

Select originating cluster

Catharine Cooper

Authorized Signature

Number: SPD-IM-04-054
Issue Date: 06/25/04

Topic: Medical Benefits

Subject: Centralization of the Prior Authorization of Medical Services and Supplies

Applies to (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> All DHS employees
<input checked="" type="checkbox"/> Area Agencies on Aging
<input type="checkbox"/> Children, Adults and Families
<input type="checkbox"/> County DD Program Managers | <input type="checkbox"/> County Mental Health Directors
<input type="checkbox"/> Health Services
<input checked="" type="checkbox"/> Seniors and People with Disabilities
<input type="checkbox"/> Other (please specify): |
|---|---|

Message:

If you have any questions about this information, contact:

Contact(s):	Tina Kitchin		
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E-mail:	Tina.C.Kitchin@state.or.us		

Progress on the Centralization of the Prior Authorization process to OMAP

After much planning and cooperation involving OMAP, SPD/AAA, and representatives from advocates, the final implementation phase occurred on May 1, 2004. All Oregon Health Plan Plus and Standard medical services, supplies and equipment that previously were authorized by SPD/AAA offices are now being authorized by OMAP. Attached is the first of four quarterly status reports.

Authorizations receive three levels of priority: Immediate (24 hour), Urgent (3 working days) and Routine (5 working days), meaning that an authorization will either be approved, denied, or pended (if it lacks complete information) within the appropriate timeframe. The final transition went smoother than anticipated, in a large way because of cooperation from local offices, with an especially big thanks to Multnomah Aging and Disability Services.

Through the month of May, all Immediate and Urgent requests and all Routine requests for incontinence supplies, hospital beds and wheel chairs were handled within the appropriate time. The turnaround time for other Routine Prior Authorizations dropped from 15 days to 12. The most common delay has been the need for some

DME providers to re-learn specifics in the Administrative Rules because they previously relied on some Medical Workers to collect the information that was the provider responsibility.

Prior Authorization Confirmations and Problem Solving

- If you wish to check the status (received, approved, denied or pended) of a Prior Authorization, check the ELGP screens. Enter this screen by typing “ELGP,prime number of the client”. To understand the various codes on this screen, place the cursor on the field and hit F1, the help key. For further instruction, see attached.
- If you want to know the oldest age of outstanding Routine Prior Authorizations currently being processed (listed by the date that OMAP received the Prior Authorization), call 1-800-642-8635 and listen to the recording. This number should not be given to clients or advocates. Prior Authorizations received later than the date given, may have already been processed.
- If the Prior Authorization has been approved but the equipment or supply has not arrived, contact the provider for further information. If concerned about the status of one pending, also first contact the provider. If unresolved and further information is needed, SPD/AAA staff may call the 1-800 number.
- If you need further assistance, SPD/AAA staff can contact either Donna Weaver (503-945-5977) or the OMAP Medical Unit (which handles Prior Authorizations) Lead Worker, Cora Elder (503-945-6520). Both are also in Groupwise.

Project Overview

In response to Department of Human Services (DHS) audit findings and recommendations, Seniors and Peoples with Disabilities (SPD), Area Agencies on Aging (AAA) and the Office of Medical Assistance Programs (OMAP) have initiated a project to locate the prior authorization (PA) of SPD/AAA services and supplies within OMAP. Exceptions to the OMAP centralization of PAs are SPD clients served by the Medically Fragile Children's Unit (MFCU), clients in managed care plans or fee-for-service clients in contracted (high cost/high risk or Health Integrated) case management. The primary reasons to centralize the PA process are:

- To ensure the consistent application of policy and procedures;
- Lower the costs of medical care;
- Reduce confusion among providers by identifying a single point of contact.

The PA Centralization project was implemented in phases. On December 1, 2003 OMAP began receiving all speech therapy, audiology and hearing aid PAs. Physical therapy, occupational therapy, home health services and private duty nursing PAs followed on January 1, 2004. The third and final phase was implemented on May 1, 2004 when OMAP began receiving PAs for durable medical equipment/supplies and prosthetic/orthotic services (DMEPOS).

With the full centralization of PAs underway, OMAP will issue monthly status reports until September 2004. These reports serve two purposes:

- Provide stakeholders with the previous month's PA processing statistics and service levels.
- Document issues that were previously identified and ensure chronic problems are effectively addressed.

OMAP Processing Performance in May 2004

Based on client need and provider request, PAs may receive three levels of service: Immediate (24 hour), Urgent (3 working days) and Routine (5 working days). Throughout all phases of the project, Immediate and Urgent PAs have been processed within their required timeframes. However, unanticipated delays in the DHS hiring effort resulted in a 15 working day turnaround for Routine PAs on May 1st. This equates to a 10-day backlog.

DMEPOS represents the majority of PAs issued by SPD and numerous actions were taken to ensure that the Routine backlog did not increase during May. SPD dedicated Kathy Giddens, RN to assist the OMAP Medical Unit (MU), new Routine PAs from seven branch offices in Multnomah County were routed to Jeanne Harold, additional OMAP Program and Policy staff were assigned to review PAs and assist with the MU RN Benefit Hotline and mandatory overtime of MU staff was requested. Thanks to the coordinated and extraordinary efforts of these individuals, the backlog was improved from 10 working days to 5 working days even as the daily average count of PAs increased to 175 from 82 in April.

During the month of May, PAs were processed in the following quantities: Kathy Giddens: 319 (8.3%), Multnomah County: 121 (3.2%), PPS staff: 75 (2.0%), and MU staff: 3318 (86.5%) for a total of 3833.

The training of 12 new staff members has proceeded on target and productivity has accelerated beyond our initial projections. With the exception of one RN, the OMAP MU is now fully staffed and we anticipate a reduction in the Routine backlog from the current 7 days (as of June 4th) to 5 days by July 1st.

OMAP Operational Plan for June 2004

Kathy Giddens has returned to her primary duties with SPD and the OMAP MU will make up for her loss by hiring a part-time former OMAP RN for 16 hours per week and expand the types of DMEPOS items processed by technical PAs staff. Although mandatory overtime was discontinued on May 10, voluntary overtime will continue to be worked in June.

OMAP will begin routing new Routine DMEPOS PAs for all SPD branches to Jeanne Harold in Multnomah County. This action will increase the daily average of expected PAs processed by SPD resources from 10 to 20.

Issues: Emerging and Resolved

Issues that were identified in earlier phases of the project were also present in May. These issues are:

1. **Incomplete PA requests.** OMAP has to do “send back” letters to request complete information in order to technically process the PA and comply with established rules. For example, the provision of acquisition costs or Manufacturer’s Suggested Retail Price (MSRP) for certain services as required by rule.
2. **Receipt of PAs for items that do not need PA.** MU notification that PAs for dual eligible clients (Medicare/Medicaid) are not required for some services covered by Medicare.
3. **Items not paid by OMAP since they are covered by the nursing facility.** Payment denial for services that are considered part of the all inclusive nursing home fee.

With respect to issues 1 and 2, MU staff and policy analysts are conducting extensive phone training. MU representatives will also provide onsite training, as warranted. Issues 3 and 4 are being addressed by OMAP policy in collaboration with SPD.

Initiatives of the size and scope of the PA Centralization project represent a significant change for all concerned. It is reasonable to expect that stakeholder apprehension and concern is justifiably high. To the greatest degree possible, OMAP follows up on each incident of customer frustration, perceived or expressed, with a thorough analysis. Our intent is to ensure that isolated events are not indicative of a chronic problem with the PA processing system. The PA of medical services often involves the exchange of complex information. In most cases, a failure to provide a timely response is a shared responsibility. OMAP pledges its commitment to ensure that delays in PA processing are kept to the absolute minimum.

ELGP

Prior Authorization Screen

The Prior Authorization Screen is used to enter and track requests for medical services requiring prior authorization before they can be paid. It also displays the status and location of a request for prior authorization, and information of the disposition of a claim.

From a clear screen, enter one of the following:

ELGP, 8 digit prime number < ENTER >

ELGP, 8 digit prime number, 9 digit prior authorization number < ENTER >

ELGP, 8 digit prime number, 9 digit prior authorization number,
1 digit page number < ENTER >

Prior Authorization Screen Example

(1)	(2)	(3)	(4)	(5)	ACTION I	ID
ELGP	#####	021380656,4				
ST/DATE	LST FLD	DATE	CLK SR	(6)MSG		
V 051802	CHG 5106	071602	1	MSG PA		HIT ENTER TO CONTINUE
PAGING						
(7)NAME	BUNNY,	BUGS JR	DOB	0408909	SSN #####	SEX M ALT
TPR Y			PRIOR AUTHORIZATION			
SEQ (8)ST	(9)DATE	(10)LOC	ST	DATE	LOC	ST DATE LOC
	RAC 071602	9400RN	RAC	071302	9400RN	PCL 070602 6202XX RAC 062902 9400RN
ST	DATE	LOC	PA NUMBER	(11)SERVICE	(12)DATE RANGE	S-FUND
ATTACH						
PCL	061302	6202XX	021380656	DMEB	050602	063002
(13) REF PROV	#####					
(14)TOS A	(15)PROC/DRUG	#####	(16)AND	#####		
(17)\$MAX \$00290.00	(18)\$CUT \$00000.00	(19)\$ADJUST \$00000.00	(20)\$REMAIN \$00126.12			
(21)#SERVICE 112	(22)#PAID 004	(23)#DENIED 000	(24)#REMAIN 108			
ABORTION			STERILIZATION DATES			
REASON POS SIGN	732	733	CLIENT	OBTAIN	INTERP	PROV PREMDEL EMERG
			000000	000000	000000	000000 000000 (31)
(25)	(26)	(27)	(28)	(29)	(30)	SERV
PROV NUM	TYPE	\$PAID	\$DENIED	DOS RANGE	ICN	EOB PAID
000000		000000000	000000000			
#####	MM	000008194	000000000	50602 50602	4002161790878	093 1
#####	MM	000008194	000000000	60102 60102	4002183790708	093 1

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ELGP

Cross Reference Fields

Number	Field	Description
1.	ELGP	Code used to access the Prior-Authorization Screen.
2.	PRIME ID	The prime number of the recipient.
3.	PA#	The unique 9 digit number assigned to each prior authorization request. The format is YYJJTTTT. <i>YY = Year</i> <i>JJJ = Julian date</i> <i>TTTT = The time of day PA entered into the system</i>
4.	LN	Indicates the line number of history segment for adjudicated claims.
5.	ACTION	Required to access screen information. No code is needed to view the screen. <i>I = Inquire</i> <i>A = Add</i> <i>C = Change</i> <i>D = Delete</i>
6.	MSG	Areas where system supplied messages to assist the user.
7.	NAME	The complete name of recipient.
8.	ST	The status of the approved, denied, or penned prior authorization request.
Code	Status	
BRI	Branch initiated; pending approval or denial	
PCL	Paid and closed; claims received for dollar amount or number of services approved	
RAC	Request active; request approved	
RCS	Request received, pending approval	

Code	Status - continued	
RCL	Referred to OMAP consultant	
RPP	Request penned to provider for additional information	
WTH	Request withdrawn	
R01- R99	Request denied; based on General Rules or OHP Administrative Rules	
Number	Field	Description
9.	DATE	Status change date for a given record.
10.	LOC	Indicates the branch location of the prior authorization request that the recipient is assigned to. <i>0001PR = OMPRO Nurse Review</i> <i>9400CH = Medically Fragile Children's Unit</i> <i>9400CM = Case Management</i> <i>9400DM = OMAP Dental Group</i> <i>9400RN = OMAP Medical Unit</i> <i>6202## = Indicates other transaction inspired</i> <i>4 digit branch + 2 digit worker ID = SPD</i>
11.	SERVICE	Identifies service category for budget tracking.
Code	Description	Approving Authority
CO60	Emergency Response System, Contract RN	SPD
DENT	Dental	OMAP, TEDS Unit
DMEA	Durable Medical	OMAP / MFCU
DMEB	Apnea Monitor	OMAP / MFCU
EPIV	Home E/P Nutrition/IV Services	OMAP / MFCU

Code	Description	Approving Authority - continued
HHLT	Home Health	OMAP / MFCU
OMAT	Ophthalmologist	OMAP, Medical Unit
OTHA	Occupational Therapy	OMAP / MFCU
PRDA	Private Duty Nurse	OMAP / MFCU
PTHA	Physical Therapy	OMAP / MFCU
SPHA	Speech/Hearing	OMAP / MFCU
SUPA	Medical Supplies	OMAP / MFCU
HOSP	Hospital Out-Patient Therapy	OMAP / MFCU
MDSX	Physician/ In-Patient/ Out-Patient Surgery Procedure	Oregon Medical Professional Review Organization (OMPRO)
12.	DT RANGE	The starting and ending date which a medical procedure was authorized.
13.	REF PROV	The 6 digit OMAP provider number of the provider who is referring the recipient to another provider. <i>Note: 999999 may be used if the referring provider is unknown</i>

Number	Field	Description
14.	TOS	A 1 digit code used in conjunction with a procedure code.
15.	PROC/ DRUG	The individual or range of services that is prior authorized. <i>Diagnosis code =3-5 digits</i> <i>Procedure code =5 digits</i>
16.	AND/ THRU	Used in conjunction with PROC/DRUG field to enter 2 or more codes that is being prior authorized.
17.	\$MAX	The maximum dollars to be paid for all services under the prior authorization.
18.	\$CUT	The dollar amount already paid for this prior authorization.
19.	ADJUST	The dollar amount of adjusted claims processed against this prior authorization.
20.	\$REMAIN	The dollar amount left for payment under the prior authorization.
21.	#SERVICE	The number of procedures/services allowed under the prior authorization.
22.	PAID	The number of procedures/services paid under this prior authorization.
23.	DENIED	The number of procedures/services denied under this prior authorization.
24.	#REMAIN	The quantity of services remaining under the prior authorization.
25.	PROV NUM	The OMAP 6 digit number for a provider that submitted a claim for payment processing under the prior authorization.
26.	TYPE	The type of provider that corresponds with field 19.

Number	Field	Description
27.	\$PAID	The dollar amount paid to the provider for claims submitted with the prior authorization.
28.	DOS RANGE	Indicates the from and through dates of service billed on the provider claim.
29.	ICN	The internal control number (ICN) assigned to the claim submitted by the provider for the prior authorization.
30.	EOB	A 3 digit code that explains how a medical claim was adjudicated.
31.	SERV PAID	The number of services paid under the authorization for the claim submitted for payment processing.