Quick Reference Guide

Summary of Authorization Requirement Updates

2018

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Summary of Authorization Requirement Updates

Health Options is pleased to present a summary of 2018 benefit changes to assist Member, provider and broker understanding of what changes will be implemented on 1/1/2018. 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
Introducing eviCore	**Prior Approvals are processed through eviCore for the following services when date of service is 1/1/18 or later:** ‣ Advanced Imaging (MRI, PET Scans, CT Scans, Nuclear Medicine, 3D Imaging), Cardiac Imaging (Myocardial Perfusion Imaging, Echo, Echo Stress, Diagnostic Heart Cath, Cardiac (MR, PET, CT) ‣ Chiropractic services ‣ Interventional Pain Management ‣ Joint Surgery (shoulders, hips, knees) ‣ Occupational Therapy ‣ Physical Therapy ‣ Speech Therapy ‣ Spine Surgery ‣ Ultrasound (OB & Non-OB)
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.
Authorization Date Range	‣ Approved services must be completed within the approved date range. ‣ Outpatient authorization date range generally defaults to 60 calendar days.
Chiropractic Services	‣ Prior approval, to include plan of care, is required after the initial evaluation. If additional services (e.g., treatment) are performed the same day as the initial evaluation, Prior Approval will be required. The provider has ten business days from the initial date of service to initiate the Prior Approval request in this scenario. ‣ No 2018 benefit limit (for medically necessary care).
Observation Stay/ Status	‣ Notification of observation stay/status must be done within 24 hours of observation status determination. ‣ Notification is available 24/7 via online authorization portal/fax/phone. ‣ Observation stays greater than 24 hours require submission of clinical documentation to initiate concurrent review. ‣ Observation services/observation status cannot exceed 48 hours. The Member either meets admission criteria or is discharged to a lower level of care. ‣ Failure to notify Health Options within 24 hours of the observation status determination will result in a benefit denial up to the time of notification. **Notification responsibility:** ‣ In-network: provider responsibility ‣ Out-of-network: Member responsibility

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Online Authorizations	‣ Health Options Medical Management department accepts authorization requests via fax or phone. ‣ Provider portal online authorizations launched 1st quarter 2018. Enrollment enhancements are anticipated 2nd quarter 2018.
Inpatient Admissions	‣ Applies to all elective and unscheduled procedures. ‣ Notification of inpatient admission to acute care facility, home health, skilled nursing facility and acute rehabilitation facility is required within 48 hours of admission. ‣ Failure to notify Health Options within 48 hours of the inpatient admission will result in an administrative denial up to the time of notification.
Physical, Occupational, Speech Therapy	‣ Prior approval, to include plan of care, is required after the initial evaluation. If additional services (e.g., treatment) are performed the same day as the initial evaluation, Prior Approval will be required. The provider has ten business days from the initial date of service to initiate the Prior Approval request in this scenario. ‣ No 2018 benefit limit (for medically necessary care).
Post-Service Authorizations	‣ Post-service authorization requests are generally discouraged. Authorization requests received beyond 10 (ten) business days of the date of service will result in a benefit denial.
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.