Quick Reference Guide

Summary of Authorization Requirement Highlights and Updates

2019

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Summary of Authorization Requirement Updates

Health Options is pleased to present a summary of 2019 Utilization Management updates to assist member, provider and broker understanding of what changes will be implemented on 1/1/2019. This summary is a high-level overview and it is not intended to be all inclusive. For more detailed information, please see Health Options Prior Approval & Notification forms located on our website at HealthOptions.org. If you have any questions, please contact Health Options Member Services at (855) 624-6463, Monday-Friday 8AM-6PM (except holidays).

Category	Description
Ambulatory Services	‣ Requests should be submitted prior to the service being rendered. ‣ Post service reviews will be processed for medical necessity up to 10 business days (BD) of the date of service (DOS). ‣ Post service changes to existing authorizations (change in CPT/HCPCS codes) will be accepted up to 10 BD of the DOS. Examples of changes to existing authorizations: ‣ Upcoding an advanced imaging procedure (MRI w/contrast performed when MRI without contrast was approved). ‣ Changing an arthroscopic procedure to an open procedure. ‣ Adding or modifying codes for services performed during surgery (when a new or different CPT code will be on a claim submission than was noted on the authorization submission). ‣ Post-service reviews or changes to an existing authorization submitted beyond 10 BD of the DOS will receive an administrative denial for lack of timely submission.
Admissions (acute care facilities)	‣ All inpatient stays (elective, scheduled and unscheduled) require Prior Approval. ‣ Notification is required within 48 hours of admission (or by noon on the first business day after the weekend) even if the patient is already discharged. Delayed notification will result in an administrative denial for days prior to notification. ‣ Concurrent review commences on the date of notification. ‣ Prior Approval is required for all extended OB stays (beyond 48 hours vaginal delivery and 96 hours for cesarean section). Approval for OB stays will be consistent with Guidelines for Perinatal Care published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. ‣ Health Options manages Prior Approval and Notification for all medical (non- behavioral health) Inpatient admissions. ‣ Elective procedures approved by Health Options or eviCore are approved for ambulatory/outpatient services. ‣ Elective Spine & Joint (e.g., shoulder, hip, knee) procedures require prior approval through eviCore even when they are associated with an inpatient admission. eviCore approvals only apply to ambulatory/ outpatient settings. Providers must notify Health Options for all inpatient stays within 48 hours. Failure to notify Health Options may result in denial of the inpatient stay.
Admission, Discharge, Transfer (ADT) Notification Requirement	‣ Health Options requires daily Admission, Discharge, Transfer updates from all in-network acute care facilities for all inpatient admissions. ‣ Notification requirements for weekend/holiday observation/admission can be achieved through ADT report submission by 12 noon the next business day. ‣ Facilities can fax reports to Health Options Medical Management Department at: (877) 314-5693.
Appeals (UM Appeals)	‣ As of 1/1/19, Health Options Medical Management team will be processing appeals for Health Options and eviCore utilization management (UM) adverse determinations. ‣ Updated Appeal submission information is included in every denial letter.

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Authorization Date Range	‣ Approved services must be completed within the approved authorization date range.
Benefit Limits	‣ List is not all inclusive (see Member Benefit Agreement) ‣ Home Health (HMO plans only): 90 combined visits per calendar year. ‣ Chiropractic services: 40 visits per calendar year beginning 1/1/2019. This includes PT codes billed by Chiropractors. ‣ Osteopathic services: 40 visits per calendar year beginning 1/1/2019. ‣ PT/OT/ST (outpatient services): 60 combined visits per calendar year.
Chiropractic Services	‣ TMJ treatment is not covered. ‣ HMO plans only cover in-network services.
Elective Procedures (pre-approved)	‣ Elective procedures approved by Health Options or eviCore are only approved for ambulatory/outpatient services. ‣ Even when an elective procedure has been approved, Notification is required within 48 hours of an admission for an elective procedure and medical necessity review is required for the entire inpatient stay.
eviCore (require review by eviCore)	‣ Advanced Imaging (MR, PET, CT, Nuclear Medicine) ‣ Ultrasound (Non-OB) ‣ Cardiac Imaging (Myocardial Perfusion Imaging, Echo, Echo Stress, Diagnostic Heart Cath, Cardiac MR, PET, CT) ‣ Joint Surgery ‣ Interventional Pain Management ‣ Spine Surgery Place of Service Considerations: ‣ Emergency Department No Prior Approval is required for services performed in the Emergency Department. ‣ Inpatient Admissions Elective Spine & Joint (e.g., shoulder, hip, knee) procedures require prior approval through eviCore even when they are associated with an inpatient admission. eviCore approvals only apply to ambulatory/outpatient settings. Providers must notify Health Options for all inpatient stays within 48 hours. Failure to notify Health Options may result in denial of the inpatient stay. ‣ Observation Stays (Effective 1/1/19) Health Options reviews the medical necessity of the entire Observation Stay to include any services/procedures rendered during the Observation Stay. Submit all applicable clinical documentation directly to Health Observations.
Laboratory Testing	Laboratory Tests/Procedures: Below is a list of lab categories that generally require Prior Approval (not all inclusive). Please use online authorization tool for specific code requirements. ‣ Allergen Specific IGE/IGG ‣ Urine Drug Testing (see Urine Drug Testing for details) ‣ Genetic Testing ‣ Molecular Pathology Procedure ‣ Necropsy (Autopsy) ‣ Unlisted Lab Codes

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Medication Prior Approval (Medical Benefit)	‣ Medications dispensed by pharmacy undergo Prior Approval through Express Scripts. ‣ Medications dispensed by non-pharmacy providers undergo Prior Approval through Health Options Medical Management team. ‣ Updated Quick Reference Guide lists BRAND and generic names (not all inclusive). ‣ CPT/HCPCS codes Prior Approval requirements are available through our online authorization portal. ‣ Home infusion is typically the preferred Site of Care when it is clinically appropriate to infuse in the home. ‣ During the review process, Members may be offered the option to voluntarily transition to an alternate site of care. ‣‣ If Member consents to an alternate Site of Care, the provider will be contacted. ‣‣ Provider can opt for voluntary transition to an alternative Site of Care.
Medical Medication Management Prior Approval Form	‣ Health Options has added a Medication (Medical Benefit) Prior Approval Form (for use with all medications that are not dispensed by a pharmacy). ‣ Medical Benefit Medication PA requests must be submitted on the Medication (Medical Benefit) Prior Approval Form. ‣ 2019: New Medication Prior Approval Form ‣‣ Requires height, weight, dose, frequency, clinical indication. ‣‣ Include weight dependent dosing (mg/kg) criteria for requested clinical indication. ‣‣ Include drug specific National Drug Code number (NDC), when known. NOTE: NDC numbers are required for all unclassified codes on claims submissions. ‣‣ Approvals will be based on units, frequency, and visits
Observation Stays	‣ 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 Obs. 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. Notification responsibility: ‣ In-network: provider responsibility ‣ Out-of-network: Member responsibility

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Category	Description
Obstetrical Ultrasounds (OB US)	‣ For review of Prior Authorization requirements for OB US, please see Quick Reference Guide: Medical Notification & Prior Approval Requirements. As of 12/29/18 Health Options will be processing all OB Ultrasound requests. Further details to follow prior to 1/1/19 implementation.
One-to-One Code Match	‣ One-to-one code match is required between codes submitted on an authorization request and claims submissions. ‣ Authorizations can be updated when the modification is submitted within 10 BD of a service/procedure. ‣ Failure to submit authorization updates within 10 BD may result in a partial or full claim payment denial. ‣ Providers can submit recommendations for code grouping/referral categories to our provider relations team. ‣ Please email or call our Provider and Network Operations team: Email: Provider@HealthOptions.org Phone: (207) 402-3347
Online Authorizations	Providers are encouraged to submit authorization requests through our online authorization portal. Providers can see CPT/HCPCS codes PA requirement status through the online portal (once a code is entered a flag will pop-up indicating the following: ‣ No PA required ‣ eviCore ‣ Non-covered To register for the provider portal, please email or call our Provider and Network Operations team: Email: Provider@HealthOptions.org Phone: (207) 402-3347
Osteopathic Manipulation Therapy (OMT)	‣ TMJ treatment is not covered. ‣ HMO plans only cover in-network services.
Reconsiderations and Peer-to-Peer reviews	Providers have two options for reconsideration for medical necessity denials. 1) Submit additional clinical information within 15 calendar days of the adverse decision date. 2) Request a peer-to-peer (P2P) review within 15 calendar days of the adverse decision. A peer-to-peer can follow a written reconsideration review when it is submitted within 15 calendar days of the adverse decision, but a written reconsideration cannot follow a P2P review.

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Therapies (Outpatient Physical, Speech, and Occupational Therapy)	This requirement applies to all outpatient Physical (PT), Speech (ST) and Occupational (OT) therapy services. ‣ Notification is required for visits 1-12. ‣ Prior Approval is required for visits 13-60. As of January 1, 2019 benefits are capped at 60 combined outpatient PT, ST, OT visits per calendar year (applies to group & individual plans). ‣ TMJ treatment is not covered. ‣ HMO plans only cover in-network services.
Therapies Notification & Prior Approval Form	Health Options has added a Therapies: Notification and Prior Approval Form (for use with all outpatient Physical, Speech, Occupational Therapy requests.) ‣ PT, ST, OT service requests must be submitted on this form.
Transportation (Ambulance Transports)	Emergency ambulance transportation (911 response) does not require Prior Approval. ‣ Benefit coverage is limited to transport to the nearest medical facility licensed and equipped to manage the care. ‣ Fixed wing air ambulance transport always requires Prior Approval even for interfacility ambulance transports. ‣ Non-emergency ambulance transportation requires Prior Approval. ‣ Interfacility urgent/routine ground ambulance transports require notification by the sending facility within one business day of the transport. ‣ Clinical review must support the transport is medically necessary and it is to the nearest medical facility licensed and equipped to manage the care. ‣ Wheelchair vans, taxis and limos are non-covered services.
Unlisted Codes	‣ All unlisted codes, that are not otherwise specified as non-covered, require Prior Approval by Health Options Medical Management team. ‣ Medical Benefit Medication claims must include National Drug Code (NDC) when submission includes any unclassified J-codes.