

# How to Make Prior Authorizations Work for You



# Agenda

-  Prior Authorization (PA)
-  Recent Updates
-  Helpful Tips
-  Web Portal
-  Telephonic Requests
-  Fax Requests
-  Appeals Process
-  Need to Know
-  Questions and Answers


# Prior Authorization


## Prior Authorization (Medical Services)


Prior Authorization is an approval from MHS to provide services designated as needing authorization before treatment and/or payment

 Inpatient authorizations = IP + 10 digits

 Outpatient authorizations = OP + 10 digits



 Emergent ER Symptoms suggesting imminent, life-threatening condition no PA required, but notification requested within **two business days**

 Urgent concurrent = Emergent inpatient admission. Determination timeline within **24 hours** of receipt of request.

 Pre-service non urgent = Elective scheduled procedures. Determination within **15 calendar days**. Benefit limitations apply (dependent on product).





# Prior Authorization

MHS Medical Management will review state guidelines and all available clinical documentation and seek Medical Director input as needed

-  PA for observation level of care (**up to 72 hours for Medicaid or 48 hours for Ambetter and Allwell**), diagnostic services do not require an authorization for contracted facilities. Non-contracted facilities do not require prior authorization.
-  If the provider requests an inpatient level of care for a covered/eligible condition, or procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review

# Prior Authorization



## Outpatient Services

-  All elective procedures that require prior authorization must have request to MHS at least **two business days** prior to the date of service
-  All urgent and emergent services do not require prior authorization, but admissions must be called in to MHS within **two business days** following the admit
-  Prior Authorizations are **not** a guarantee of payment
-  Members **must** be Medicaid Eligible on the date of service

***\*Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims***













# Prior Authorization

## Transfers

-  MHS requires **notification and approval** for all transfers from one facility to another at least two business days in advance
-  MHS requires **notification** within two business days following all emergent transfers Transfers include, but are not limited to:
  - Facility to facility
  - Higher level of care changes require PA and it is the responsibility of the transferring facility to obtain

# Prior Authorization

## Services that require prior authorization regardless of contract status:

-  Injectable drugs (see [mhsindiana.com/provider-guides](https://mhsindiana.com/provider-guides) for up-to-date list of codes)
-  Nutritional counseling (unless diabetic)
-  Pain management programs, including epidural, facet and trigger point injections
-  PET, MRI, MRA and Nuclear Cardiology/SPECT scans
-  Cardiac rehabilitation
-  Hearing aids and devices
-  Home and Institutional hospice (coverage varies by product)
-  In-home infusion therapy
-  Orthopedic footwear
-  Respiratory therapy services
-  Pulmonary rehabilitation
-  Home care (except after an IP admission with benefit limitations)

# Prior Authorization

## Is Prior Authorization Needed?

- MHS website: [mhsindiana.com](https://mhsindiana.com)
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers






**PROVIDER Quick Reference Guide**  
Effective May 1, 2017

Applies to all Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) packages.  
For an Ambetter Provider Quick Reference Guide, please visit [ambetter.mhsindiana.com](https://ambetter.mhsindiana.com). Coverage is subject to specific benefit package of member.

**1-877-647-4848**  
TTY/TDD: 1-800-743-3333

**mhsindiana.com**

**GENERAL OFFICE HOURS:**  
8 a.m. to 5 p.m., EST, closed holidays

**MEMBER SERVICES AND PROVIDER SERVICES:**  
8 a.m. to 8 p.m.

**REFERRALS AND AUTHORIZATIONS:**  
8 a.m. to 5 p.m., closed 12 p.m. to 1 p.m.

**AFTER-HOURS:**  
MHS' 24/7 Nurse Advice Line for members is available to answer calls for emergent authorization needs. Or, you may leave a message on our after-hours recording system. Messages are returned within two business days.

**MANAGED HEALTH SERVICES (MHS)**

**ELECTRONIC PAYER ID:**  
68069

**CLAIMS ADDRESS:**  
Managed Health Services  
P.O. Box 3000  
Farmington, MD 21640-3800

Claims sent to MHS' Indianapolis address will be returned to provider.

**MEDICAL NECESSITY APPEALS ONLY ADDRESS:**  
ATTN: APPEALS  
550 N. Harding Street  
Suite 101  
Indianapolis, IN 46204

**CLAIMS APPEALS ADDRESS:**  
Managed Health Services  
P.O. Box 3000  
Farmington, MD 21640-3800

Providers have 60 calendar days from the date of the Explanation of Payment to file an adjustment, rebuttal, or appeal a decision.

Failure to do so within the specified timeframe will waive the right for reconsideration.

**CLAIMS REFUNDS:**  
To refund claims overpayment, please send check and documentation to:  
Coordinated Care Corporation  
75 Remittance Dr., Suite 6446  
Chicago, IL 60675-6446

**MHS FAX NUMBERS**

**PROVIDER SERVICES: 1-866-601-5534**  
Ex. Claims-related documents

**MEMBER SERVICES: 1-866-913-1629**  
Ex. Member portal address/changes

**NETWORK MANAGEMENT: 1-866-913-4344**  
Ex. Provider enrollment, office or billing address changes

**MEDICAL APPEALS: 1-866-794-7993**  
Ex. Referrals, Prior Authorizations

**CASE MANAGEMENT: 1-866-694-3633**  
Ex. Member Referrals to CHC/DH

**MHS WEBSITE: MHSINDIANA.COM**

[mhsindiana.com/providers](https://mhsindiana.com/providers) ..... Latest MHS provider updates and news, as well as forms, manuals, guides, online PA tool and tutorials. (Please visit [mhsindiana.com/forms](https://mhsindiana.com/forms) to get the latest forms for submission to MHS.)

[mhsindiana.com/health](https://mhsindiana.com/health) ..... MHS' Health Library. Click on "KRAHES Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.

[mhsindiana.com/login](https://mhsindiana.com/login) ..... MHS' Secure Provider Portal lets you submit prior authorization, claims, claim adjustments, and view your panel's medical records and care gaps.

[mhsindiana.com/transactions](https://mhsindiana.com/transactions) ..... Information for electronic processing and payment of claims with MHS.

**OTHER RESOURCES**

[payspanhealth.com](https://payspanhealth.com) ..... MHS is pleased to partner with PaySpan to provide an innovative web based solution for Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA). This service is provided at no cost to providers and allows online enrollment at [payspanhealth.com](https://payspanhealth.com).

You can find out more about the information in this Guide in the MHS Provider Manual, online at [mhsindiana.com/providers/resources](https://mhsindiana.com/providers/resources), or by contacting MHS at 1-877-647-4848.

001700LJUL 6/17



# Prior Authorization

## Medicaid Pre-Auth

**DISCLAIMER:** All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by [Envolve Vision](#)

Dental services need to be verified by [Envolve Dental](#)

Ambulance and Transportation services need to be verified by [LCP Transportation](#)

Behavioral Health/Substance Abuse services need to be verified by [Cenpatico](#)

Non-participating providers must submit Prior Authorization for all services.

For non-participating providers, [join our network](#).

Are services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are services for infertility?	<input type="radio"/>	<input type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input type="radio"/>

To submit a prior authorization [Login Here](#).

# Prior Authorization

## Medicaid Pre-Auth Needed?

[Become a Provider](#)

[CLAS Standards](#)

[MHS Provider Webinars](#)

[Partnered Member Events](#)

[Pharmacy Benefits Information for Providers](#)

[Prior Authorization](#)

[Transactions](#)

[PaySpan Health](#)

[POWER Account Resource Center](#)

[Provider Information Resource Center](#)

[Provider Guides](#)

[Dental Providers](#)

[Presumptive Eligibility](#)

[Quality Improvement](#)

[HEDIS®](#)

[Practice Guidelines](#)

[Immunization Information](#)

**DISCLAIMER:** All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the [provider manual](#). If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by [Envolve Vision](#)

Complex Imaging, MRA, MRI, PET and CT scans need to be verified by [NIA](#)

Hoosier Healthwise dental services need to be verified by [State](#)

Healthy Indiana Plan (HIP) and Hoosier Care Connect dental services need to be verified by [Envolve Dental](#)

Ambulance and Transportation services need to be verified by [LCP Transportation](#)

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)

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**Are Services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?**

YES ☐ NO ☐

Types of Services	YES	NO
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Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are services for infertility?	<input type="radio"/>	<input type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input type="radio"/>

# Prior Authorization

Are Services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

YES ☐ NO ☒

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

Check

C

Conditional










**99394** - PREV VISIT EST AGE 12-17

Pre-authorization is required if service is rendered at home except for Primary Care Providers or Health Department. In all other locations, Pre-authorization is required for non-participating providers.

To submit a prior authorization [Login Here](#).

# Prior Authorization




## Information Needed to Complete All PAs:

-  Member's Name, RID, and Date of Birth
-  Type of service needed (e.g. office visit, outpatient surgery, DME, inpatient admission, testing, physical therapy, occupational therapy, speech therapy etc.)
-  Date(s) of service
-  Ordering Physician with NPI number
-  Servicing Physician with NPI number
-  HCPCS/CPT codes requested for approval
-  Diagnosis code
-  Contact person, including phone and fax numbers
-  Clinical information to support medical necessity (home care requires a signed POC)
  - Including current (within three months) clinical that is pertinent to the requested service, history of symptoms, previous treatment and results, physician rationale for ordering treatments and/or testing (MD exam notes)

Providers must request updates to prior authorizations **within 30 days** from the original date of service before claim submission.

# **Recent PA Updates**

# Therapy Services - (Speech, Occupational, Physical Therapy)

-  10/1/17 authorization is no longer required
-  Must follow billing guidelines (GP, GN, GO modifiers)
-  National Imaging Associates, Inc. (NIA) will conduct retrospective review to evaluate medical necessity
  - If requested, medical records can be uploaded to RadMD.com or faxed to NIA at 1-800-784-6864
  - Medical necessity appeals will be conducted by NIA
    - Follow steps outlined in denial notification
    - NIA Customer Care Associates are available to assist providers at 1-800-424-5391

# Durable & Home Medical Equipment

- 👤 Members and referring providers do not need to search for a DME provider or provider of medical supplies to service their needs
- 👤 Order is submitted directly to MHS, through the Medline portal, unless PA is required, and delivered to the member
- 👤 Availability via Medline's web portal to submit orders and track delivery
- 👤 Prior authorization required by the **ordering physician** for all non-participating DME providers.
- 👤 Does not apply to items provided by and billed by physician office
- 👤 Exclusions applicable to specific hospital based DME/HME vendors

# Durable & Home Medical Equipment



Requests should be initiated via **MHS secure portal**

- **Web Portal:** Simply go to [mhsindiana.com](https://mhsindiana.com), log into the provider portal, and click on “Create Authorization.” Choose DME and you will be directed to the Medline portal for order entry.
- **Fax Number:** 1-866-346-0911
- **Phone Number:** 1-844-218-4932




# Helpful Tips


# Additional Information Needed

## Bariatric Surgery

 Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, and psychologist report


## Pain Management

 Must have documentation of at least six weeks of therapy on area receiving treatment

 Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies

 Include prior injection test results for injection series

## Home Health

 Physician's orders and signed plan of care, including most recent MD notes about the issue at hand

 Home care plan, including home exercise program

 Progress notes for medical necessity determination

# Outpatient Radiology PA Requests

 MHS partners with NIA for outpatient Radiology PA Process

 PA requests can be submitted via:

- NIA Web site at [RadMD.com](http://RadMD.com)
- 1-866-904-5096
- Not applicable for ER and Observation requests

# Pharmacy Requests

## Engage Pharmacy Solutions

 Preferred Drug Lists and authorization forms are available at [mhsindiana.com/provider/pharmacy](https://mhsindiana.com/provider/pharmacy)

- PA requests
  - Phone 1-866-399-0928
  - Fax non specialty drugs 1-866-399-0929
  - Specialty drugs 1-866-678-6976
  - [pharmacy.engagehealth.com](https://pharmacy.engagehealth.com)

 Formulary integrated into many EHR solutions




 Online PA submission available through CoverMyMeds

- [covermymeds.com](https://covermymeds.com)

 Online PA forms for Specialty Drugs on [mhsindiana.com](https://mhsindiana.com)

# **Web Portal**

# Web Authorization

-  Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at [mhsindiana.com/login](https://mhsindiana.com/login)
  - When using the portal, providers can upload supporting documentation directly
-  **Exceptions**: Must submit hospice, home health and biopharmacy PA requests via **fax**
-  Providers also can check authorization status on the portal

# Secure Portal Registration or Login



[Home](#) [Find a Provider](#) [Portal Login](#) [Events](#) [Contact Us](#)

Contrast ☒ On ☐ Off [a](#) [a](#) [a](#) language▼

FOR MEMBERS

FOR PROVIDERS

GET INSURED

## FOR PROVIDERS

Login

Become a Provider

Prior Authorization +

Dental Providers

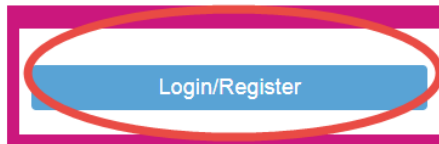
Pharmacy +

Provider Resources +

QI Program +

Provider News

## Portal Login



[Click here for more information](#) on the Provider Portal functions and training documents.

### Behavioral Health Secure Portal

[Click here for the Cenpatico behavioral health portal.](#)

### Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

### Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login button. A new window will open. You can login or register.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

# Registration

## Registration Complete!

Your Progress 

Thank you for completing your registration! A Superior HealthPlan provider services specialist will be sending you an email when your profile has been activated. Please allow up to 2 business days for processing.

If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call 866-895-8443 for additional assistance.

Login



Features

Join Our Network

CREATE ACCOUNT

## The Tools You Need Now!

Our site has been designed to help you get your job done.

For registration or secure website questions call (866) 912-0327.

Manage all products with ease in one location



### Check Eligibility

Find out if a member is eligible for service.



### Authorize Services

See if the service you provide is reimbursable.



### Manage Claims

Submit or track your claims and get paid fast.

### Login

User Name ( Email )

name@domain.com

Password

Login

[Forgot Password / Unlock Account](#)

### Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

### How to Register

Our registration process is quick and simple. Please click the button to learn how to register.

Provider Registration Video

Provider Registration PDF



Eligibility



Patients



Authorizations



Claims



Messaging



Help

Provider Name

Viewing Dashboard For:

Tax ID Number

Medicaid

GO

## Quick Eligibility Check

Member ID or Last Name

123456789 or Smith

Birthdate

mm/dd/yyyy

Check Eligibility

## Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	08/19/2017	C	4
	08/19/2017	T	3
	08/19/2017	C	1
	08/19/2017	F	8

## Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics--Coming Soon >

## Recent Activity

Date

Activity

## Quick Links


[Provider Resources](#)







Please allow 24-48 hours for your account to be verified. An email will be sent once access to the portal tools have been granted to the respective account.



# Authorizations

 View, create and filter group authorizations



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
  Help

Viewing Authorizations For :

**Authorizations**

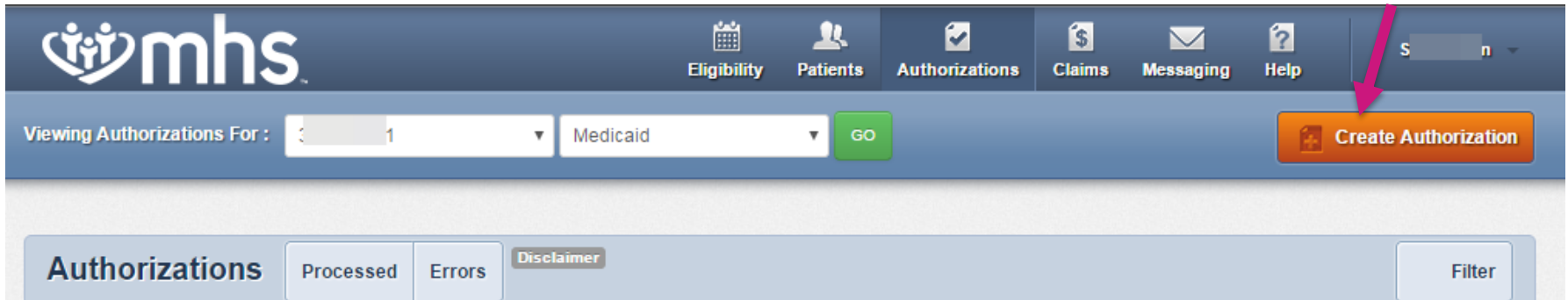
Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	O [REDACTED] 1	Al [REDACTED] H	07/24/2017	10/24/2017	E11.9	OUTPATIENT	DME
<b>PARTIAL_APPROVE</b>	C [REDACTED] 9	[REDACTED] V	06/14/2017	09/19/2017	B07.9	OUTPATIENT	Office Visit

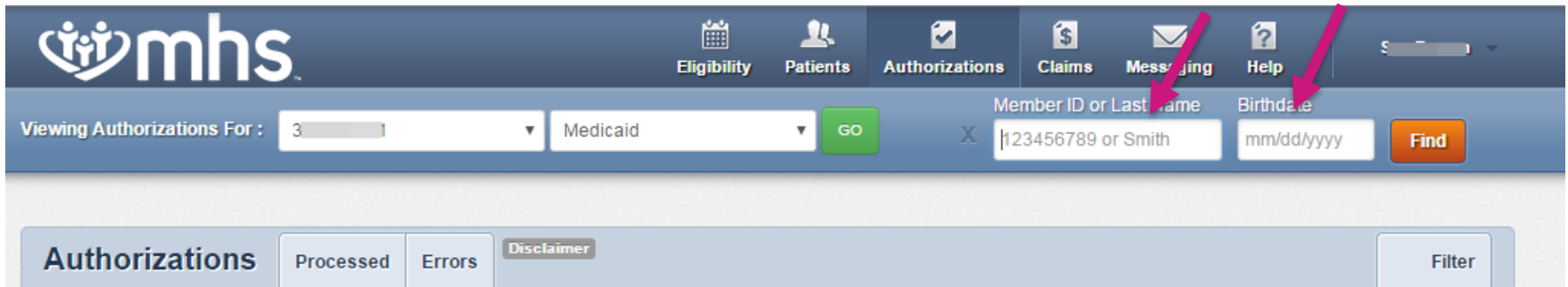
# Creating a New Authorization

 Click **Create Authorization**

 Enter **Member ID** or **Last Name** and **Birthdate**




The screenshot shows the MHS web interface. At the top is the MHS logo and a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar is a section for 'Viewing Authorizations For :'. It includes a dropdown menu with '1' selected, a 'Medicaid' dropdown, and a green 'GO' button. To the right of this section is an orange button labeled 'Create Authorization', which is highlighted with a red arrow.








This screenshot shows the same MHS web interface, but with the search fields highlighted. The 'Viewing Authorizations For :' section is the same. To the right, there are two input fields: 'Member ID or Last Name' and 'Birthdate'. The 'Member ID or Last Name' field contains the text '123456789 or Smith', and the 'Birthdate' field contains the text 'mm/dd/yyyy'. A red arrow points to the 'Member ID or Last Name' field, and another red arrow points to the 'Birthdate' field. Below these fields is an orange 'Find' button. The bottom of the page shows the 'Authorizations' section with tabs for 'Processed', 'Errors', and 'Disclaimer', and a 'Filter' button.

# Creating a New Authorization

## Select a Service Type



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
 Provider Name

Viewing Authorizations For :
 

TIN NUMBER

Medicaid

GO

Create Authorization

**Authorization For**

NE

DOB:

MEDICAID NBR:

By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4648 for after-hours urgent admission, inpatient notifications or requests.

Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.

As of 10/1/15 Retro Authorizations with ICD-9 codes should not be submitted on the web. Authorizations after 10/1/15 should use ICD-10 codes.

**Enter Authorization**

**1. PROVIDER REQUEST**

☐ Urgent Request
 

Select a Service Type

NEXT >

Select a Service Type

**Medical Outpatient**

- Biopharmacy
- DME
- Drug Testing
- Genetic Testing & Counseling
- Home Health
- Imaging
- Office Visit
- Outpatient Services
- Transport

**Medical Inpatient**

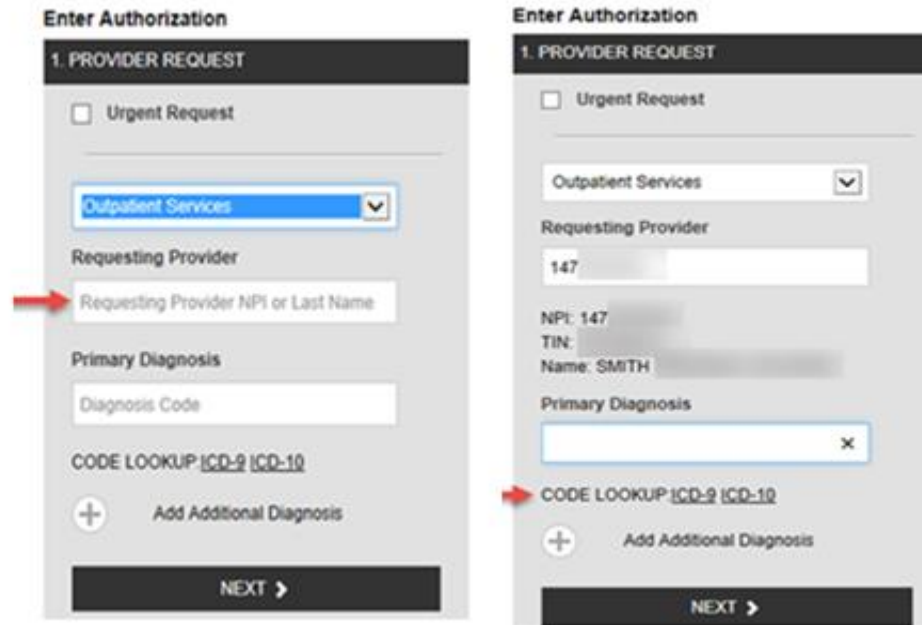
- C-Section Delivery
- Medical
- Premature/False Labor
- Rehab Inpatient
- Skilled Nursing
- Surgical Inpatient
- Transplant
- Vaginal Delivery

**2. SERVICE LINE**

**3. FINISH UP**

# Creating a New Authorization

Select Provider NPI    Add Primary Diagnosis

The image displays two side-by-side screenshots of a web form titled "Enter Authorization". Both screenshots show the "1. PROVIDER REQUEST" section. The left screenshot shows the "Urgent Request" checkbox, a dropdown menu for "Outpatient Services", and a red arrow pointing to the "Requesting Provider NPI or Last Name" input field. The right screenshot shows the same form but with the "Requesting Provider" field populated with "147", the "NPI: 147", "TIN:", and "Name: SMITH" fields filled, and a red arrow pointing to the "Primary Diagnosis" input field. Both screenshots include a "CODE LOOKUP: ICD-9 ICD-10" link, an "Add Additional Diagnosis" button, and a "NEXT >" button at the bottom.


# Creating a New Authorization

 If required Add Additional Procedures

Authorization For

DOB:  MEDICAID NBR:

**PROVIDER REQUEST**


 Service Type: Outpatient Outpatient Services  
**SMITH**   
**GENERAL SURGERY**  
 Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX  
 Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM  
 NPI: 147   
 TIN:   
 Phone:

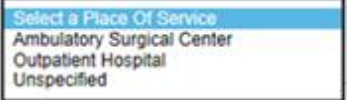
Enter Authorization


**1. PROVIDER REQUEST** [EDIT](#)

**2. SERVICE LINE**

TIN:   
 Name: SMITH   
 07/14/2015 - 07/24/2015  
 1  
 Primary Procedure  
 44970  
 LAPAROSCOPY RUSGICAL  
 APPENEDECTOMY  
[CODE LOOKUP](#)

 Add Additional Procedures

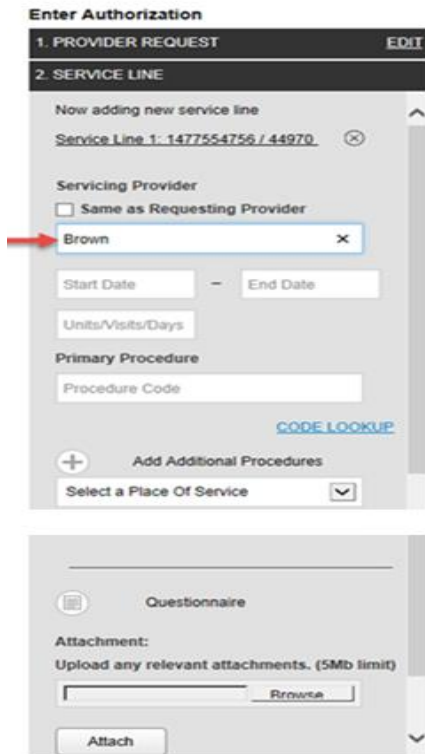

 Select a Place Of Service  
 Ambulatory Surgical Center  
 Outpatient Hospital  
 Unspecified

 Add New Service Line

**NEXT** >

# Creating a New Authorization

## Service Line Details



**Enter Authorization**

**1. PROVIDER REQUEST** [EDIT](#)

**2. SERVICE LINE**

Now adding new service line

Service Line 1: 1477554756 / 44970

Servicing Provider

☐ Same as Requesting Provider

Brown

Start Date - End Date

Units/Visits/Days

Primary Procedure

Procedure Code

[CODE LOOKUP](#)

+ Add Additional Procedures

Select a Place Of Service

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

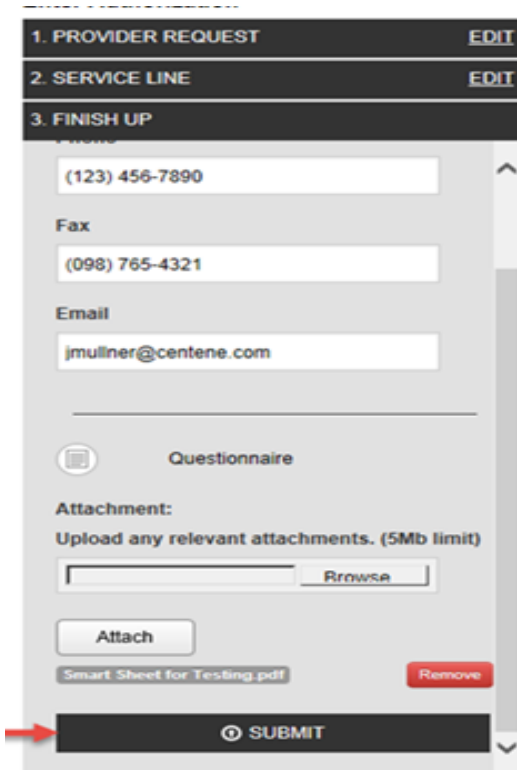
Browse

Attach

- Provider Request will appear on the left side of the screen
- Update Servicing Provider
  - Check box if same as Requesting Provider
  - Update Servicing Provider information if not the same
- Update Start Date and End Date
- Update Total Units/Visits/Days
- Update Primary Procedure
  - Code lookup provided
- Add any additional procedures
- Add additional Service Line if applicable
  - All service lines added will appear on the left side of the screen

# Creating a New Authorization

-  Submit a new Authorization
- **Confirmation Number**



1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Phone  
(123) 456-7890

Fax  
(098) 765-4321

Email  
jmuliner@centene.com

Questionnaire

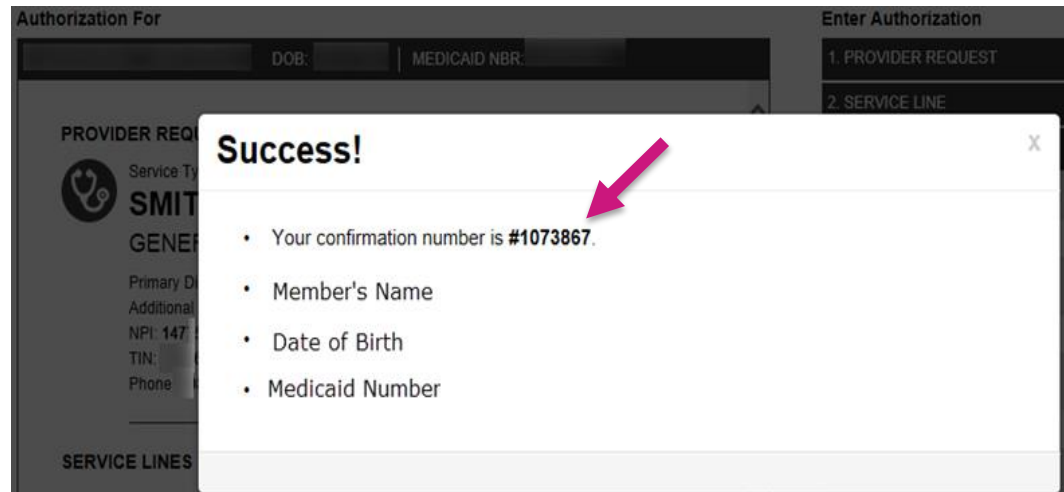
Attachment:  
Upload any relevant attachments. (5Mb limit)

[Browse](#)

[Attach](#)

Smart Sheet for Testing.pdf [Remove](#)

[SUBMIT](#)



Authorization For

DOB: | MEDICAID NBR: |

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

PROVIDER REQUEST

Service Type  
SMITH  
GENERAL  
Primary Doctor  
Additional  
NPI: 147  
TIN:  
Phone

SERVICE LINES





**Success!**

- Your confirmation number is **#1073867**.
- Member's Name
- Date of Birth
- Medicaid Number

# Telephonic



# Telephone Authorization

-  Providers can initiate Prior Authorization through the MHS referral line by calling 1-877-647-4848
  - Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
  - After hours, MHS 24 hour nurse line available to take emergent requests.
-  The PA process begins at MHS by speaking with the MHS non-clinical referral staff
-  For procedures requiring additional review, we will transfer providers to a “live” nurse line to facilitate the PA process
-  Please have all clinical information ready at time of call

# **Fax Authorization**

# Fax Authorization

**1-866-912-4245: MHS Medical Management Department**

Patient Information					
Medicaid ID/RID#:					
DOB:					
Patient Name:					
Address:					
City/State/Zip:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Medical Diagnosis (Use of ICD-9 Diagnostic Code is Required)					
Dx1		Dx2		Dx3	

*Member RID, name, and  
DOB **required***

*Diagnosis code(s)  
**required***

Please check the requested assignment category below:

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> DME         | <input type="checkbox"/> Inpatient            | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Purchased   | <input type="checkbox"/> Observation          | <input type="checkbox"/> Speech Therapy   |
| <input type="checkbox"/> Rented      | <input type="checkbox"/> Office Visit         | <input type="checkbox"/> Transportation   |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Hospice     | <input type="checkbox"/> Outpatient           |   |

*Check service category*

# Fax Authorization

Requesting Provider Information:
NPI#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID#:
Name
Address:
City/State/Zip:
Phone:
Fax:

← Enter the **referring** provider's information

← Enter the **rendering** provider's individual NPI#

# Fax Authorization

Dates of Service Start                  Stop		Procedure/ Service Codes	Modifier(s)		Requested Service	Taxonomy	POS	Units	Dollars

# Self-Referral Services

## Exceptions to prior authorization requirements

Members can see these specialists and get these services without a direct referral from their PMP:

- Podiatrist
- Chiropractor
- Family planning
- Immunizations
- Routine vision care
- Routine dental care
- Behavioral health by type and specialty
- HIV/AIDS case management
- Diabetes self management

*\*Benefit limitations apply*

# **Prior Authorization Denial and Appeal Process**

# PA Denial and Appeal Process

## If MHS denies the requested service:

- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request this.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **33 days** of the denial

The attending physician has the right to a peer-to-peer discussion with an MHS physician

- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848
- They must request peer-to-peer within **10 days** of the adverse determination

***\*Prior authorization appeals are also known as medical necessity appeals***



# PA Denial and Appeal Process


 Send Prior Authorization/Medical Necessity Appeals to:

**Managed Health Services**

**Attn: Appeals Coordinator**

**550 North Meridian Street, Suite 101**

**Indianapolis, IN 46204**

 Providers must initiate appeals within **33 days** of the receipt of the denial letter for MHS to consider

 We will communicate determination to the provider within **20 business days** of receipt

 ***A prior authorization appeal is different than a claim appeal request***

 Applicable to members and non-contracted providers

# **Need to Know**

# Prior Authorization (PA) Request

Providers can update previously approved PAs within 30 days of the original date of service prior to claim denial for changes in:

- Dates of service
- CPT/HCPCS codes
- Physician

*\*Providers may make corrections to the existing PA as long as the claim has not been submitted*

# Prior Authorization (PA) Request




 MHS strives to return a decision on **all** PA requests within **two business days** of request

 Reasons for a delayed decision may include:


- Lack of information or incomplete request
- Illegible faxed copies of PA forms – e.g. handwriting is illegible or fax is otherwise not readable
- Request requiring Medical Director review

 MHS has up to **seven days** to render PA decisions

# Prior Authorization (PA) Request

-  PA approval requires the need for medical necessity
-  If your claim is denied, please contact Provider Services at 1-877-647-4848 to determine the cause of the denial
-  Medical Management **does not** verify eligibility or benefit limitations
  - Provider is responsible for eligibility and benefit verification

# Continuity of Care PA Request

 MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.

 Reference: MHS Provider Manual Chapter 6



# MHS Provider Relations Team

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# Provider Network Territories

## Physical Health

### PROVIDER NETWORK TERRITORIES

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##### JENNIFER GARNER

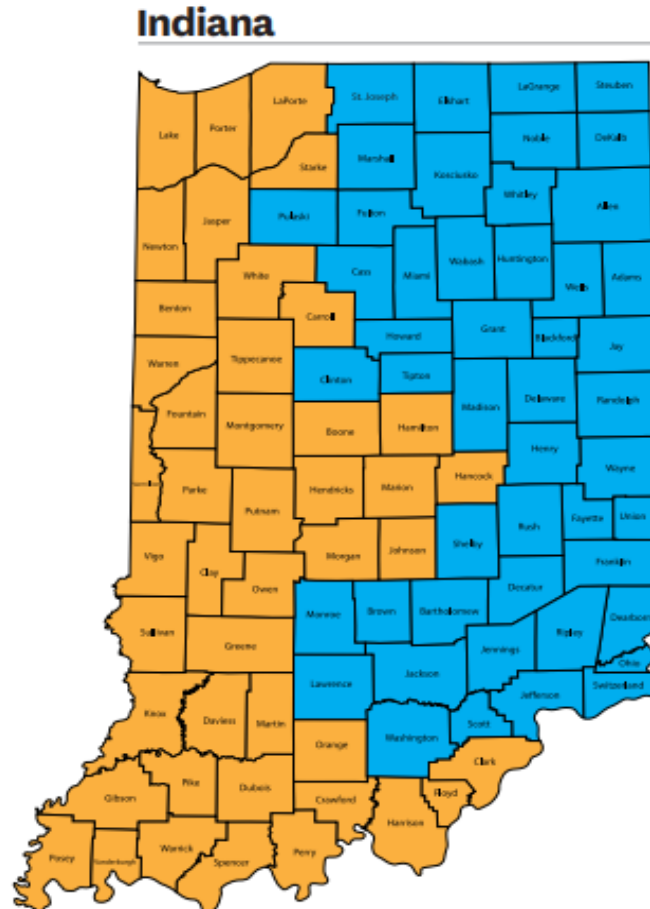
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# Review

-  Learned about the PA process and timelines
-  Highlighted the recent change regarding DME/HME and Therapy PA requirements
-  Reviewed PA submission options
-  Reviewed the Appeals Process

# **Questions?**

**Thank you for being our partner in care.**