

Overview

Notification & Prior Approval

2019

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Clarification update: 11.1.2018



Services that generally do not require Prior Approval

- Emergency Services (9-1-1) – transportation and ED evaluation/treatment
- Once care is transitioned from the ED (i.e., to OR, observation, admission), notification is required within 48 hours of admission
- Generally, procedures performed in provider office or ED (Place of Service: 11 & 23)
- Outpatient laboratory procedures

Services Requiring Notification

- All In-Network Admissions (Acute Care Hospital, Acute Rehab, Home Health, Skilled Nursing Facility)
- Crisis Evaluations
- Transfer from one Acute Care Hospital (ACH) to Another ACH
- Transfer to Hospice
- Clinical Trial and/or Study associated services
- OB Admissions
- Observation (overnight whether or not Member uses a bed)

Service Categories Requiring Prior Approval ([Click here for Quick Reference Guide: eviCore Medical Prior Approval Requirements](#))

- Advanced Imaging (CT/PET Scans, MRI, MRA, SPECT/brain, 3D Rendering)
- Allergy Testing
- Ambulance (Non-Emergency-Ground, Air, Water)
- Behavioral Health Services (BHS)
- Cardiac Rehabilitation
- Cardiac Testing
- Cardiovascular Procedures
- Chemotherapy
- Chiropractic services
- Colonoscopies
- Dental and Orthognathic related services
- Dialysis (End Stage Renal Disease- ESRD)
- Durable Medical Equipment (DME) ([Click here for Quick Reference Guide: DME Durable Medical Equipment](#))
- Early Intervention Services
- Elective inpatient procedures/admissions

- ENT services/procedures
- Gastroenterology and General Surgery
- Genetic/Pharmacogenetic Testing/Molecular Diagnostics
- Genitourinary Procedures
- Hearing Aids or Repairs
- Hyperthermia Treatment
- Home Infusion Therapy
- Home Health Services
- Hospice/Hospice Respite Care
- Infusion/Injections – Selected Medical Benefit drugs and biologicals ([Click here for Quick Reference Guide: Medications \(Medical Benefit\) Prior Approval Requirements](#))
- In-Home Biometric Monitoring
- Inpatient Admissions (All)
- Long Term Acute Care Hospital (LTACH)
- New Technology
- Nuclear Cardiac/Radiology Studies
- Nutritional Products/Services
- Nutritional Therapy
- Observation Stays
- Occupational Therapy
- Ophthalmology Procedures
- Orthopedic Procedures
- Osteopathic Manipulation
- Out of Network Services: Second Opinions and some Behavioral Health Services
- Outpatient Procedures, surgeries, services
- Pain Management Services/injections
- Parenteral and Enteral Therapy
- Physical Therapy
- Potentially Unproven Services
- Pulmonary Rehabilitation
- Radiation Treatment
- Reconstructive/potentially cosmetic procedures
- Second Opinions (only for non-plan providers)
- Sleep Studies – home and lab
- Speech Therapy
- Surgical procedures done in inpatient or ambulatory care/outpatient settings
- Transplant and related services

- Transportation (Air and non-emergency)
- Ultrasound (OB & non-OB)
- Unlisted CPT codes (always require review regardless of place of service)
- Urgent Care Center (UCC) (No PA required for an urgent care visit, but any service that requires PA in the UCC must be Prior Approved)
- Wigs/Artificial Hair Pieces
- Wound Care Products/Procedures (Prior Approval required for Provider Office or Outpatient Wound Center)

Non-Covered Services - General Overview (not all inclusive)

- Acupuncture
- Alternative/Complementary Treatment/Therapy
- Artificial Heart Transplant
- Category III codes
- Clinical Trials and/or Studies
- Cochlear Implants
- Commercial Diet Plans/Programs
- Cosmetic Procedures
- Custodial Care
- Dental Care (unless otherwise stated)
- Dental Implants/Prostheses
- Durable Medical Equipment that is not lowest cost that meets Member's needs
- Erectile or Other Sexual Dysfunction Treatment
- Experimental or Investigational
- Food or Dietary Supplements
- Hearing Care (unless otherwise stated)
- Infertility/Surrogacy Treatment/Procedures
- Orthotic Devices
- Over-the-Counter medications/supplies (unless otherwise stated)
- Refractive Surgery
- Reversing Voluntary Induced Sterility
- Routine Circumcisions
- Routine Foot Care
- S-codes once CMS designates alternate code
- Spinal Decompression Devices
- Temporomandibular Joint Syndrome (TMJ)

To submit authorization requests:

<p>Health Options authorizations:</p> <ul style="list-style-type: none"> ▸ Quick Reference Guide: Health Options Medical Prior Approval & Notification Requirements ▸ Portal: Provider.HealthOptions.org ▸ Fax: (877) 314-5693 ▸ Phone: (855) 542-0880 	<p>eviCore authorizations:</p> <p>Quick Reference Guide: eviCore Medical Prior Approval Requirements</p> <p>Portal: eviCore.com/Pages/ProviderLogin.aspx</p> <p>Phone: (855) 316-2673</p> <p>Please call for all urgent requests.</p> <p>Fax: (800) 540-2406 (Radiology, Cardiology, Ultrasound)</p> <p>Fax: (855) 774-1319 (Spine, Joints, (shoulder, hip, knee) and Pain Management)</p>
<p>Behavioral Health authorizations:</p> <ul style="list-style-type: none"> ▸ Quick Reference Guide: Behavioral Health Prior Approval & Notification Requirements ▸ Fax: (207) 761-3079 ▸ Phone: (855) 481-7047 	<p>Pharmacy/Medication authorizations (Express Scripts)</p> <ul style="list-style-type: none"> ▸ Fax: (877) 329-3760 ▸ https://client.medco.com/CWSCommonService/Login

Authorization Submission Guidelines

The above authorization guidelines provide a **high level** overview of service categories that generally require Notification and Prior Approval.

Health Options reserves the right to update the Notification/Prior Approval list without notice. We will provide a 60-day notice for any substantive changes.

Health Options' Provider Relations, Utilization Management (UM), and Claims teams work collaboratively to facilitate a courteous and respectful workflow for our provider partners. While we do not modify the authorization inclusion list solely based on provider preference, we welcome feedback on how we can improve the provider experience with the Utilization Management process. Please feel free to provide feedback to our Provider Relations team at Provider@HealthOptions.org.

Provider Requirements

Member Eligibility

It is the provider's responsibility to check Member eligibility status on the date of service to confirm Member is still eligible for benefits.

Timely Authorization Submissions

Emergency Services

'911' emergency ambulance transports and Emergency Department services do not require prior approval; however, once the medical condition is stabilized, Notification and Prior Approval requirements apply for all services that require Notification and Prior Approval. Treatment received outside the Emergency Department, whether routine or urgent, may require Prior Approval. See Health Options Notification and Prior Approval requirements posted at HealthOptions.org.

Urgent Services

Urgent services include medical care or treatment with respect to which the application of time periods for making non-urgent Prior Approval decisions could seriously jeopardize the life or health of the Member or ability of the Member to regain maximum function, or in the opinion of the provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the authorization request.

Place of Service Considerations

Emergency Department

No Prior Approval is required for services performed in the Emergency Department.

Inpatient Admissions

Health Options will perform Medical Necessity review for the entire stay.

Notification is required within 48 hours (or by noon on the first business day after the weekend) even if the patient is already discharged.

Delayed notification may result in an administrative denial for admission days prior to notification.

An approved day of Admission is based on the clinical presentation and is not necessarily for all services rendered during the stay.

Health Options will review the Admission claim submission.

If medical necessity is not met for any service or procedure provided during the admission, the applicable line item may be denied.

Facility/provider has appeal rights.

Observation Stays (Effective 1/1/19)

Health Options will perform Medical Necessity review for the entire stay.

Notification is required within 24 hours (or by noon on the first business day after the weekend) even if the patient is already discharged.

Delayed notification may result in an administrative denial for observation days prior to notification.

An approved day of Observation Stay is based on the clinical presentation and is not necessarily for all services rendered during the stay.

Submit all supporting clinical documentation as soon as feasible and within 10 BD of the 1st Observation day.

Health Options will review the Observation claim submission.

If Health Options determines additional clinical information is needed to support medical necessity of any services/procedures rendered during an Observation Stay, a request will be made to the facility.

Examples include but not limited to:

- Genetic Testing
- Surgical Procedures
- Unlisted Procedures
- Diagnostic Imaging

If medical necessity is not met, line item may be denied. Facility/provider has appeal rights.

Concurrent Review

Concurrent review (e.g., ongoing inpatient care) decisions are generally rendered within 24 hours (one calendar day) of receipt of all necessary information. Facilities are required to notify the Plan 24 hours prior to the last covered day. This is required when an extended stay is anticipated.

Urgent Pre-Service Authorization Requests

If you indicate the authorization request is urgent, you are personally attesting that the requested service is urgent based on the Member's clinical presentation and it is not based on Member, provider or organization convenience.

If 'urgent' is selected inappropriately and our Medical Management team determines that the request is for routine care, we will change the status to routine and process accordingly.

Routine Pre-Service Authorization Requests

Routine services that require Prior Approval should be submitted before the service is rendered.

Routine pre-service ambulatory/outpatient requests are generally rendered within two (2) business days of receipt of all necessary information.

Urgent pre-service ambulatory/outpatient service requests are generally rendered within 48 hours (two calendar days) of receipt of all necessary information.

Post-Service Authorization Requests

Post-service authorization requests are generally discouraged. Authorization requests received beyond 10 (ten business days of the date of service) will result in an administrative/benefit denial.

Minimum Necessary Information

Observation stays and inpatient admissions require Member demographics and at least one diagnosis.

Ambulatory/Outpatient services require Member demographic information, at least one diagnosis, and all applicable CPT/HCPCS procedure codes associated with the service request.

Appropriate Level of Care

Health Options does not reimburse for claims that are submitted for an amount that is higher than the approved level of care.

Decision Turnaround Times (TATs)

Health Options and our partners strive to make medical necessity decisions as swiftly as possible upon receipt of all necessary information. We continuously monitor adherence to TATs and implement a corrective action plan if our overall TAT scoring drops below 90%.

Submission of all relevant written clinical information at time of authorization submission will expedite clinical review. If additional clinical information is needed, the UM team will notify provider what information is missing. The UM decision turnaround time is extended to accommodate submission of additional clinical information. If the requested clinical information is not received within designated timeframes, the authorization will be denied for lack of sufficient information to inform decision.

General guidelines (exceptions apply) for Medical Necessity decision turnaround times are based on receipt of all necessary information:

- Urgent concurrent (e.g., ongoing inpatient care) – one calendar day
- Routine concurrent (e.g., ongoing home health, outpatient services) – one business day
- Urgent Pre-Service – two calendar days
- Routine Pre-Service – two business days
- Retrospective service – 30 calendar days

Our UM team monitors urgent requests on weekends and holidays. UM will process urgent decisions within established turnaround times. Requests for additional clinical information may be required.

Turnaround Time Overview:

- Business Day (BD): Monday-Friday (except recognized holidays)
- Calendar Day (CD): Sunday-Saturday: includes weekends/holidays
- Day of receipt = day zero (not included in turnaround count)

Examples: UM Decision turnaround time:

1) Routine Pre-Service request: Anticipate decision by 5pm (ET) on **2nd business day**

Received anytime Fri on holiday weekend: Fri (day 0), Sat/Sun (day 0), Mon/Holiday (day 0), Tue (BD 1), **Wed (BD 2)**

2) Urgent Pre-Service request: Anticipate decision by 5pm (ET) on **2nd calendar day**

Received anytime Fri on holiday weekend: Fri (day 0), Saturday (CD 1), **Sun (CD 2)**

3) Urgent concurrent review: Anticipate decision by 5pm (ET) on **1st calendar day**

Received anytime Tue: Tue (CD 0), **Wed (CD 1)**