax. The IHCP uses the following Attachment Transmission Codes:
  - BM – By mail
  - FX – By fax

- **Attachment Report Type Code** – Indicates the type of attachment being sent to the IHCP that supports the 278 request data. The code indicates the title or contents of a document, report, or supporting item. This code is used in Report Type Code, Data Element 755. For a complete listing of Attachment Report Type Codes, see the National Electronic Data Interchange Transaction Set Implementation Guide: Health Care Services Review—Request for Review and Response: 278: ASC X12N 278 (004010X094) and (004010X094A1) Addenda. Examples include the following codes:
  - B3 – Physician order
  - DS – Discharge summary
  - OB – Operative note

- **Attachment control number (ACN)** – Identifies each attachment. The ACN is created by the provider and must consist of at least two, and no more than 30, characters. The IG allows for 80 characters; however, the IHCP processes only 30 characters. This code is used in Attachment Control Number, Data Element 67.

The following instructions are for submitting paper attachments for electronic claims:

- Each paper attachment submitted for a 278 transaction must include a unique ACN. Write the unique ACN on each attachment.

- An attachment with multiple pages must have the ACN on each page.
A maximum of 10 attachments is allowed per service level and 10 per subscriber level.

- The ACN must be unique per document, and documents cannot be shared between requests.
- Providers must write the ACN, member ID, provider identification number, and date of service on each attachment to ensure that the attachment is linked to the appropriate request.
- Paper attachments for an electronic request must be mailed or faxed to the following as appropriate based on the program assignment of the member:

  **Medical PA:**
  
  Prior Authorization Department  
  ADVANTAGE Health Solutions-FFS  
  P.O. Box 40789  
  Indianapolis, IN 46240  
  Fax: 1-800-689-2759
  
  Prior Authorization Department  
  ADVANTAGE Health Solutions-CS  
  P.O. Box 80068  
  Indianapolis, IN 46280  
  Fax: 1-800-689-2759

If the attachments are not received within 30 calendar days of the request submission, the request is denied. If attachments are received, and one specific attachment needed for processing is missing, the provider may receive an electronic response indicating additional information is needed to process the request.

Electronic PA requests are submitted individually or in batch files. Each request must contain the name and number of the UMO. All admission requests for nursing facilities and intermediate care facilities for individuals with intellectual disability (ICFs/IID), specialty 031, are forwarded to the Family and Social Services Administration (FSSA) Long Term Care (LTC) Unit. All other nonpharmacy PA requests are reviewed by the appropriate PA department based on the program assignment of the member. The UMO information listed in Table 6.7 is required for 278 request submissions.

**Table 6.7 – UMO Information**

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Long-Term Care Requests</th>
<th>All Other Nonpharmacy Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>UMO Name</td>
<td>LTC Unit</td>
<td>ADVANTAGE Health Solutions-FFS, ADVANTAGE Health Solutions-CS</td>
</tr>
<tr>
<td>UMO Identifier</td>
<td>LTC Unit</td>
<td>ADVANTAGE Health Solutions-FFS, ADVANTAGE Health Solutions-CS</td>
</tr>
</tbody>
</table>

**Retroactive Prior Authorization Requests**

PA is given after services have begun, or supplies have been delivered, only under the circumstances outlined in this manual. When a retroactive request is submitted with the 278 transaction, providers must indicate in the Message segment of the request that the request is for a retroactive PA.
Request for Transportation Services

When submitting a PA request with the 278 transaction, the following information is required in the Message segment of the request. Unlike submitting a paper request for PA, an attachment is not required when the Message segment provides this information:

- Member’s condition
- Level of service required, such as wheelchair van, Commercial Ambulatory Service (CAS), or taxi
  - The member’s condition must support the level of service requested.
- Reason for and destination of service, such as dialysis or physical therapy treatments
- Frequency of service and treatment per the physician’s order, such as twice per week
- Duration of service and treatment per the physician’s order, such as three months
- Total mileage for each trip, such as 129 miles
- Total waiting time for each trip, such as two hours

278 Response

A 278 response transaction is communicated to the provider indicating approval, approval with modification, or denial of a request for all electronic PA requests. An electronic response is not provided for paper requests. The Health Care Services Response section of the IG allows the payer – the IHCP in this case – to perform the following functions:

- Provide a response to each 278 request received
- Provide a short text message to the provider regarding what is needed, such as missing information needed to process the request
- Provide a reason for rejection
- Provide information indicating the PA status
- Request an attachment
- Return information received on the request to the provider
- Continue to send providers a paper notice

Action Codes

Action codes are assigned by the PA reviewer to identify the type of action taken on the request. Action codes that can appear on a 278 response to the requesting provider are listed in Table 6.8.

Providers receive a 278 response that gives the review outcome information. These action codes are returned only if the appropriate PA department is able to review the request. Providers continue to receive paper notification for PA in addition to an electronic response.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Certified in total</td>
</tr>
<tr>
<td>A3</td>
<td>Not certified</td>
</tr>
<tr>
<td>A4</td>
<td>Pended</td>
</tr>
<tr>
<td>A5</td>
<td>Modified</td>
</tr>
</tbody>
</table>
Reject Reason Codes

Reject reason codes may be returned to the provider when the system rejects the 278 transaction before PA department review. The provider also receives a follow-up action code identifying the action the provider must take to correct the transaction rejection. Providers do not receive paper notification of system-generated rejections. A complete list of reject reason codes is available in the 278 IG.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>Contact payer</td>
</tr>
<tr>
<td>NA</td>
<td>No action required</td>
</tr>
</tbody>
</table>

ARCHIVED
Section 4: Institutional Prior Authorization Policy Requirements

General Information

Specific criteria pertaining to prior authorization (PA) services covered in this section can be found in 405 IAC 5. Several references in this section are made to the previous version of the Indiana Administrative Code (IAC). Copies of the previous rule can be obtained from earlier versions of the provider manual.

Diagnosis-Related Group Inpatient Hospital Admission Prior Authorization Policy Requirements

Inpatient acute care hospital PA requirements are addressed for two distinct areas – substance abuse inpatient care and surgical procedures. Providers must apply appropriate PA policies and procedures to the respective service dates. PA for substance abuse inpatient care and surgical procedures is outlined in Table 6.9.

Diagnosis-related group (DRG) methodology is used for the Indiana Health Coverage Programs (IHCP). If the DRG methodology cannot be assigned, a Level of Care (LOC) is assigned to the case.

Note: The IHCP requires PA for all psychiatric, rehabilitation, and substance abuse stays, and certain burn cases. The IHCP does not reimburse providers for days that are not approved for PA.

Table 6.9 – DRG Inpatient Hospital Admission PA Policy Requirements

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Inpatient Care</td>
<td>PA for inpatient detoxification, rehabilitation, and aftercare for chemical dependency must include consideration of the following information:</td>
</tr>
<tr>
<td></td>
<td>• Review on a case-by-case basis by the appropriate PA department based on the program assignment of the member</td>
</tr>
<tr>
<td></td>
<td>• Treatment, evaluation, and detoxification based on the stated medical condition</td>
</tr>
<tr>
<td></td>
<td>• Need for safe withdrawal from alcohol or other drugs</td>
</tr>
<tr>
<td></td>
<td>• History of recent convulsions or poorly controlled convulsive disorder</td>
</tr>
<tr>
<td></td>
<td>• Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting</td>
</tr>
<tr>
<td></td>
<td>Admission to a general hospital floor is not indicated unless the medical services are required for life support and cannot be rendered in a substance abuse treatment unit or facility.</td>
</tr>
</tbody>
</table>
Surgical Procedures

PA is required for all procedures outlined in 405 IAC 5-3-13. Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate DRG but is subject to retrospective review for medical necessity. Criteria for determining the medical necessity for inpatient admission includes the following information:

- Technical or medical difficulty during the outpatient procedure as documented in the medical record
- Presence of physical or mental conditions, which make prolonged preoperative or postoperative observations by a nurse or other skilled medical personnel a necessity
- Performance of another procedure simultaneously, which itself requires hospitalization
- Likelihood of another procedure, which would require hospitalization following the initial procedure

Policy Parameters for Prior Authorization of Inpatient Psychiatric Admission

Tables 6.10 and 6.11 include guidelines for inpatient psychiatric admissions to freestanding psychiatric hospitals and acute care hospital psychiatric units. Specific PA criteria for inpatient psychiatric services are found in 405 IAC 5-20.

Table 6.10 – Inpatient Psychiatric Admission PA Policy Parameters, Distinct Part Inpatient Psychiatric Services in Acute Care Hospitals

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Precertification</td>
<td>Emergency and nonemergency admissions to psychiatric units of</td>
</tr>
<tr>
<td>Reviews and 1261A Forms</td>
<td>acute care hospitals require telephone precertification and</td>
</tr>
<tr>
<td></td>
<td>concurrent review. The facility is responsible for initiating</td>
</tr>
<tr>
<td></td>
<td>both with the appropriate PA department based on the program</td>
</tr>
<tr>
<td></td>
<td>assignment of the member for each admission. The precertification</td>
</tr>
<tr>
<td></td>
<td>review must be followed by a written certification of need</td>
</tr>
<tr>
<td></td>
<td>(1261A form) within 10 days of a nonemergency admission and</td>
</tr>
<tr>
<td></td>
<td>within 14 working days of an emergency admission.</td>
</tr>
</tbody>
</table>
### Certification of Need Requirements

Reimbursement is available for inpatient care provided in the psychiatric units of acute care hospitals only when the need for admission has been certified. The certification of need must be completed as follows:

- By the attending physician or staff physician
- By telephone precertification review before admission for an IHCP member admitted to the facility as a nonemergency admission, to be followed by a written certification of need within 10 business days of admission
- By telephone precertification review within 48 hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written certification of need within 14 working days of admission. If the provider fails to call within 48 hours of emergency admission, not including Saturdays, Sundays, and legal holidays, reimbursement is denied for the period from admission to the actual date of notification. (Denial of the certification of need may be appealed as outlined in Section 7: Prior Authorization Administrative Review and Appeal Procedures.)
- In writing within 10 business days of receiving notification of an eligibility determination for individuals applying for the IHCP while in the facility and covering the entire period for which reimbursement is being sought
- Concurrently – or as requested by the Family and Social Services Administration (FSSA) or the appropriate PA department based on the program assignment of the member – to recertify that the patient continues to require inpatient psychiatric hospital services

### Basis for Reimbursement

Reimbursement is denied for any days during the inpatient psychiatric hospitalization that are found to be not medically necessary. Telephone precertifications of medical necessity provide a basis for reimbursement only if adequately supported by the written certification of need submitted in accordance with the previously listed requirements. If the required written documentation is not submitted within the specified time frame, reimbursement is denied.

### Form Requests

The FSSA Division of Family Resources (DFR) State Form 1261A, Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility, fulfills the requirements for written certification of need. Providers should request this form from PEN Products at (317) 838-7192.

### Summary

Hospitals must submit a 1261A form to the appropriate PA department based on the program assignment of the member for every emergency and nonemergency admission to a psychiatric unit. ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS reviews the written certification of need for each admission and determines whether inpatient psychiatric care was warranted. Reimbursement is denied for any days for which the facility cannot justify a need for inpatient psychiatric care.
### Table 6.11 – Inpatient Psychiatric Admission PA Policy Parameters, Inpatient Psychiatric Services in Freestanding Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>State-Operated Facilities</td>
<td>State-operated facilities continue to submit the 1261A forms to the IHCP office. The IHCP agency reviews the written certification of need for each member and determines whether inpatient psychiatric care is warranted, and what length of stay is justified given the patient’s medical needs. Reimbursement is denied for any days for which the facility cannot justify a member’s need for inpatient psychiatric care.</td>
</tr>
</tbody>
</table>
| Certification of Need Requirements | Pursuant to 42 CFR Sec. 456.171, reimbursement is available for services in a freestanding inpatient psychiatric facility only when ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS has authorized each admission. The certification of need must be completed as follows:  
  • By the attending physician or staff physician for members between 22 and 65 years old in a psychiatric hospital of 16 beds or less, and for members 65 years old and older  
  • In accordance with 42 CFR Sec. 441.152(a) and 441.153 for members 21 years old and younger  
  • By telephone precertification review before admission for IHCP members admitted to the facility as a nonemergency admission, to be followed by a written certification of need within 10 business days of admission  
  • By telephone precertification review within 48 hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written certification of need within 14 working days of admission  
  – If the provider fails to call within 48 hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, reimbursement is denied for the period from admission to the actual date of notification.  
  (Denial of the certification of need may be appealed as outlined in Section 7: Prior Authorization Administrative Review and Appeal Procedures.)  
  • In writing within 10 business days after receiving notification of an eligibility determination for individuals applying for the IHCP while in the facility and covering the entire period for which reimbursement is being sought  
  • In writing at least every 60 days after admission – or as requested by the FSSA or the appropriate PA department based on the program assignment of the member – to recertify that the member continues to require inpatient psychiatric hospital services |
| Basis for Reimbursement         | Reimbursement is denied for any days during which the inpatient psychiatric hospitalization is deemed not medically necessary. Telephone precertification of medical necessity provides a basis for reimbursement only if adequately supported by the written certification of need submitted in accordance with the requirements listed previously. If the required written documentation is not submitted within the specified time frame, reimbursement is denied. |
Prior Authorization for Psychiatric Residential Treatment Facilities

The IHCP requires PA for admission to a psychiatric residential treatment facility (PRTF). Before approval can be given for an admission to a PRTF, documentation to support the admission must be provided. ADVANTAGE Health Solutions processes PRTF requests for FFS members, ADVANTAGE-CS members, MDwise-CS members, and Hoosier Healthwise members.

The required documentation includes the following:

- PRTF Admission Assessment or PRTF Extension Request Tool, as appropriate
- Intake assessment
- Indiana Health Coverage Programs Prior Authorization Request Form
- Certification of Need for Admission (Form 1261A)
- Child and Adolescent Needs and Strengths (CANS) Assessment
- Physician history and physical
- Initial Master Multidisciplinary Treatment Plan
- Documentation indicating the severity of the member’s mental disorder
- Nursing notes from the inpatient treatment
• Documentation indicating that intermediate or long-term care in a secure facility is needed for the member

• Freedom of Choice Form

If the member is hospitalized, documentation should include a current inpatient treatment plan and the nursing notes related to the inpatient treatment. On receipt of the PA request, a decision is issued within seven calendar days, excluding holidays.

If the request warrants the need for urgent review, the provider can call the appropriate PA department based on the program assignment of the member to ask for an emergency PA number. At this time, the PA request is placed in a pending status awaiting all required documentation as stated previously. This documentation can be mailed or faxed. All documentation must be submitted within 14 business days of the date of the initial request for emergency review. When the documentation is received, a decision is issued. If the admission is approved, the approval is back-dated to the date of the admission or to the date of the initial telephone or fax request. However, if the request for admission is denied, the provider is not reimbursed by the IHCP for any days of the PRTF stay. Each PA request is reviewed for medical necessity on a case-by-case basis.

Emergency admissions are not permitted. Members with emergency situations should be placed in an acute psychiatric facility and follow any criteria deemed necessary for that placement.

Admission Criteria

All the following criteria must be present for psychiatric residential care:

• The member’s mental disorder is rated severe, or the presence of two or more diagnoses on Axes I and II indicates that the member’s disturbance is severe or complex. Mental disorder as classified in the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV).

• The member’s behavior has disrupted his or her placement in the family or in a group residence two or more times in the past year, or the member has a persistent pattern of behavior that has severely disrupted life at home and school over the nine months preceding inpatient care. For children younger than 12 years old, these time frames are six months for a family or group residence, and six months for home and school.

• Family functioning or social relatedness is seriously impaired as evidenced by one or more of the following circumstances:
  – History of severe physical, sexual, or emotional maltreatment
  – History of a disrupted adoption or multiple, two or more, foster family placements
  – A physical assault against a parent or adult caregiver
  – A history of sexual assault by the member
  – A history of fire setting resulting in damage to a residence
  – Runaways from two or more community placements by a child younger than 14 years old
  – Other impairment of family functioning or social relatedness of similar severity

• The illness must be of a subacute or chronic nature where there has been failure of acute or emergency treatment to sufficiently ameliorate the condition to allow the member to function in a lower level of care. The following are examples of lower levels of care:
  – Family or relative placement with outpatient therapy
  – Day or after-school treatment
  – Foster care with outpatient therapy
  – Therapeutic foster care
  – Group child care supported by outpatient therapy
  – Therapeutic group child care
Partial hospitalization

Other

The following symptom complexes must show a need for extended treatment in a residential setting due to a threat to self or others:

- Self-care deficit, not age-related. Basic impairment of needs for nutrition, sleep, hygiene, rest, or stimulation included in the following:
  - Self-care deficit severe and long-standing enough to prohibit participation in an alternative setting in the community, including refusal to comply with treatment (for example, refusing medications)
  - Self-care deficit places child in life-threatening physiological imbalance without skilled intervention and supervision – for example, dehydration, starvation states, or exhaustion due to extreme hyperactivity
  - Sleep deprivation or significant weight loss

- Impaired safety such as threat to harm others. Verbalization or gestures of intent to harm others caused by the member’s mental disorder, such as the following indicators:
  - Threats accompanied by one of the following behaviors:
    - Depressed mood (irritable mood in children, weight gain, weight loss)
    - Recent loss
    - Recent suicide attempt or gesture, or past history of multiple attempts or gestures
    - Concomitant substance abuse
    - Recent suicide or history of multiple suicides in family or peer group
    - Aggression toward others
  - Verbalization escalating in intensity, or verbalization of intent accompanied by gesture or plan
  - Impaired thought processes (reality testing). Inability to perceive and validate reality to the extent that the child cannot negotiate his or her basic environment, nor participate in family or school (paranoia, hallucinations, delusions). The following indicators are examples of this behavior:
    - Disruption of safety of self, family, or peer or community group
    - Impaired reality testing sufficient to prohibit participation in any community educational alternative
  - Nonresponsive to outpatient trial of medication or supportive care
  - Severely dysfunctional patterns of behavior that prohibit any participation in a lower level of care – for example, habitual runaway, prostitution, or repeated substance abuse

- Member must show need for long-term treatment modalities. Modalities can include behavior modification treatment with some form of aversive therapy and operant conditioning procedures. Special, strictly educational programs do not qualify as behavior therapy. Modalities include multiple therapies such as group counseling, individual counseling, recreational therapy, expressive therapies, or so forth.

**Policy Parameters for Hospice Prior Authorization**

The Indiana Health Coverage Programs (IHCP) *Hospice Provider Manual*, which is available on the Manuals page at indianamedicaid.com, provides complete information about the hospice program. Specific criteria pertaining to PA for hospice services can be found in 405 IAC 5-34-4. The PA information that follows is a guideline for determining procedures requiring PA; however, see the IAC as the primary reference.
The hospice analyst reviews the following documentation for accuracy and completeness to authorize services for the requested period:

- Medicaid Physician Certification form – Indicates the hospice member’s prognosis and diagnosis that prompted hospice election
- Medicaid Hospice Election form – Indicates the IHCP member’s willingness to choose the service
- Medicaid Hospice Plan of Care form – Monitors treatment modalities and processes

The IHCP hospice provider must submit documentation to the ADVANTAGE Health Solutions PA Department within 10 days of the member’s election effective date, and for each benefit period for approval of the hospice benefit.

The hospice authorization enables reimbursement at all IHCP hospice LOC.

PA is required for any IHCP-covered service not related to the hospice member’s terminal condition, if PA is otherwise required.

PA is not required for pharmacy services (for conditions not related to the member’s terminal condition), dental services, vision care services, and emergency services.

**IHCP Managed Care Members Electing the Hospice Benefit**

Members must be enrolled in Care Select or with one of the managed care entities (MCEs) before hospice authorization can be completed. Members who elect to enroll in the IHCP hospice benefit become eligible for hospice care the day following disenrollment from Care Select or the MCE. Care Select, the FSSA’s managed care program for the aged, blind, and disabled, also excludes hospice members.

The hospice provider can determine whether the IHCP member is in Care Select or with an MCE by using one of the IHCP Eligibility Verification System options outlined in Chapter 3: Electronic Solutions of this manual. Hospice providers can fax member enrollment information, for Care Select or MCE members only, to the IHCP PA contractor. On receipt of the enrollment information, the hospice analyst contacts the appropriate person at the Care Select health plan or the MCE on the same day. The hospice provider may start billing the IHCP the day after the member is disenrolled.

The ADVANTAGE Health Solutions Hospice disenrollment fax line is (317) 810-4488. To facilitate the hospice authorization process, the hospice provider must fax the hospice election form to the ADVANTAGE Health Solutions-FFS PA Department to initiate the disenrollment of the member from Care Select or an MCE. The corresponding hospice physician certification form and hospice plan of care must be sent to the ADVANTAGE Health Solutions-FFS PA Department within 10 business days, as outlined in 405 IAC 5-34-4, to ensure that the request is timely.

If the hospice fails to check IHCP eligibility to determine whether a member is enrolled in Care Select or an MCE and fails to immediately fax the Medicaid Hospice Election form to the ADVANTAGE Health Solutions-FFS PA Department, the hospice provider will not receive payment for the dates of service when the IHCP member was still enrolled in Care Select or with an MCE.

To ensure that ADVANTAGE Health Solutions-FFS can coordinate with the Care Select or MCE contractor to disenroll a member from Care Select or the MCE on the same date, the ADVANTAGE Health Solutions-FFS PA Department must receive the Medicaid Hospice Election form by fax before 4 p.m. Eastern Time. This ensures that there is ample time for MAXIMUS Administrative Services to process the disenrollment on that day along with its overall workflow.
There are exceptional circumstances in which the IHCP reimburses the hospice for days the member was auto-enrolled in Care Select or MCE while the hospice authorization was in process. In those circumstances, the IHCP reimburses the hospice by special batch claim. A special batch claim appears on an upcoming Remittance Advice (RA) with an internal control number (ICN) that starts with 90, and the RA reflects the member name, recipient identification number (RID), hospice service dates, billed amount, and paid amount.

The IHCP issues special batch claims for the following scenarios in which a hospice provider admits a member enrolled in Care Select or an MCE to its hospice program:

- Weekend admissions can be faxed to ADVANTAGE Health Solutions FFS Prior Authorization Department after hours, nights, weekends, and holidays. The hospice must still meet the timeliness requirement of faxing the IHCP hospice election form on the first possible business day by the 4 p.m. deadline. For instance, if the member was admitted on Friday at 8 p.m., the IHCP Hospice Election form must be faxed to ADVANTAGE Health Solutions-FFS on the following Monday before the 4 p.m. deadline.

- If a member expires on the day of admission, ADVANTAGE Health Solutions-FFS cannot disenroll the member from the hospice program (even if the hospice provider faxed the form to ADVANTAGE Health Solutions-FFS the day of admission).

- One-day admissions in which the hospice member revokes or is discharged from hospice care are also treated for expenditure payout purposes as the one-day admission in which a member expires on the day of admission. Hospice providers are reminded that the IHCP does not pay for room and board under the IHCP hospice benefit if the hospice member expires or is physically discharged from the nursing facility on the day the member elected hospice. If an expenditure payout is warranted, the IHCP reimburses the hospice only for the hospice per diem.

To meet the parameters for the expenditure payout for the three scenarios outlined previously, the hospice must be able to follow these procedures:

- Produce a copy of the Medicaid eligibility verification strip that demonstrates that the hospice checked eligibility at admission, per the IHCP Provider Agreement.

- Fax the Medicaid Hospice Election form and other paperwork to ADVANTAGE Health Solutions-FFS on the first available business day so that ADVANTAGE Health Solutions-FFS can perform a review for medical necessity.

- Complete the UB-04 claim form so that the FSSA may request that HP issue an expenditure payout.

ADVANTAGE Health Solutions-FFS notifies the FSSA about each expenditure payout situation, and the FSSA then contacts the hospice provider regarding the required documentation.

To facilitate paperwork for hospice providers and to minimize the possibility of auto-enrollment of hospice members between hospice benefit periods, the following policy changes are in effect:

- The hospice provider may complete and fax to the ADVANTAGE Health Solutions-FFS Prior Authorization Unit the IHCP Hospice Physician Certification form and the IHCP hospice plan of care two weeks before the start date of the recertification period.

- The hospice provider must assume responsibility for contacting the ADVANTAGE Health Solutions-FFS hospice analyst before faxing the paperwork so that the ADVANTAGE Health Solutions-FFS hospice analyst can be prepared for its impending arrival.

- A quality assurance (QA) review before submitting documentation may eliminate return of incomplete forms.

Additional information regarding IHCP managed care members electing the IHCP hospice benefit can be found in Section 6 – Hospice Authorization Process of the IHCP Hospice Provider Manual.
Medicaid Hospice Authorization

Hospice providers should remember that the Medicare and Medicaid hospice programs are primarily for the treatment of terminal illness and related conditions. Home and Community-Based Services (HCBS) waiver programs and Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE) are supplements to Medicare or Medicaid hospice. From a funding stream perspective, the IHCP has always noted that there is a hierarchy of funding streams as follows:

- Private Pay/Medicare (Medicare Hospice)
- Medicaid (Medicaid Hospice)
- HCBS waiver programs
- CHOICE

Federal Medicare regulations require hospices to list on the plan of care the frequency and scope of all hospice-covered services needed to treat the terminal condition. Practices have included, but are not limited to, the following examples:

- Hospices indicating that homemaker services are not covered under the hospice program when the Medicare and Medicaid hospice per diems include homemaker services
- Hospices indicating that the member has declined home health aide services and that the family is providing these services when the corresponding HCBS waiver plan of care or CHOICE plan of care reflects that the member is receiving attendant care or home health aide services under these programs
- Hospice providers indicating that home health aide services can be provided only two times weekly and failing to explain what medical conditions or changes in the member’s medical acuity would warrant that the hospice plan of care be modified to increase the frequency and scope (to meet the member’s change in medical acuity)
- Hospice core nursing services being delegated to the HCBS waiver respite nurse
- Hospice durable medical equipment (DME) not being provided for the terminal illness while permitting HCBS waiver program to provide DME for the terminal illness
- Hospice-covered medications not being included in the hospice plan of care while the HCBS waiver program continued to pay for the medications required to treat the terminal diagnosis

In an effort to ensure better coordination among the personal care services, the IHCP requires hospice providers to submit the following additional documentation:

- On the Indiana Health Coverage Programs Prior Authorization Request Form, the hospice must list other care-giving services received by the member, including, but not limited to, services provided by HCBS waiver programs or CHOICE.
- The hospice plan of care must list the frequency and scope of the visits planned by each discipline to treat the member’s terminal illness and related conditions.
- The hospice plan of care must also list the frequency and scope of overlapping services provided by the HCBS waiver program or CHOICE for the member’s nonterminal conditions.

The IHCP requests this additional information to ensure coordination among the different hospice provider case managers. The Medicaid prior authorization unit can approve the medical necessity only with regard to the hospice care. The HCBS waiver case managers and CHOICE case managers must adjust their respective care plans. The IHCP or the FSSA has the discretion to review care plans from various programs to ensure that there is no duplication of service across program lines when serving a member.
Emergency Admission

An emergency service is a service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in one of the following situations:

- Serious jeopardy to the member’s health
- Serious impairment to body functions
- Serious dysfunction of any body organ or part

PA Not Required for Emergency Admissions for Burn Cases

All inpatient stays for burn care are excluded from prior authorization (PA) requirements when billed with an admit type 1 (emergency) or type 5 (trauma). If the member does not have PA, inpatient burn unit claims received with admit types other than 1 or 5 that group to a burn diagnosis-related group (DRG) will continue to deny for Edit 3007 – Dates of service not on PA database.

Emergency Admission Prior Authorization Policy Requirements – Hoosier Healthwise and Care Select Considerations

In accordance with Indiana Code (IC) 12-15-12-0.5, the covered inpatient and outpatient services are required to include the following procedures:

- Furnished by a provider qualified to furnish emergency services
- Needed to evaluate or stabilize an emergency medical condition

See Chapter 8: Billing Instructions of this manual or IC 12-15-12-0.3 for the definition of an emergency medical condition.

IC 12-15-12-0.7 also defines post-stabilization care services as covered services related to an emergency medical condition. These services are provided after a member is stabilized to maintain the stabilized condition, or under the circumstances described in the following subsections to improve or resolve the member’s condition.

Care Select

Urgent admissions that require PA must be reported to the ADVANTAGE Health Solutions-CS on the date of admission or within 48 hours of admission if the admission is after normal business hours. PAs may be faxed to the ADVANTAGE Health Solutions-CS Prior Authorization Department after hours, nights, weekends, and holidays. The same standards for PA are applied as would have been applied if the authorization had been requested before the admission. Hospital admission staff should notify ADVANTAGE Health Solutions of an admission via telephone.

The IHCP reimburses providers for post-stabilization care services for Care Select members under the following conditions:

- The services are pre-approved by the member’s PMP.
- The services are not pre-approved but are administered to maintain the member’s stabilized condition within one hour of a request for pre-approval of further post-stabilization care services.
• The services are not pre-approved but administered to maintain, improve, or resolve the member’s stabilized condition if any of the following occur:
  − ADVANTAGE Health Solutions-CS does not respond to a request for pre-approval within one hour.
  − ADVANTAGE Health Solutions-CS cannot be contacted.
  − ADVANTAGE Health Solutions-CS and the treating physician cannot reach an agreement concerning the member’s care.

**Risk-Based Managed Care**

Members enrolled in the RBMC component of Hoosier Healthwise or HIP can seek emergency care from providers not contracted with the managed care entity (MCE) without authorization, subject to the *prudent layperson standard* for emergency medical conditions. Information about MCE authorization procedures can be requested from the MCE at the telephone number provided by the IHCP Automated Voice Response (AVR) or Web interChange systems. Additional resources include *Chapter 1: General Information* of this manual or indianamedicaid.com.

For RBMC members, the member’s MCE is financially responsible for post-stabilization care services for members under the following conditions:

• The services are pre-approved by a representative of the member’s MCE.

• The services are not pre-approved but are administered to maintain the member’s stabilized condition within one hour of a request for pre-approval of further post-stabilization care services.

• The services are not pre-approved, but administered to maintain, improve, or resolve the member’s stabilized condition if any of the following occur:
  − The MCE representative does not respond to a request for pre-approval within one hour.
  − The MCE representative cannot be contacted.
  − The MCE representative and the treating physician cannot reach an agreement concerning the member’s care, and a physician representing the MCE is not available for consultation.

If the MCE representative and the treating physician cannot reach agreement, the MCE allows the member’s treating physician an opportunity to consult with a physician representing the MCE. The treating physician may continue with care of the member until a physician representing the MCE is reached or until one of the following criteria is met:

• A plan physician with privileges at the treating hospital assumes responsibility for the member’s care.

• A plan physician assumes responsibility for the member’s care through transfer.

• The MCE and treating physician reach an agreement concerning the member’s care.

• The member is discharged.

**Policy Parameters for Elective Hospital Inpatient Admission**

PA is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries, and newborn stays do not require PA. Observation does not require PA.

This requirement applies to members of all ages served by traditional Medicaid, those in the Care Select program, and, in some cases, dually eligible members. A member who is dually eligible for
Medicare and Medicaid must request Medicaid PA for an inpatient stay that is not covered by Medicare. If a stay is covered by Medicare, in full or in part, the member does not require PA. The effective date of January 1, 2011, applies to inpatient stays with an admit date on or after January 1, 2011.

Providers are required to contact ADVANTAGE Health SolutionsSM (1-800-784-3981) at least two business days before admission. All inpatient hospital PAs are requested via telephone. The facility must call before the admission and provide criteria for medical necessity. Retroactive PA for dual members may be requested if Medicare will not cover the inpatient stay because the member has exhausted his or her Medicare benefit or if the stay is not a Medicare-covered service.

The IHCP follows Milliman guidelines for all nonemergent and urgent care inpatient admissions. If IHCP criteria already exist, that criteria are used first when determining if admissions are appropriate. If criteria are not available within Milliman or IHCP policy, the IHCP relies on medical necessity determination of current evidence-based practice. To ensure a 48-hour turnaround, the PA request should be made by a clinical staff person. For nonemergent and urgent care admissions that occur outside normal business hours, including weekends and holidays, providers have 48 hours from the time of admission to request PA.

When requesting a prior authorization, providers must provide the following information:

- Member name and RID
- Procedure requested, including Current Procedural Terminology (CPT) code
- Location service is to be performed (facility)
- Medical condition being treated, including the ICD code
- Medical necessity of the procedure
- Admitting physician or surgeon
- Date of admission
- The estimated length of stay (LOS)
- National Provider Identifier (NPI)
- Documentation of the denial, if requesting retroactive PA for a dually eligible member who has had coverage denied by Medicare
Section 5: Non-Institutional Prior Authorization
Policy Parameters

General Information

This section outlines prior authorization (PA) guidelines for non-institutional providers. The information in this section is a guideline for determining PA requirements. Specific PA criteria about non-institutional provider services are found in 405 IAC 5.

Practitioner Prior Authorization Policy Requirements

PA for services rendered by practitioners is described in the following paragraphs. The following specific practitioner types are outlined in this manual:

- Doctor of chiropractic medicine (DCM)
- Doctor of medicine (MD)
- Doctor of osteopathy (DO)
- Doctor of podiatric medicine (DPM)
- Health services provider in psychology (HSPP)
- Optometrist
- Dental providers

Physician Services

Specific criteria about PA for medical services are found in 405 IAC 5-25. These PA requirements are a guideline for determining procedures that require PA, but the Indiana Administrative Code (IAC) should be referred to as the primary reference.

The following medical services require PA as specified in 405 IAC 5-3-13(a):

- Reduction mammoplasties
- Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem
- Intersex surgery
- Blepharoplasties for significant obstructive vision problems
- Sliding mandibular osteotomies for prognathism or micrognathism
- Reconstructive or plastic surgery
- Bone marrow or stem-cell transplants
- All organ transplants covered by the Medicaid program
- Home health services
- Maxillofacial surgeries related to diseases of the jaws and contiguous structures
- Submucus resection of nasal septum and septoplasty when associated with significant obstruction
• Weight reduction surgery, including gastroplasty and related gastrointestinal surgery
• Procedures ordinarily rendered on an outpatient basis, when rendered on an inpatient basis
• Brand medically necessary drugs
• Psychiatric inpatient admissions, including admissions for substance abuse
• Rehabilitation inpatient admissions
• Genetic testing for detection of cancer of the breasts or ovaries
• Long-term acute care hospitalizations
• Mastectomies for gynecomastia
• Psychiatric residential treatment facility services
• Surgical procedures involving the foot; see also podiatry services

**Note:** Outpatient mental health services require PA after 20 visits. See Chapter 8: Billing Instructions for a list of applicable CPT codes included in this requirement.

Evaluation and management (E/M) services are limited to a maximum of 30 office visits per member per provider per rolling 12-month period without PA. Additional office visits require PA and must be medically necessary.

E/M services listed in Table 6.12 require PA after 30 visits per member per rolling calendar year.

**Table 6.12 – Evaluation and Management Services Requiring PA after 30 Visits per Member per Rolling Calendar Year**

<table>
<thead>
<tr>
<th>E/M Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205</td>
<td>New patient, office, or other outpatient services</td>
</tr>
<tr>
<td>99211-99215</td>
<td>Established patient, office, or other outpatient services</td>
</tr>
<tr>
<td>99381-99387</td>
<td>New patient, initial visit, preventive medicine</td>
</tr>
<tr>
<td>99391-99397</td>
<td>Established patient, periodic visit, preventive medicine</td>
</tr>
</tbody>
</table>

Any physician service rendered during an inpatient hospital stay requiring PA and paid for under a Level of Care (LOC) methodology – such as psychiatric, rehabilitation, and burn stays – that did not receive PA is not reimbursed.

**Podiatry Services**

Specific criteria pertaining to PA for podiatry services are found in 405 IAC 5-26. The IAC should be referred to as the primary reference.

Prior authorization is required for the following:
• Hospital stays as outlined in 405 IAC 5-17.
• When a podiatrist prescribes or supplies corrective features built into shoes, such as heels, lifts, and wedges, for a member under 21 years of age.
• When a podiatrist fits or supplies orthopedic shoes for a member with severe diabetic foot disease subject to the restrictions and limitations outlined in 405 IAC 5-19.

Any podiatry service rendered during inpatient days that was not prior authorized is not reimbursed.

Any podiatry service rendered during an outpatient visit that was not prior authorized is not reimbursed.

**Chiropractic Services**

Specific criteria pertaining to PA for chiropractic services can be found in 405 IAC 5-12. The IAC should be referred to as the primary reference.

Reimbursement is limited to a total of 50 office visits or treatments per member per year, which includes a maximum reimbursement of no more than five office visits per member per year.

**Dental Services**

Specific criteria pertaining to PA for dental services can be found in 405 IAC 5-14. The IAC should be referred to as the primary reference. Chapter 8: Billing Instructions of this manual contains additional policies and billing procedures for dental services.

**Dentures**

Under an agreement approved by the court, Indiana Medicaid has agreed not to deny Medicaid coverage for medically necessary dentures, partial dentures, and associated repairs and relines, based on the fact that the Medicaid member on whose behalf the request for services is made received such services within the last six years, when the services are otherwise covered.

Under the terms of the agreement, the State is permitted to deny coverage of these services if the member is no longer eligible for Medicaid, or if the State determines that the request is not medically necessary. The court also allows Medicaid to require the member to use the most cost-effective treatment instead of the specifically requested treatment, as long as the cost-effective procedures meet the medically necessary needs of the member. Indiana Medicaid is requesting that dental providers work with members that meet this criterion and resubmit the PA request for consideration.

Under the agreement, a service is “medically necessary” when it meets the definition of “medically reasonable and necessary service” as defined in 405 IAC 5-2-17. Indiana Medicaid determines medical necessity by reviewing documentation submitted by the provider to support the functional and medical needs of the member. When submitting the Indiana Prior Review and Authorization Dental Request form, the dentist should complete all applicable information and include all descriptions necessary to create a complete clinical picture of the member and the need for the request. The request should include any information about bone or tissue changes due to shrinkage, recent tooth loss, weight loss, bone loss in the upper or lower jaw, recent sickness or disease, or any changes due to physiological aging. If the member’s primary source of nutrition is parenteral or enteral nutritional supplements, a plan of care to wean the member from the nutritional supplements must be included with the request. The dentist office’s telephone number must also be included on the PA request, in case the PA analyst has questions. Prior authorization is not required for members younger than 21 years of age; however, the provider must maintain documentation to support medical necessity in the member’s medical record.

Medical necessity is determined by documentation supporting the functional, medical need for the complete or partial denture. Eight posterior teeth in occlusion and four maxillary and four mandibular teeth in functional contact with each other are considered adequate for functional purposes.
Immediate dentures (D5130 and D5140) are covered for adults only; however, the Indiana Health Coverage Programs (IHCP) does not reimburse an additional amount for immediate dentures beyond the current denture allowance. The 60-day waiting period between the date of the last extraction and the date of the initial impression is waived. However, additional charges related to furnishing dentures before the 60-day waiting period are not reimbursed. The member may be held responsible for these additional charges if advance notice is given and documented in the record.

**Partials**

Acrylic partial dentures (D5211 and D5212) are covered when medically necessary based on the previously listed criteria. Cast metal partial dentures (D5213 and D5214) are covered for members with facial deformities due to congenital, developmental, or acquired defects. Flexible base partial dentures (D5225 and D5226) are covered for members with facial deformities due to congenital, developmental, or acquired defects, as well as members with documented allergic reactions to other denture materials.

**Partials for Replacement of Anterior Teeth Only**

Requests for partial dentures that replace anterior teeth only are not approved. Anterior tooth replacement is considered purely an aesthetic or cosmetic concern and not medically necessary.

**Relines and Repairs**

Denture relines (D5750-D5761), repairs to dentures (D5510 and D5520), and repairs to partial dentures (D5610-D5660) are covered only when the reline or repair extends the useful life of a medically necessary denture or partial that is six or more years old. Members 21 years of age and older require PA for relines and repairs to dentures and partials. The PA request must indicate that the member is eligible for a new prosthesis, but a repair or reline will extend the useful life of the existing prosthesis. PA is not required for members younger than 21 years of age; however, documentation to support medical necessity must be maintained by the provider in the medical record.

**Prior Authorization for Dental Procedures at a Hospital or Ambulatory Surgical Center**

Certain steps must occur when obtaining IHCP PA for dental procedures when the service is performed in a hospital or an ambulatory surgical center (ASC). The steps are as follows:

- For members in Care Select, obtain PA for dental procedures and related facility and anesthesia services by contacting the member’s primary medical provider (PMP) for authorization.

- For members in one of the Hoosier Healthwise managed care entities (MCEs):
  - For State dental procedures subject to PA, the provider must contact ADVANTAGE Health Solutions-FFS by calling 1-800-269-5720. Providers must check the IHCP Provider Manual, bulletins, and banner pages for dental procedures that require PA. Submit claims for dental procedures to HP for claims processing and payment.
  - PA for facility and anesthesia services must be requested by contacting the MCE in which the member is enrolled.

**Orthodontic**

The IHCP covers orthodontic procedures for members younger than 21 years of age. All orthodontic services require PA. See Chapter 8: Billing Instructions of this manual for additional information. For PA questions, contact ADVANTAGE Health Solutions SM at 1-800-269-5720.
Spinal Cord Stimulation

Spinal cord stimulation (SCS) is used to treat chronic pain syndromes intractable to other treatment modalities. SCS is frequently used to treat failed back surgery, complex regional pain syndromes, peripheral neuropathies, angina, peripheral vascular disease, post-herpetic neuralgia, occipital neuralgia, and chronic pelvic pain. This treatment is considered a last resort for members who have not benefited from other treatment options for the management of intractable, chronic pain. SCS is a covered service for all IHCP programs.

Spinal Cord Stimulation Prior Authorization Criteria

SCS treatment must be evaluated in a three- to seven-day trial stimulation period before permanent implantation. Providers must request PA for the trial and permanent phases of this service. The IHCP covers SCS services only with the appropriate ICD codes, CPT codes, and HCPCS codes. All other diagnoses of chronic, nonmalignant, neuropathic pain are considered for approval on a case-by-case basis by a pain management consultant if all other PA criteria are met.

For SCS billing requirements, see Chapter 8: Billing Instructions of this manual.

Genetic Testing

This section covers the PA criteria for genetic testing for breast and ovarian cancer (BRCA). See Chapter 8: Billing Instructions for billing requirements.

Breast and Ovarian Cancer

The IHCP grants PA for genetic testing related to breast and ovarian cancer, using the HCPCS codes listed in Chapter 8: Billing Instructions, when medically necessary in the following circumstances. Providers must submit documentation with the PA request and must maintain the documentation in the member’s medical record:

- Clinically affected members (invasive breast cancer or ovarian cancer at any age) meeting at least one of the following criteria:
  - One or more first-degree (mother, father, sister, or daughter) or second-degree (aunt, uncle, grandmother, niece, or granddaughter) relatives with invasive breast cancer diagnosed before age 50
  - One or more first- or second-degree relatives with ovarian cancer
  - One or more first- or second-degree relatives with male breast cancer
- Members with a personal history of at least one of the following (no family history required):
  - Invasive breast cancer before age 50
  - Ovarian cancer at any age
  - Both invasive breast cancer and ovarian cancer at any age
  - Male breast cancer at any age
- Members with a family member (related by blood) with a known BRCA 1 or BRCA 2 mutation
- Members with Ashkenazi (Eastern European) Jewish ancestry with invasive breast cancer at any age or meeting any of the preceding criteria
BRCA testing of men with breast cancer is considered medically necessary for either of the following indications:

- To assess the man’s risk of recurrent breast cancer
- To assess the breast cancer risk of a female member where the affected male is a first- or second-degree blood relative of that member

BRCA 1 and BRCA 2 testing to assess the risk of breast or prostate cancer in men without breast cancer is considered not medically necessary.

**Genetic Testing for Management of Breast Cancer Treatment**

The IHCP requires PA for Oncotype DX genetic testing of breast cancer tumors. To obtain PA for S3854, all the following criteria must be met:

- Member has had surgery and full pathological evaluation of the specimen has been completed.
- Histology is ductal, lobular, mixed, or metaplastic.
- Histology is not tubular or colloid.
- Estrogen reception is positive (ER+), or progesterone receptor is positive (PR+), or both.
- HER2 receptor is negative.
- pN0 (node negative) or pN1mi with axillary lymph node micrometastasis is less than or equal to 2mm.
- Member has one of the following:
  - Tumor size 0.6-1.0 cm moderate/poorly differentiated
  - Tumor size 0.6-1.0 cm well-differentiated with any of the following unfavorable features: angiolymphatic invasion, high nuclear grade, or high histologic grade
  - Tumor size greater than 1.0 cm and less than or equal to 4.0 cm
- Member does not have a pT4 lesion.
- Chemotherapy is a therapeutic option being considered and will be supervised by the practitioner ordering the gene expression profile.

**Chromosomal Microarray Analysis Genetic Testing**

The IHCP requires PA for Chromosomal Microarray Analysis (CMA) testing. To obtain PA, all the following conditions must be met:

- Any indicated biochemical tests for metabolic disease have been performed, and results are nondiagnostic.
- FMR1 gene analysis (for Fragile X), when clinically indicated, is negative.
- In addition to a diagnosis of nonsyndromic developmental delay/intellectual delay (DD/ID) or Autism Spectrum Disorder (ASD), the child has one or more of the following:
  - Two or more major malformations
  - A single major malformation or multiple minor malformation in an infant or child who is also small-for-dates
  - A single major malformation and multiple minor malformations
• The results for the genetic testing have the potential to impact the clinical management of the member.
• Testing is requested after the parents have been engaged in face-to-face genetic counseling with a healthcare professional who is licensed under Indiana Code Article 25-17.3.

Practitioner Prior Authorization Policy Parameters – Managed Care Considerations

Care Select

PA requirements are uniform for members enrolled in Traditional Medicaid and Care Select. To determine medical necessity, the ADVANTAGE Health Solutions PA Department reviews all requests for Traditional Medicaid members and Care Select members. Requests may be suspended for information not previously requested. Removal of services from PA does not modify the current requirement for PMP certification for Care Select members for other services. Additional information about PMP authorization for services provided to Care Select members is in the CMO provider manuals found on the CMO websites for Care Select.

Risk-Based Managed Care

Services rendered to members enrolled in risk-based managed care (RBMC) that are not carved out are authorized by the MCEs and subject to the appropriate criteria. Additional information or questions about the MCE authorization procedure should be directed to the MCE specified on the member’s eligibility record. The specific MCE information is available through the IHCP Automated Voice Response (AVR) system, Web interChange, or the electronic 270/271 transaction. Additional resources include Chapter 1: General Information of this manual or indianamedicaid.com.

The criteria for review and approval may vary from one MCE to another. For information about PA for one of the Hoosier Healthwise MCEs, please contact the appropriate MCE using the contact information presented in Chapter 1: General Information of this manual.

Home Health Prior Authorization Policy Requirements

All home health services require PA, except services ordered in writing by a physician before the member’s discharge from a hospital, and that do not exceed 120 hours within 30 days of discharge. These limits refer to services provided by a registered nurse, licensed practical nurse, and home health aide. Therapies such as occupational, physical, and speech are limited to 30 units of service within 30 days of an inpatient discharge from a hospital. The hospital discharge date is counted as day one.

An authorized representative of the home health agency (HHA) submits PA requests for home health agency services. The PA form must contain the information specified in Section 2: Prior Authorization Procedures of this chapter. In addition, the following information must be submitted with the Indiana Health Coverage Programs Prior Authorization Request Form, which is available on the Forms page at indianamedicaid.com:

• Copy of the written plan of treatment, signed by the attending physician, current through date of request
• Estimate of costs for the required services as ordered by the physician and set out in the written plan of treatment
  – The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.
• Number and availability of nonpaid caregivers that assist in member care (even if none is available)
• Number of members receiving home health services in a single household, so that care can be coordinated to use services in the most efficient manner
• Number of hours of service per day, number of visits per day, and number of days per week the service is to be provided
• More than three home health visits per day, provided to the same household or member
• Other non-IHCP home health services provided to the IHCP member, including (not limited to) the following:
  – Medicare
  – Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE) program
  – IHCP waiver programs
  – Private insurance
  – Private pay
  – School systems
  – Any other paid caregivers

  Note: Include the number of hours per day and number of days per week for each of these services.

For specific PA criteria for home health services, see 405 IAC 5-16.

**Home Health Nursing Services**

Specific criteria pertaining to PA for nursing services can be found in 405 IAC 5-22-2. The following PA requirements should be used as a guideline for determining procedures requiring PA, but the IAC is the primary reference.

IHCP reimbursement is available for intermittent or part-time nursing provided in the home by visiting nurse services. PA is required for all nursing services rendered by registered nurses (RNs), licensed practical nurses (LPNs), and home health aides from agencies that are IHCP providers. The exceptions are services ordered in writing by a physician before the member’s discharge from an inpatient hospital. These services may continue for a period not to exceed 120 hours within 30 days of discharge.

PA includes consideration of the following information:
• Prescribed or ordered in writing by a physician
• Provided in accordance with a written plan of treatment developed by the attending physician
• Intermittent or part-time, except for ventilator-dependent members with a developed plan of home healthcare
• Deemed medically reasonable and necessary
• Deemed less expensive than any alternate mode of care
• Provided to a member at his place of residence per 405 IAC 1-4.2-2
  - A member may work or attend school outside the home and still receive Medicaid home health services. The PA request must specify the assistance needed to complete these outside activities.

• Physical therapy, occupational therapy, and respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in 405 IAC 5-22-8, 405 IAC 5-22-10, and 405 IAC 5-22-11

• Written evidence of physical involvement and personal member evaluation is required to document the acute medical needs. A current plan of treatment and progress notes about the necessity and effectiveness of therapy must be attached to the PA request, and a copy must be available for post-payment audit.

Members are accepted for care on the basis of a reasonable expectation that the agency can adequately meet the member’s health needs in the member’s residence. Medical care must follow a written medical plan of care established and periodically reviewed by the physician or attending physician as follows:

(1) The medical plan of care shall be developed in consultation with the agency staff and in consideration of all pertinent diagnoses, including the following:

   (A) Mental status
   (B) Types of services and equipment required
   (C) Frequency of visits
   (D) Prognosis
   (E) Rehabilitation potential
   (F) Functional limitations
   (G) Activities permitted
   (H) Nutritional requirements
   (I) Medications and treatments
   (J) Safety measures to protect against injury
   (K) Instructions for timely discharge or referral
   (L) Other appropriate items

Orders for therapy services include the specific procedures and modalities to be used, and the amount, frequency, and duration of each. The therapist and other agency personnel participate in developing the medical plan of care.

(2) The total medical plan of care must be reviewed by the physician or attending physician and home health agency personnel as often as the severity of the member’s condition requires, but at least once every two months. Agency healthcare professional staff must promptly alert the person responsible for the medical component of the member’s care to any changes that suggest a need to alter the medical plan of care. A written summary for each member must be sent to the physician or attending physician at least every two months.

When an existing plan of care overlaps a new prior authorization request, the clinical summary portion of the prior authorization form should be updated to reflect any change in the member’s status. For example, if the plan of care covers a period from March 15 to May 15, and the new prior authorization request is from April 20 to October 20, the plan of care period overlaps the requested prior authorization period; therefore, the clinical summary portion of the prior authorization form should be updated to reflect any change in the member’s status.

An encounter is a direct personal contact between a member and the person authorized by the home health agency to furnish services to the member. The frequency of visits is the number of encounters in a given period between a member and the person authorized by the home health
agency to furnish services to the member. Frequency of visits may be expressed as a number or range. The number of encounters must be at least one.

Note: To meet Indiana State Department of Health (ISDH) and PA guidelines, the specific frequency and duration must be on the signed plan of care and the prior authorization request, as given in the following example: A skilled nurse is required for wound care setup, two hours per day, Monday through Friday, for nine weeks.

A similar federal regulation is cited at 42 CFR 484.18(a):

(a) Standard: Plan of Care: The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of care.

Health-related nursing care, such as homemaker, chore services, and sitter or companion services, are not covered except as specified under applicable IHCP waiver programs.

The IHCP may grant PA for skilled services under the home health benefit; however, the HHA must bill the IHCP for services that were provided as described in the following example:

• The skilled nurse renders home health aide services because the agency was unable to contract a home health aide.

The agency must then document that the nurse rendered the home health aide service. The agency must bill the IHCP using the appropriate code for home health aide services. If the post-payment review identifies that the agency billed for skilled nursing services rather than for home health aide services, the IHCP recoups the overpayment.

Therapy Prior Authorization Policy Requirements

Specific criteria pertaining to PA for therapy services can be found in 405 IAC 5-22-6 through 405 IAC 5-22-11. The following PA requirements should be used as a guideline for determining procedures requiring PA, but the IAC is the primary reference.

Therapy services can be reimbursed to HHAs or directly to an individual therapy provider. Prior review and authorization are required for all therapy services with the following exceptions:

• Initial evaluations
• Emergency respiratory therapy
• Any combination of therapy services ordered in writing by a physician at the member’s hospital discharge, up to 30 hours, sessions, or visits in 30 calendar days
• Deductible and copayment for services covered by Medicare Part B
• Oxygen equipment and supplies necessary for the delivery of oxygen in nursing facilities included in the facility’s per diem rate

• Therapy services provided by a nursing facility, or large private or small intermediate care facility for individuals with intellectual disability (ICF/IID), which are included in the facility’s per diem rate

The following criteria for PA of therapy services apply to occupational therapy, physical therapy, respiratory therapy, and speech pathology:

• Written evidence of physical involvement and personal member evaluation is required to document acute medical needs. A physician (MD or DO) must order therapy. A current plan of treatment and progress notes (about the necessity and effectiveness of therapy) must be attached to the PA request and be available for audit purposes.

• A qualified therapist or qualified assistant under the direct supervision of the therapist must provide therapy.

• Therapy must be of a level of complexity and sophistication, and the condition of the member must be such that the judgment, knowledge, and skills of a qualified therapist are required.

• IHCP reimbursement is available only for medically necessary therapy.

• Therapy for rehabilitative services is covered for a member no longer than two years from the initiation of the therapy, unless there is a significant change in medical condition requiring longer therapy. Rehabilitative services for members younger than 18 years old can qualify for PA for longer periods on a case-by-case basis, as can respiratory therapy services.

• Maintenance therapy, as defined in 405 IAC 5-22-1, is not a covered service. The ruling in A.M.T. et al. vs. Michael Gargano (S. D. Ind. 2011), Cause Number 1:10-cv-0358-JMS-TAB, should be taken into consideration.

• Ongoing progress evaluations are not separately reimbursed under the IHCP. When a member is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program.

• An hour of billed therapy service must include a minimum of 45 minutes of direct member care, with the balance of the hour spent in related member services.

• Therapy services are not approved for more than one hour per day per type of therapy.

• Requests for therapy services that would duplicate other services provided to a member are not eligible for prior authorization.

Home Health/Nursing/Therapy Prior Authorization Policy Requirements – Hoosier Healthwise Considerations

If a member changes programs between Traditional Medicaid (FFS) or Care Select, PAs that are approved by ADVANTAGE Health Solutions PA Department are available in IndianaAIM for claims processing by HP and do not require a new request.

If a member changes programs from Hoosier Healthwise or HIP to Traditional Medicaid or Care Select, PAs that are approved by a Hoosier Healthwise plan are not available in IndianaAIM for claims processing. See Outstanding Prior Authorizations for Nonpharmacy Services for information regarding the process of transferring a PA to Traditional Medicaid or the new CMO.
Risk-Based Managed Care

PA requirements must follow the guidelines set forth in IAC 5-22-2 (nursing services; prior authorization requirements). Additional information about MCE authorization procedures can be directed to the MCE at the telephone number provided through the IHCP AVR system, Web interChange, or electronic 270/271 transaction. Other resources include Chapter 1: General Information of this manual or indianamedicaid.com.

Outpatient Mental Health Prior Authorization Policy Requirements

Specific criteria pertaining to PA for outpatient mental health services are found in 405 IAC 5-20-8. The following PA requirements should be used as a guideline for determining procedures requiring PA, but the IAC is the primary reference.

• PA is required for mental health services provided in an outpatient or office setting that exceed 20 units per member, per provider, per rolling 12-month period.

A current plan of treatment and progress notes about the necessity and effectiveness of therapy must be attached to the PA form, and a copy must be available for audit purposes.

Neuropsychological and Psychological Testing

PA is required for all units of neuropsychological and psychological testing. This applies to Current Procedural Terminology (CPT) codes 96101 – Psychological testing, 96110 – Developmental screening, 96111 – Developmental testing, and 96118 – Neuropsychological testing.

Psychiatric Diagnostic Interviews

One unit is allowed for psychiatric diagnostic interviews per provider, per member, per 12 months without PA; except as follows:

• A maximum of two units per rolling 12-month period of time per member, per provider, may be reimbursed without PA, when a member is separately evaluated by both a physician or HSPP and a midlevel practitioner. This applies to CPT codes 90791 – Psychiatric diagnostic evaluation and 90792 – Psychiatric diagnostic evaluation with medical services. Of the two units allowed without PA, one unit must be provided by the physician or HSPP and one unit must be provided by the midlevel practitioner.

All additional units of psychiatric diagnostic interviews require prior authorization.

Medicaid Rehabilitation Option Services

Per 405 IAC 5-21.5-17(b), PA is required for Medicaid Rehabilitation Option (MRO) services under the following circumstances:

• A member has used all units of one or more of the services authorized in the service package within the defined service package term, and additional units of that service are needed.

• A member needs a service that is not authorized within a service package.

• A service package that is provided through a certified DMHA ACT team.
A member who is denied an MRO service package may submit prior authorization for a specific MRO service.

Services may be prior authorized for retroactive Medicaid eligibility periods.

405 IAC 5-21.5-17(c) provides the following providers, as referenced in 405 IAC 5-3-13, may submit prior authorization:

- Doctor of medicine
- Doctor of osteopathy
- HSPP

**Care Select**

Members enrolled in Care Select can continue to access mental health services on a self-referral basis from any IHCP-enrolled provider qualified to render the service; these members are subject to all PA criteria established for IHCP fee-for-service (FFS) billing. Mental health services rendered to members enrolled in Care Select and provided by facilities, physicians, or practitioners enrolled in the IHCP with specialties other than mental health are subject to authorization by the member’s PMP, and are billed to HP as FFS claims.

**Risk-Based Managed Care**

Members enrolled with an MCE in the risk-based component of Hoosier Healthwise or HIP can continue to access mental health services on a self-referral basis from any IHCP-enrolled provider qualified to render the service. The authorization and reimbursement entity for mental health services for MCE-enrolled members depends on the specialty under which the billing provider is enrolled.

Services rendered to MCE-enrolled members by IHCP providers that are performing services under the MRO or specialty of psychiatric residential treatment facilities (PRTFs) are carved out of the MCE’s responsibility and are subject to all PA and reimbursement criteria established for IHCP FFS billing. PAs are submitted to the ADVANTAGE Health Solutions-FFS PA address, and claims are submitted to HP using the IHCP FFS criteria.

Mental health services rendered to MCE-enrolled members, which are provided by facilities, physicians, or practitioners that the IHCP enrolled with specialties other than PRTF or performing services under the MRO, are the responsibility of the MCE and are authorized and reimbursed by the MCE.

For additional information about MCE authorization procedures, call the MCE at the telephone number provided through the IHCP AVR system, Web interChange, or electronic 270/271 transaction. Other resources include Chapter 1: General Information of this manual or indianamedicaid.com.

**Medical Supplies and Equipment Prior Authorization Policy Requirements**

Specific criteria pertaining to PA for medical supplies, durable medical equipment (DME), and home medical equipment (HME) can be found in 405 IAC 5-19. The following PA requirements should be used as a guideline for determining procedures requiring PA, but the IAC and any subsequent bulletins are the primary reference.
Medical Supplies

Two vendors are contracted by the Indiana Health Coverage Programs (IHCP) to provide incontinence, ostomy, and urological supplies, including diapers, underpads, ostomy bags, and gloves, to fee-for-service (FFS) members. The contracted vendors are the following:

- **Binson’s Home Health Care Centers**
  1-888-217-9610
  binsons.com

- **J&B Medical Supply Company**
  1-866-674-5850
  jandbmedical.com

Members enrolled in the 590 Program, Medical Review Team (MRT), First Steps, Pre-Admission Screening and Resident Review (PASRR), Long Term Care, and risk-based managed care (RBMC) programs are excluded from this policy change.

Members with Medicare or third-party insurance must follow the guidelines of Medicare or their primary insurance plans to receive reimbursement of these products. Crossover claims, crossover Medicare Replacement Plan, and claims with a third-party payment amount indicated for these supplies are not affected by this policy change.

Before supplying these products, providers must verify the following:

- Member’s Medicare eligibility and product coverage for the date of service
- Member’s eligibility and product coverage from the primary carrier for the date of service

If Medicare or the primary carrier does not cover this type of service, the claims process following Medicaid rules as though Medicaid is primary. In this case, claims from a noncontracted vendor are denied.

There are instances when the use of tapes, adhesives, gloves, and other supplies are not related to incontinence, ostomy, or urological conditions. IHCP members are not restricted to purchasing the following supplies listed only through mail order from one of the two contracted vendors. Therefore, the following codes are billable by appropriate providers:

- A4364 (adhesive liquid)
- A4456 (adhesive remover wipes)
- A4402 (lubricant)
- A4450 and A4452 (tape)
- A4455 (adhesive remover)
- A4927 (gloves)
- A5120, A5121, and A5122 (skin barrier)

See *Incontinence, Ostomy, and Urological Supplies Covered only under Contract* on the Code Sets page at indianamedicaid.com for a list of the procedure codes for supplies affected by the policy change. Claims for these supplies are denied if billed by noncontracted providers.

Members are required to participate in a nursing assessment to help determine the appropriate products, brands, and quantities. All nursing assessments are performed by a licensed nurse who is employed by the vendor.
PA is not required for the reimbursement of incontinence supplies unless they are supplied by an out-of-state provider or the member is using high-end incontinence products. Prior authorization for high-end incontinence products will be granted based upon medical necessity. The following information must be submitted to determine medical necessity:

- Member has sampled all applicable products from the two vendors and submitted documentation indicating why the products sampled were not appropriate (for example, leakage, skin breakdown, and so on).

High-end incontinence products are currently limited to only HCPCS T codes listed in *Incontinence, Ostomy, and Urological Supplies Covered only under Contract* on the Code Sets page at indianamedicaid.com. For high-end products, provider must submit claim with U9 modifier for the claim to process correctly.

**Monthly Maximum and Annual Allowance for Incontinence Supplies Per Member**

The monthly maximum allowable reimbursement for incontinence supplies is $162.50 per member.

The annual maximum allowable reimbursement continues to be $1,950 per member. The total for any combination of supplies billed using codes listed in *Incontinence, Ostomy, and Urological Supplies Covered only under Contract* on the Code Sets page at indianamedicaid.com is limited to $1,950 per member, per rolling calendar year.

Incontinence supplies can be provided to members only in 30-day increments. Although a physician may write an order for a longer period of time, providers may provide each member with only a 30-day supply at a time.

The incontinence codes applicable to the monthly and annual maximum are shown in *Incontinence, Ostomy, and Urological Supplies Covered only under Contract* on the Code Sets page at indianamedicaid.com.

**Durable Medical Equipment and Home Medical Equipment**

PA is required for all DME and HME rented or purchased with IHCP funds, except for the following items:

- Cervical collars
- Back supportive devices, such as corsets
- Hernia trusses
- Oxygen — and supplies and equipment for its delivery for nursing facility residents
- Parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters
- Eyeglasses

In accordance with IC 12-15-21-6, see the Fee Schedule at indianamedicaid.com to see if DME and HME require PA.

PA is required for oxygen concentrators, except when used for nursing facility residents certified by a physician as needing oxygen therapy.

All oxygen equipment and supplies, including concentrators and portable liquid oxygen equipment, require PA for members in home settings. A physician must certify the member’s need for oxygen.
The IHCP does not require PA for ventricular assist devices (VADs) and their surgical implantation. However, members who receive bridge-to-transplant or destination therapy, and who can continue therapy on an outpatient basis, require accessory equipment for use with the VAD. Patient supplies and replacement of this equipment do require PA.

The VAD powerbase is the electrical supply for the VAD. The hospital or DME provider purchases the equipment and loans it to the member. The physician must submit a PA request for HCPCS code L9900 – Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code and modifier R – rental use. Additionally, PA is required for patient supplies and replacement equipment such as the system controller, rechargeable batteries, travel case, shower kit, and other miscellaneous supplies.

Designated DME, HME, or medical supplies require that a Medical Clearance form be submitted with the PA request to justify medical necessity. See Section 2: Prior Authorization Procedures of this chapter for specific procedures and a comprehensive list of items requiring a Medical Clearance form.

All repairs of purchased DME and HME require PA.

PA requests for DME and HME are reviewed on a case-by-case basis, using the following criteria:

- The item must be medically necessary for the treatment of an illness or injury, or to improve the function of a body part.
- The item must be adequate for the medical need; however, items with unnecessary convenience or luxury features are not authorized.
- The anticipated period of need, plus the cost of the item, is considered in determining whether the item is rented or purchased.

Standard wheelchairs are included in the nursing home per diem rate per 405 IAC-5-13-3. A request for prior authorization of a custom wheelchair for a member in a long-term care (LTC) facility can be submitted only if there is medical necessity for the custom wheelchair. For example, if the member’s diagnosis requires sitting in a particular upright position due to a breathing difficulty, there may be a need for a customized wheelchair. The normal PA process must be followed, using IHCP PA and medical clearance forms.

LTC members receive 24-hour care in nursing facilities. This care includes safety, propulsion, and evaluation of the member for skin breakdown, and following an active plan of care to prevent and treat decubitus ulcers. Therefore, custom wheelchairs should not be requested for the sole purpose of providing safety, preventing decubitus ulcers, allowing self-propulsion, or providing restraint.

HCPCS code E1028 – Wheelchair accessory, manual swing-away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory must be used for PA and billing for universal headrest plates. Requests for approval of the universal headrest plate using HCPCS code E1399 – Durable medical equipment, miscellaneous deny for appropriate coding. Providers should submit their usual and customary charge (UCC) using HCPCS code E1028.

Reimbursement of the universal headrest plates are subject to the following PA criteria:

- Universal headrest plates are covered when the initial headrest ordered for a new wheelchair does not meet the member’s needs upon the first or subsequent fittings. On the PA request, the provider must document the brand name and model of the original headrest and include an explanation of why the headrest did not meet the member’s needs. The provider must indicate the brand name and model of the subsequent headrest to be used on the wheelchair.
- Universal headrest plates are covered for a used wheelchair if the member’s condition changes and the wheelchair back is not predrilled for the headrest. The provider must provide documentation of the medical necessity for the headrest.
• Replacement universal headrest plates are covered with documentation of an explanation for the replacement (for example, plate is damaged due to high tone or spasticity of the member).

Universal headrest plates are not covered for the initial headrest ordered for use on a new wheelchair. The wheelchair back should be pre-drilled to accommodate the headrest initially ordered with the wheelchair. Providers should direct questions to Customer Assistance at 1-800-577-1278.

Automatic External Defibrillators and Wearable Cardioverter Defibrillators

The IHCP covers two types of automatic external defibrillators (AEDs) with PA for individual use. The IHCP covers the AED, E0617 – *External defibrillator with integrated electrocardiogram analysis*. The IHCP also covers the wearable cardioverter defibrillator (WCD), K0606 – *Automatic external defibrillator, with integrated electrocardiogram analysis, garment type*.

The IHCP covers an AED (E0617) or a WCD (K0606), based on the physician’s clinical assessment of the member’s medical needs. The AED and the WCD are capped rental items.

Prior Authorization Criteria

The IHCP covers the AED (E0617) and the WCD (K0606) under the same PA criteria. The AED or the WCD is covered for members in two circumstances as described in Table 6.13.

### Table 6.13 – Prior Authorization Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>The member has one of the following conditions (1-5):</td>
</tr>
<tr>
<td></td>
<td>1. A documented episode of cardiac arrest due to ventricular fibrillation, not due to a transient or reversible cause</td>
</tr>
<tr>
<td></td>
<td>2. A sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia, either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute myocardial infarction², and not due to a transient or reversible cause</td>
</tr>
<tr>
<td></td>
<td>3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy</td>
</tr>
<tr>
<td></td>
<td>4. Coronary artery disease with a documented prior myocardial infarction, with a measured left ventricular ejection fraction² less than or equal to 0.35, and inducible, sustained ventricular tachycardia (VT) or ventricular fibrillation (VF) during an EP study. To meet this criterion, both (a) and (b) must occur:</td>
</tr>
<tr>
<td></td>
<td>a) The myocardial infarction must have occurred more than four weeks prior to the external defibrillator prescription; and,</td>
</tr>
<tr>
<td></td>
<td>b) The EP test must have been performed more than four weeks after the qualifying myocardial infarction.</td>
</tr>
</tbody>
</table>
Members must meet either (1) both criteria A and B; or (2) criterion C

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Documented prior myocardial infarction and a measured left ventricular ejection fraction less than or equal to 0.30; and a QRS duration of greater than 120 milliseconds. Members must not have the following:</td>
<td></td>
</tr>
<tr>
<td>a) New York Heart Association classification IV; or</td>
<td></td>
</tr>
<tr>
<td>b) Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm; or</td>
<td></td>
</tr>
<tr>
<td>c) A coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within the past three months; or</td>
<td></td>
</tr>
<tr>
<td>d) An enzyme-positive myocardial infarction (MI) within the past month; or</td>
<td></td>
</tr>
<tr>
<td>e) Clinical symptoms or findings that make them candidates for coronary revascularization; or</td>
<td></td>
</tr>
<tr>
<td>f) Irreversible brain damage from pre-existing cerebral disease; or</td>
<td></td>
</tr>
<tr>
<td>g) Any disease, other than cardiac disease (for example, cancer, uremia, liver failure), associated with a likelihood of survival of less than one year.</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Implantation surgery is contraindicated.</td>
</tr>
<tr>
<td>C</td>
<td>A previously implanted defibrillator now requires removal.</td>
</tr>
</tbody>
</table>

¹ Transient or reversible causes include conditions such as drug toxicity, severe hypoxia, acidosis, hypocalcemia, hyperkalemia, systemic infections, and myocarditis (not all-inclusive).

² Myocardial infarctions must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.

Claims for defibrillators for other indications will be denied as not medically necessary. The IHCP will not purchase an AED and a WCD for one member, nor rent an AED and a WCD simultaneously for one member.

Prior Authorization Criteria for Accessories K0607 – K0609

PA criteria for accessories are based on the estimated average life expectancies of the accessories. The replacement battery for automated external defibrillator, garment type only, each (K0607) and replacement electrodes for use with automated external defibrillator, garment type only, each (K0609), are used for the AED (E0617) and WCD (K0606).

K0607 – Replacement Battery

1. The member must currently be renting or have purchased an AED (E0617) or WCD (K0606 with integrated electrocardiogram analysis, garment type).
2. The battery being replaced must be at least 11 months old or completely discharged.

K0608 – Replacement Garment (Only for WCD)

1. The member must currently be renting or have purchased a WCD with integrated electrocardiogram analysis, garment type (K0606).
2. The garment must be damaged or worn beyond repair and have been in use at least five months.

K0609 – Replacement Electrodes

1. The member must currently be renting or have purchased an AED (E0617) or the WCD with integrated electrocardiogram analysis, garment type (K0606).
2. The electrodes being replaced must have been used for at least 22 months, or it must be proven that
the equipment is broken or damaged beyond repair.

Medical Supplies and Equipment Prior Authorization Policy
Requirements – Managed Care Considerations

Care Select

DME and HME services for members enrolled in Care Select do not require PMP authorization. These
services are subject to the IHCP FFS PA criteria described previously.

Risk-Based Managed Care

Authorization for DME, HME, and supplies is the responsibility of the MCE for enrolled members.
For additional information about MCE authorization procedures, contact the MCE at the telephone
number provided through the IHCP AVR system, Web interChange, or electronic 270/271 transaction.
Other resources include Chapter 1: General Information of this manual or indianamedicaid.com.

Transportation Prior Authorization Policy Requirements

Specific criteria pertaining to PA of transportation services are found in 405 IAC 5-30. The following
PA requirements should be used as a guideline for determining procedures requiring PA, but the IAC is
the primary reference.

PA is required for the following transportation services:

• Trips exceeding 20 one-way trips per member, per rolling 12-month period, except emergency
  ambulance services, transportation to or from a hospital for an admission or discharge, members on
dialysis, and members residing in nursing homes
  – Claims for transportation of members on dialysis should be filed using diagnosis codes V56.0,
    V56.1, or V56.8 – Patient undergoing renal dialysis. Claims for transportation of nursing home
    residents should be filed using diagnosis code V70.5 – Patient residing in nursing facility.

• Trips that are 50 miles or more one way

• Transportation rendered by any provider to or from an out-of-state, nondesignated area
  – Requests can be made in writing by either fax or mail.
  – The request must include a description of the anticipated care and a brief description of the
    clinical circumstances necessitating the need for transportation by air or to another state.

• Airline or air ambulance and transportation services rendered by a provider located out of state in a
  nondesignated area
  – Requests can be made in writing by either fax or mail.
  – The request must include a description of the anticipated care and a brief description of the
    clinical circumstances necessitating the need for transportation by air or to another state.

• In-state train or bus services
  – These services require prior authorization by the local county office of the FSSA Division of
    Family Resources (DFR) in which the member resides, not the IHCP office or contractor.
Family member services
   - These services require prior authorization by the county office of the FSSA DFR in which the
     member resides, not the IHCP office or contractor.

Per 405 IAC 5-30-1, Medicaid reimbursement is available for emergency and nonemergency
transportation, for a maximum of 20 one-way trips per member, per rolling 12-month period of time,
except when medical necessity for additional trips is demonstrated and documented through the prior
authorization process.

When submitting a PA request in writing, the following information should be noted on or attached to
a properly completed Indiana Health Coverage Programs Prior Authorization Request Form, which is
available on the Forms page at indianamedicaid.com:
   • Proper procedure codes for the requested services
   • Member’s age
   • Level of service required (such as wheelchair van, commercial ambulatory service – CAS – or taxi)
     - The member’s condition must support the level of service requested.
   • Reason for and destination of service (such as dialysis or physical therapy treatments at county
     hospital or community health clinic)
   • Frequency of service and treatment per the physician’s order (such as twice a week)
   • Duration of service and treatment per the physician’s order (such as three months)
   • Total mileage for each trip (such as 129 miles)
   • Total waiting time for each trip (such as two hours)

PA requests must include a brief description of the anticipated care and description of the clinical
circumstances necessitating the need for the transportation.

Twenty One-Way Trip Limitation and Exemptions
Transportation is limited to 20 one-way trips per member, per rolling calendar year. Providers must
request PA for members who exceed 20 one-way trips if frequent medical intervention is required.
However, some services are exempt from the 20 one-way trip limitation. Information about those
services is included in the following sections.

Emergency Transportation Services
Emergency ambulance transportation is exempt from the 20 one-way trip limitation. Providers must
indicate that the transportation was an emergency by using the Y indicator in field 24I on the CMS-
1500 or in the Emergency Indicator on the 837P.

Hospital Admission or Discharge
Transportation services for transporting a member to a hospital for admission or for transporting the
member home following discharge from the hospital are exempt from the 20 one-way trip limitation.
This includes inter-hospital transportation when the member is discharged from one hospital for the
purpose of admission to another hospital. The transportation modifiers must be used to indicate the
place of origin and destination for each service.
Members on Renal Dialysis or Members Residing in Nursing Homes

Members on renal dialysis and members residing in nursing homes are exempt from the 20 one-way trip limitation. Claims for members undergoing dialysis or members in nursing homes must be filed with one of the following diagnosis codes: V56.0, V56.1, or V56.8 – Patient undergoing renal dialysis or V70.5 – Patient residing in nursing facility. The diagnosis code should be entered on the CMS-1500 or 837P, and a 1 should be placed in field 24E of the CMS-1500 claim form or the Diagnosis Code Pointer on the 837P, to indicate that the first diagnosis code applies.

Accompanying Parent or Attendant

Procedure codes for accompanying parent or attendant are not applied to the member’s 20 one-way trip limitation. Prior authorization is required for an accompanying parent or attendant only when the trip exceeds 50 miles one way. Additional information about the accompanying parent or attendant policy is included in Chapter 8: Billing Instructions of this manual.

Additional Attendant

Procedure codes A0424 – Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged) and A0130 U6 – Non-emergency transportation: wheelchair van, additional attendant are not applied to the member’s 20 one-way trip limitation. Prior authorization is required for procedure codes A0424 and A0130 U6 when the trip exceeds 50 miles one way.

Transportation Prior Authorization Policy Requirements – Managed Care Considerations

Care Select

Transportation services for members enrolled in Care Select do not require PMP authorization. These services are subject to the IHCP FFS criteria described previously.

Risk-Based Managed Care

Authorizations for transportation services are the responsibility of the MCE for enrolled members. Additional information about MCE authorization procedures can be directed to the MCE at the telephone number provided through the IHCP AVR system, Web interChange, or electronic 270/271 transaction. Other resources include Chapter 1: General Information of this manual or indianamedicaid.com.
Prior Authorization Criteria for Food Supplements, Nutritional Supplements, and Infant Formulas

Per 405 IAC 5-24-9, food supplements, nutritional supplements, and infant formulas are covered only when no other means of nutrition is feasible or reasonable. Prior authorization for these items is required. Approval is subject to the following criteria:

- The feasibility or reasonableness of other means of nutrition, as documented by the requesting practitioner, and as determined by the office’s contractor on a case-by-case basis.

- Authorization is not granted when convenience of the member or the member’s caretaker is the primary reason for the request for the service.

- Coverage is not available in cases of routine or ordinary nutritional needs.

- Coverage is not available in cases in which the item is to be used for other than nutritional purposes.

- Hyperalimentation and total parenteral nutritional products do not require prior authorization. These products may be separately billed to Medicaid for residents of long-term care facilities.

Providers must coordinate with the appropriate entity when seeking approval for Medicaid coverage of infant formula. If the eligible Medicaid member is assigned to Traditional Medicaid on the date of service, ADVANTAGE Health Solutions™ is responsible for processing the required PA. Members who are assigned to Care Select must contact ADVANTAGE. Information about obtaining PA through ADVANTAGE can be found on the Prior Authorization page at indianamedicaid.com.

If the eligible Medicaid member is enrolled in Hoosier Healthwise on the date of service, the member’s managed care entity (MCE) is responsible for approving Medicaid coverage of the infant formula. Each MCE has developed its own policy and procedure for how medical necessity for infant formula must be documented and approval obtained.

While awaiting authorization, the Women, Infants and Children (WIC) program will provide a supplemental amount of exempt infant formula or medical food. Pursuant to 7 CFR 246.10(d)(1)(iii) and 246.10(d)(1)(iv), to receive this WIC benefit, members must obtain documentation of a qualifying condition from a healthcare professional licensed to write medical prescriptions. Please note that members should be referred to WIC only as a secondary provider. Medicaid becomes the primary provider after approval as a covered benefit is granted.
Section 6: Out-of-State Prior Authorization Policy Parameters

Service Coverage

The Indiana Health Coverage Programs (IHCP) reimbursement is available for the following services referred to in 405 IAC 5-5-1, provided outside the state of Indiana:

- Acute general hospital care
- Chiropractic services
- Dental services
- Durable medical equipment (DME) and supplies
- Pharmacy services
- Physician services
- Podiatry services
- Therapy services
- Transportation services

Prior Authorization Requirements for Out-of-State Services

The services listed previously require prior authorization (PA), except as follows:

- Emergency services provided out-of-state do not require PA. Providers must request PA for continuation of inpatient treatment within 48 hours of the admission.
- Members of the adoption-assistance program placed outside Indiana receive approval for all routine medical and dental care provided out-of-state.

Designated Out-of-State Areas

Members can receive the services listed previously in the following designated out-of-state areas, subject to the PA requirements for in-state services:

- Chicago, Illinois (includes all active IHCP providers with locations in ZIP Codes of 606xx, 607xx, and 608xx)
- Cincinnati, Ohio
- Danville, Illinois
- Hamilton, Ohio
- Harrison, Ohio
- Louisville, Kentucky
- Owensboro, Kentucky
- Oxford, Ohio
- Sturgis, Michigan
- Watseka, Illinois
Out-of-State Primary Medical Providers and Auto-assignment

Primary medical providers (PMPs) who have PMP service locations in the designated out-of-state counties are eligible to receive new Hoosier Healthwise risk-based managed care (RBMC) members through the auto-assignment process, in addition to members who they may receive through member self-selection. Before this policy change, the designated out-of-state PMPs received RBMC members only through member self-selection. Out-of-state PMPs in other areas continue to receive self-selections only.

Service Restrictions

As noted in 405 IAC 5-5-2(b), PA is not approved for the following services outside Indiana and is not covered outside Indiana for designated areas listed previously:

- Nursing facilities, intermediate care facilities for individuals with intellectual disability (ICFs/IID), or home health agency services
- Any other type of long-term care (LTC) facility, including facilities directly associated with or part of an acute care general hospital

As noted in 405 IAC 5-5-2(c), PA can be granted for any period from one day to one year for out-of-state medical services listed previously, if the service meets criteria for medical necessity and any one of the following criteria is also met:

- Service is not available in Indiana. However, care provided by out-of-state Veterans Administration and Shriners hospitals is an exception to this requirement.
- Member has previously received services from the provider.
- Transportation to an appropriate Indiana facility would cause undue expense or hardship to the member or the IHCP.
- Out-of-state provider is a regional treatment center or distributor.
- Out-of-state provider is significantly less expensive than the Indiana provider – for example, a large laboratory versus an individual pathologist.

Out-of-State Suppliers of Medical Equipment

As noted in 405 IAC 5-5-3, to be treated as an in-state provider for purposes of the PA rule, any out-of-state supplier of medical equipment must comply with the following:

- Maintain an Indiana business office, staffed during regular business hours, with telephone service.
- Provide service, maintenance, and replacements for IHCP members whose equipment has malfunctioned.
- Qualify with the Indiana secretary of state as a foreign corporation.
Section 7: Prior Authorization Administrative Review and Appeal Procedures

Note: The information in this section does not apply to pharmacy services. For pharmacy appeals, see Chapter 9: IHCP Pharmacy Services Benefit of this manual.

General Information

Prior authorization (PA) administrative review and appeal procedures are outlined in the following sections of the Indiana Administrative Code (IAC):

• 405 IAC 5-7
• 405 IAC 1.1

Appeals on PA issues are conducted in accordance with 405 IAC 1.1. All PA decisions receive a Notice of Appeal Rights with the decision letter, outlining the procedures to be used.

Administrative reviews are completed by the PA vendor that denied the request. If the administrative review is submitted to the incorrect PA contractor, the request will be returned to the provider for submission to the appropriate organization for review. If the member has been assigned to a different program since the request for PA was denied, providers can either appeal to the PA vendor that denied the request or submit a new PA request for review to the correct PA vendor.

Note: For Hoosier Healthwise or HIP managed care entity (MCE)-related issues, the member or provider should contact the MCE member or provider services’ toll-free number to submit a grievance or appeal. See contact information in Chapter 1: General Information of this manual.

Administrative Review

A provider requesting review of the modification or denial of a PA must request an administrative review within seven working days of the receipt of notification of modification or denial.

• When administrative review is desired but the member continues to be hospitalized, ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS must receive a letter notifying the appropriate PA Hearings and Appeals Department of the intent to request an administrative review within seven working days of the receipt of notification of modification or denial. If the provider wants to continue with the appeal, ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS must receive the entire medical record within 45 calendar days after discharge. If the program assignment of the member has changed since the denial of the initial PA request, a new PA request may be submitted to the PA vendor based on the new program assignment of the member.

• Failure to request a timely administrative review as outlined in 405 IAC 5-7-2(b) results in the loss of the right to request an administrative hearing.

• The ADVANTAGE Health Solutions-FFS or ADVANTAGE Health Solutions-CS IHCP medical director or designee renders the administrative review decision of the contractor within seven working days of receipt of all necessary documentation.
The requesting provider and member receive written notification of the decision containing the following information:
- The IHCP contractor determination and the rationale for the decision
- The Notice of Appeal Rights through the Indiana Family and Social Services Administration (FSSA)

To initiate an administrative review, providers must include the following information with the request:

- Copy of the original Indiana Health Coverage Programs Prior Authorization Request Form
  - The form is available on the Forms page at indianamedicaid.com.
- Summary letter, including pertinent reasons the services are medically necessary
  - Include the PA number, member’s name, and recipient identification number (RID).
- All documentation including medical records, equipment consultations, progress notes, case histories, and therapy evaluation
  - Documentation should be pertinent to the case and support the medical necessity of the requested service.
- Name, telephone number, and address of the provider submitting the request
  - This information is required in the event it is necessary to contact the provider for additional information or clarification.
- Entire medical record sent with review requests for inpatient hospitalizations
- This information should be sent to the following address:

  Attention: Administrative Review
  Prior Authorization Department
  ADVANTAGE Health Solutions-FFS
  P.O. Box 40789
  Indianapolis, IN 46240

  Attention: Administrative Review
  Prior Authorization Department
  ADVANTAGE Health Solutions-CS
  P.O. Box 80068
  Indianapolis, IN 46280

  Fax all ADVANTAGE Health Solutions-FFS and ADVANTAGE Health Solutions-CS requests for Administrative Review to 1-866-368-2644.

**Administrative Hearing**

The following subsections address the administrative hearing appeal process for providers and members.

**Provider Appeals**

Any provider that has submitted a request for prior review and authorization can appeal a denial or modification of the request after exhausting the administrative review process. The appeal request must be in writing and must be signed by the requesting provider or designee. Provider appeals of PA decisions are conducted in accordance with the member appeals regulation, 405 IAC 1.1.
Provider requests for administrative hearings must be submitted within 33 calendar days of the administrative review decision to the following address:

**Hearings and Appeals**
Indiana Family and Social Service Administration
402 West Washington Street, Room E034
Indianapolis, IN 46204

For Hoosier Healthwise MCE-related issues, providers should contact the MCE provider services telephone number to submit a grievance or appeal.

**Member Appeals**

If a member disagrees with a denial or modification of a PA request for services by the FSSA, the county office of the FSSA Division of Family Resources (DFR), or the contractor, the member can ask for a hearing pursuant to **42 CFR 431.200 et seq. and 405 IAC 1.1**. A hearing is requested by filing a signed, written **Appeal and Request for Hearing** with the county office or with the Hearings and Appeals Section of the FSSA. The address for the FSSA is in the next subsection. The filing must be within 33 calendar days of the date the adverse decision was received or takes effect, whichever is later. If the request is for a continuing service (for example, home healthcare), at least 10 days’ notice plus three days’ mailing time must be given before the effective date of the denial or modification, except as permitted under **42 CFR 431.213** and **42 CFR 431.214**.

As required by statute, if the request for a hearing is received before the effective date of the denial or modification of continuing services, services are continued at the authorized level of the previous PA.

The request must state which requested item the member is appealing. At the hearing, the member has the right to self-representation or to be represented by legal counsel, a friend, a relative, or another spokesperson of the member’s choice. The member is given the opportunity to examine the entire contents of his or her case file, and any and all materials used by the FSSA, county office, or the contractor that made the adverse determination. Other IHCP and assistance benefits are not affected by a request for a hearing.

Members enrolled in fee-for-service are not required to request an administrative review from the contractor before filing a request for a hearing with FSSA. For Hoosier Healthwise MCE-related issues, members should contact the MCE member services telephone number to submit a grievance or appeal.

**Notification Procedures**

All member requests for administrative hearings should include a letter with the appellant’s signature stating the reason for appeal. The request should be sent to the following address:

**Hearings and Appeals**
Indiana Family and Social Service Administration
402 West Washington Street, Room E034
Indianapolis, IN 46204

As an alternative, the request can be sent to the local county office (member only). **Chapter 1: General Information** of this manual provides a link to the addresses of the county offices.

The request must be sent within 33 calendar days of the date the notification of denial or modification is received.
Index

2
278 request ........................................ 6-29
278 response ..................................... 6-36
278 transaction ................................ 6-29
5
590 Program authorizations .................. 6-27
A
accessories K0607 – K0609 PA criteria ... 6-68
action codes ........................................ 6-36
administrative hearing .......................... 6-76
member appeals .................................. 6-77
notification procedures ......................... 6-77
provider appeals ................................ 6-76
administrative review ............................ 6-75
administrative review and appeal procedures 6-75
AEDs ................................................... 6-67
approval of nonspecific codes ................. 6-33
automated attendant ............................. 6-16
automatic external defibrillators ................ 6-67
automatic external defibrillators PA criteria . 6-67
automation of pharmacy prior authorization
for fee-for-service claims ....................... 6-14
C
Care Select ......................... 6-8, 6-48, 6-57, 6-63, 6-69
certification type codes ....................... 6-30
chiropractic services PA ...................... 6-53
D
data elements ...................................... 6-30
certification type codes ....................... 6-30
facility type codes ............................. 6-31
level of service codes ......................... 6-31
release of information codes ............... 6-31
service type codes ............................ 6-30
decision letter .................................... 6-24
dental procedures at a hospital ............... 6-54
dental procedures at an ASC ................. 6-54
dental services
  dentures ........................................... 6-53
  partials .......................................... 6-54
  partials for replacement of anterior teeth . 6-54
dental services PA ......................... 6-53
denture relines .................................... 6-54
denture repairs ................................... 6-54
dentures .......................................... 6-53
designated out-of-state areas ................. 6-73
diagnosis segment ............................. 6-32
diagnosis-related group methodology ...... 6-38
DME .................................................. 6-65
DRG inpatient hospital admission PA policy
requirements ....................................... 6-38
DRG methodology ............................. 6-38
duplicate requests .............................. 6-33
durable medical equipment .................. 6-65
E
electronic PA requests ......................... 6-34
electronic transaction .......................... 6-29
emergency admission
  PA policy ......................................... 6-48
  PA policy RBMC ............................... 6-49
  PA required .................................... 6-48
  emergency service ............................ 6-48
evaluation and management services requiring
PA .................................................... 6-52
examples of system update requests ........ 6-25
F
facility type codes ............................. 6-31
fax PA requests .................................. 6-24
fee-for-service .................................... 6-8
fee-for-service Care Select .................... 6-13
FFS .................................................... 6-8
H
HIP prior authorization criteria .............. 6-13
HIPAA ............................................... 6-29
HME .................................................... 6-65
home and community-based waiver services
  authorizations ................................... 6-27
home health nursing services ............. 6-14, 6-58
home health PA policy requirements ....... 6-57
home health services
  RBMC ............................................. 6-62
home health/nursing/therapy PA policy
requirements
  Hoosier Healthwise considerations ....... 6-61
home health/nursing/therapy services
  RBMC ............................................. 6-62
home medical equipment ..................... 6-65
home PA policy requirements
  Hoosier Healthwise considerations ....... 6-61
hospice PA policy parameters ............... 6-44
I

incontinence supplies ........................................ 6-64, 6-65
Indiana Health Coverage Programs Prior Authorization Request Form
instructions .......................................................... 6-17
Indiana Dental Prior Review and Authorization
Dental Request Form
instructions .......................................................... 6-20
inpatient hospital DRG admission PA policy requirements .................................. 6-38
inpatient psychiatric admission PA policy parameters, distinct part inpatient psychiatric services in acute care hospitals .......................................................... 6-39
inpatient psychiatric admission PA policy parameters, inpatient psychiatric services in freestanding psychiatric hospitals ......... 6-41
inpatient psychiatric admission prior authorization policy parameters .......................................................... 6-39
institutional PA policy requirements ................................ 6-38
introduction to prior authorization .......................................................... 6-8
K

K0607 – replacement battery ........................................ 6-68
K0608 – replacement garment ........................................ 6-68
K0609 – replacement electrodes ........................................ 6-68
L

level-of-service codes ........................................ 6-31
limitations .................................................................... 6-9
M

managed care entity .................................................. 6-8
managed care members with hospice .................................. 6-45
MCE ........................................................................... 6-8
Medicaid Second Opinion Form ......................................... 6-23
medical clearance forms ........................................ 6-23
procedures ....................................................................... 6-23
medical services PA .................................................. 6-51
medical supplies .................................................. 6-64
medical supplies and durable medical equipment ........................................ 6-63
medical supplies and equipment
Care Select ........................................................................ 6-69
RBMC ........................................................................... 6-69
risk-based managed care ........................................ 6-69
medical supplies and equipment PA policy requirements .......................................................... 6-63
member appeals .................................................. 6-77
member eligibility .................................................. 6-13
mental health outpatient services ........................................ 6-62
message segment .................................................. 6-33
modifiers .......................................................... 6-33

modifiers .......................................................... 6-33

N

ew new requests for PA .......................................................... 6-19
non-IHCP PA requests ........................................ 6-27
non-institutional PA policy parameters ........................................ 6-51
nonpharmacy PA .................................................. 6-18
nursing policy requirements
Hoosier Healthwise considerations ........................................ 6-61
nursing services ........................................ 6-14, 6-58
RBMC .......................................................... 6-62
O

out-of-state PA policy service coverage ........................................ 6-73
service restrictions ........................................ 6-74
out-of-state PA policy parameters ........................................ 6-73
out-of-state services PA requirements ........................................ 6-73
out-of-state suppliers of medical equipment ........................................ 6-74
outpatient mental health ........................................ 6-63
risk-based managed care ........................................ 6-63
outpatient mental health PA policy requirements ........................................ 6-62
outpatient mental health services ........................................ 6-62
outstanding prior authorizations for nonpharmacy services ........................................ 6-11
P

PA administrative review and appeal procedures ........................................ 6-75
PA and Medicare .................................................. 6-28
PA and third party .................................................. 6-28
PA inquiry .................................................. 6-20
PA institutional policy requirements ........................................ 6-38
PA policy parameters for non-institutional ........................................ 6-51
PA policy requirements practitioner ........................................ 6-51
PA procedures .................................................. 6-13
PA requests through Web interChange ........................................ 6-10
PA therapy policy requirements ........................................ 6-60
PA update decision letter ........................................ 6-26
decision description ........................................ 6-26
paper attachments .................................................. 6-34
partial dentures .................................................. 6-54
repairs .................................................. 6-54
replacement of anterior teeth ........................................ 6-54
physician services PA ........................................ 6-51
physician signature stamps ........................................ 6-10
podiatry services PA ........................................ 6-52
practitioner PA policy parameters ........................................ 6-57
Hoosier Healthwise considerations ........................................ 6-57

Library Reference Number: PRPR10004
Published: May 26, 2015
Policies and Procedures as of January 1, 2015
Version: 15.0

6-79