Guide to Prior Approval for Medical, Behavioral Health, and Prescription Services

COMMUNITY Health Options®

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Guide to Prior Authorization for Medical, Behavioral, and Prescription Services

This document provides helpful information on Prior Approval, notification requirements and your appeal rights. Prior Approvals and notifications can be submitted by your provider using the Community Health Options Notification/Prior Approval form. Understanding how insurance processes work will help you get the most out of your plan and be your healthiest self.

Prior Approval and Notification Requirements for Medical and Behavioral Health Services/Procedures

Some types of health services, treatments, prescription drugs/infusions and medical equipment require Prior Approval and/or notification to ensure your plan covers the service or procedure.

- **Emergency Services:** Emergency ambulance transport (911 response) and hospital-based emergency department services do not require Prior Approval. However, once your medical condition has been stabilized, notification and Prior Approval requirements apply.
- **Urgent Care Services:** Prior Approval and notification are not required for visiting an urgent care center; however, some services the urgent care center provides during the visit may be subject to Prior Approval and notification requirements.
- **In-Network Services:** In-network providers are responsible for submitting Prior Approval and notification to Community Health Options prior to the scheduled procedure. **If you believe a Prior Approval or notification request has been delayed, please contact your provider's office.**
- **Out-of-Network Services:** When receiving care from an out-of-network provider, you are responsible for Prior Approval and notification requirements. If you are unsure about the authorization requirements, contact the Member Services phone number located on the back of your Member ID card. ***Note, your timely phone call to Member Services satisfies your notification responsibility. If we have not received the required clinical information from your out-of-network provider, Community Health Options will attempt to contact your provider to obtain the necessary information.***

Services Requiring Notification

Some types of health services and treatments require notification. Notification is required within 48 hours of any inpatient admission. If timely notification is not provided, you may receive an administrative denial, meaning you will not receive coverage for the service.

- Generally, if an in-network provider fails to provide timely notification to Community Health Options and the service is denied, you should not be billed for the service, unless you signed an authorization waiver prior to the service or procedure being performed.
- If you fail to notify us of an out-of-network service, the out-of-network provider can bill you for the service, even if Community Health Options denies payment to the provider.

Notification is required for the following services:

- All admissions (acute hospital, acute rehabilitation, behavioral health residential, skilled nursing, and hospice).
- Clinical trial and/or study and associated services
- Crisis evaluation
- Crisis stabilization
- Inpatient medical withdrawal management (inpatient detox services)

Services Requiring Prior Approval

Some types of health services require Prior Approval. The request must be obtained before the service or within ten business days of the service.

- Advanced imaging (CT, MRI, PET, etc.)
- Allergy testing
- Hospice/Hospice respite care
- Intensive outpatient procedures (IOP)

- Applied behavioral analysis (ABA)
- Assertive community treatment (ACT)
- Cardiac (heart) tests and procedures
- Chemotherapy
- Colonoscopies
- Dialysis
- Durable medical equipment
- Elective inpatient admissions
- Electroconvulsive therapy (ECT)
- Experimental/Investigational services (generally non-covered)
- Fertility services
- Gender-affirming surgery
- Genetic labs and diagnostics
- Home health services
- Nuclear radiology studies
- Out-of-network services (please call us)
- Pain management devices
- Partial hospitalization (PHP)
- Potentially cosmetic procedures
- Prosthesis (an artificial body part)
- Radiation treatment
- Reconstructive procedures
- Residential treatment admissions
- Sleep studies
- Surgical procedures
- Transcranial magnetic stimulation (TMS)
- Transplants and related services

Prior Approval is required for the following drug categories covered under the medical benefit (which are not dispensed by a pharmacy), but is not limited to:

- Alpha-1 proteinase inhibitor
- Botulinum toxins
- Blood clotting factors
- Enzyme replacement drugs
- Erythropoiesis (blood cell) stimulating agents
- Gene therapies
- Granulocyte-colony stimulating factors
- Growth hormones
- Hepatitis C drugs
- Hereditary angioedema agents
- HeR2 receptor drugs
- Immunoglobulins
- Home health services
- Immunologic agents
- Inflammatory conditions (e.g., Crohn's, Rheumatoid Arthritis, Ulcerative Colitis)
- Lyme disease (IV/Injectable antibiotics)
- Metabolic disorders
- High-cost infusions/injections
- Multiple sclerosis drugs
- Cancer agents (infusions, injections)
- Ophthalmic (eye) injections
- Osteoporosis (bone loss) agents
- Pegylated interferons
- Pulmonary (lung) arterial hypertension

Prior Approval and Notification Requirements for Prescriptions

Some types of prescriptions require Prior Approval and/or notification to ensure your plan covers the drug. If you do not receive approval, the drug may not be covered. Importantly, you may be required to first try certain drugs to treat your medical condition before the plan covers another drug for that condition. For more detailed information about your pharmacy benefits, contact the Member Services phone number located on the back of your Member ID card.

Express Scripts, our Pharmacy Benefit Manager, maintains a process by which you, your provider or your authorized representative can request Prior Approval for the medication(s) designated in the formulary by:

- PA (Prior Approval)
- ST (Step Therapy)
- QL (Quantity Limit)

You may initiate the Prior Approval process or request an exception to coverage for a non-formulary drug in one of three ways:

- Contacting your provider
- Contacting Express Scripts at (800) 282-2881
- Filling out the Express Scripts Prior Authorization Form

Your Appeal Rights

Medical Benefit
You have the right to request an appeal if you disagree with a denial of service(s). You may call the Member Services phone number on the back of your Member ID card for information and assistance filing an appeal or requesting an external review of a denied service.

Prescription Benefit
You have the right to request an appeal if you disagree with the denial of coverage for a prescription drug. You, your representative, or your health care provider may appeal the adverse determination. You may call the Express Scripts Administrative Appeals Department at (800) 282-2881 or the Community Health Options Member Services phone number on the back of your Member ID card for assistance filing an appeal or requesting an external review of a denial for coverage of a prescription drug.

For more detailed information, please call the Member Services phone number located on the back of your Member ID card. Note: These are general guidelines and are subject to change.