Iowa Department of Human Services

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INFORMATIONAL LETTER NO.1628-MC

DATE: March 11, 2016

TO: All Iowa Medicaid Providers and Managed Care Organizations (MCOs)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Prior Authorizations (PA) for Providers Participating with MCOs

EFFECTIVE: April 1, 2016

*******This letter replaces Informational Letters No. 1607-MC dated January 21, 2016, and 1591-MC dated December 15, 2015 *******

The IA Health Link managed care program will begin on April 1, 2016. This letter updates and replaces Informational Letters 1607 and 1591 which directed providers on the PA process for the IA Health Link program for all other services that require a PA, including pharmacy drugs.

PAs are used by the IME to ensure program integrity by requiring that all services are medically necessary. The MCOs will honor existing IME PAs for 90 days for all services and providers.

For New or Renewal of Services:

- Effective April 1, 2016, the MCOs will be responsible for PA requests and authorizations.
- Providers should seek PA under the MCOs' policies to ensure timely and appropriate reimbursement.
- During the first 30 days of the transition to managed care, from April 1-30, 2016, no prior authorizations will be required, except for pharmacy drug claims.
- Pharmacy Drug Claim PAs
    - Beginning April 1, 2016, all prescribers, whether in-network or out-of-network, must follow the MCOs' pharmacy drug PA requirements included in the health plans Provider Manuals.
    - Drug claims requiring a PA will not be processed by the MCOs if there is not an approved PA in place.
    - Providers should continue to follow the IME pharmacy drug PA policies and processes for the Fee-for-Service (FFS) members.
- Other PAs for Services and Providers
    - Beginning May 1, 2016, all Medicaid providers whether in-network or out-of-network must follow the MCOs' PA requirements included in the health plans' Provider Manuals.
    - All claims submitted without a PA will be subject to retrospective review by the MCOs to determine if services were medically necessary.

    - The medically necessary definition remains the same at it is today per state and federal requirements. Just like today, if a claim is determined not to be medically necessary, payment may be recovered.
- Services previously covered by Magellan Behavioral Health that do not require a PA through the IME may require a PA with the MCOs.
- MCO Provider Manuals[1] are available on the DHS website.
- Providers may contract with as many of the three selected MCOs as they wish and are encouraged to complete the contracting process as early as possible for full participation.

Impact on Long Term Services and Supports:

Typically, long term care services do not require PA. Instead, these services are established based on level of care (LOC) determinations and, for those on Home and Community Based Services (HCBS) waivers, service plan determinations.

- LOC and service plans will be reviewed and updated on the regular renewal schedule.
- After March 31, all Individual Consumer Directed Attendant Care (CDAC) providers enrolled with Iowa Medicaid will be considered enrolled and contracted with the participating MCOs. They will be paid at 100 percent of the established rate floor. Claims must be submitted directly to the appropriate MCO, adhering to the MCO's claims submission and timeliness guidelines. Services will continue to require approval through the member's case management agency and/or the MCO's community case manager.
- Services may only be modified through an updated assessment. Assessments may only be updated if the member's needs have changed or at annual review.

See the following pages for the PA process for all services and providers except pharmacy drug PAs.

If you have any questions please contact the IME Provider Services Unit at 1-800-338-7909, or email at IMEproviderservices@dhs.state.ia.us.

[1] https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization/provider-materials

Prior Authorization (PA) Process

Applies to all services and providers except pharmacy drug prior authorizations. Prescribers must follow the pharmacy drug prior authorization process with the member's Managed Care Organization (MCO) regardless of network status

Front End - Dates of Service April 1, 2016 - April 30, 2016:

1. Prior authorizations with the MCOs are strongly encouraged so providers can become accustomed to the MCO specific policies and procedures. Out-of-network providers are encouraged to become accustomed to the PA process of each MCO but will not be expected to obtain PAs for medically necessary services during this time.
2. Providers should continue to treat and refer members as they currently do to ensure continuity of care for routine services.
3. Providers should seek single case agreements or contract with MCOs if they plan to continue to serve one or more Medicaid members after March 31, 2016.
4. Provider training and outreach provided by the MCOs shall be comprehensive and open to in-network and out-of-network providers. Training shall include PA and billing processes such that avoidable delays in provider payment or member service delivery shall not occur.
5. Each MCO shall have additional training materials on their website accessible for both in-network and out-of-network providers.
6. MCOs will have call centers open for additional PA requests and education. Accurate and timely information shall be incorporated in the call center scripts and job aids related to the PA process for in-network and out-of-network providers.
7. All existing PAs at the time of the member enrollment shall be honored for the first 90 days or as otherwise designated in the contract.
8. Existing PAs shall be loaded into each MCO's system based on their membership.
9. Home and Community Based Services (HCBS) service plans shall be loaded into each MCO's system based on their membership.
    a. HCBS service plans cannot be altered without an updated assessment,
    b. Assessments shall only be performed annually or if a member has a significant change in needs.

Back End - Dates of Service April 1, 2016 - April 30, 2016:

10. Lack of PAs on file will not prevent claims from being paid for these dates of service.
11. Claims shall be paid by the MCO within the timeframes designated in the contract for both in and out-of-network providers.
    a. Pay or deny ninety percent (90%) of all clean claims within fourteen (14) calendar days of receipt, ninety-nine point five percent (99.5%) of all clean claims within twenty-one (21) calendar days of receipt and one hundred percent (100%) of all claims within ninety (90) calendar days of receipt.

12. MCOs may do retrospective reviews of claims not receiving a PA to ensure medical necessity but shall not suspend payments for review prior to payment. This process must be approved by the department.
13. If a retrospective review is to be conducted, it must be completed within 90 days of the date the claim is paid.
14. MCOs must document the information that is requested to complete the retrospective review, the reason the request is being made, and the timeframe for the provider to submit the requested information. Providers must submit information to the MCOs within the designated timeframes to ensure a timely review.
15. MCOs shall provide education to providers on their PA process as part of retrospective review determination.
16. MCOs may recover payments from providers for reimbursed services determined not to be medically necessary.
17. Providers should be educated in the MCO prior authorization policies to ensure to reduce the risk of recovery for claims paid when the service is determined to not be medically necessary. See No. 2 and 3 above.
18. The MCOs shall report the volume and outcome of the retrospective reviews on the 30th day of each month.
19. Determination of lack of medical necessity is considered an adverse action and may be appealed by the member.

Front End - Dates of Service May 1, 2016 - ongoing:

1. PAs with the MCOs are required.
2. Provider training and outreach provided by the MCOs shall be comprehensive, ongoing, and open to in-network and out-of-network providers. Training shall include PA and billing processes such that avoidable delays in provider payment or member service delivery shall not occur.
3. Each MCO shall have additional training materials on their website accessible for both in-network and out-of-network providers.
4. MCOs will have call centers open for additional PA requests and education. Accurate and timely information shall be incorporated in the call center scripts and job aids related to the PA process for in-network and out-of-network providers.
5. For the first year, existing PAs at the time of the member enrollment shall be honored for the first 90 days or as otherwise designated in the contract. After the first year, existing PAs at the time of the member enrollment shall be honored for the first 30 days or as otherwise designated in the contract.
6. Existing PAs shall be loaded into each MCO's system based on their membership.
7. HCBS service plans shall be loaded into each MCO's system based on their membership.
    a. HCBS service plans cannot be altered without an updated assessment,
    b. Assessments shall only be performed annually or if a member has a significant change in needs.

Back End - Dates of Service May 1, 2016 - ongoing:

8. Claims shall be paid by the MCO within the timeframes designated in the MCO contract, Section 13.4.6.
9. MCOs may do retrospective reviews of claims to ensure medical necessity. This process must be approved by the department.
10. MCOs shall provide education to providers on their PA process as part of retrospective review determination.
11. MCOs may recover payments from providers for reimbursed services determined not to be medically necessary.
12. Providers should be educated in the MCO PA policies to ensure to reduce the risk of recovery for claims paid when the service is determined to not be medically necessary. See No. 2 and 3 above.
13. The MCOs shall report the volume and outcome of the retrospective reviews on the 30th day of each month.
14. Determination of lack of medical necessity is considered an adverse action and may be appealed.