# Overview

## NOTIFICATION & PRIOR APPROVAL GUIDE

## 2021

# Services Requiring Notification

- All Admissions (Acute Care Hospital, Acute Rehab, Home Health, Skilled Nursing Facility)
- Crisis Evaluation (medical necessity waived if submitted within 10business days
- 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

Services requiring notification are subject to medical necessity review (unless otherwise specified)

- Advanced Imaging
- Allergy Testing
- Ambulance (Non-Emergency- Ground, Air, Water)
- Behavioral Health Services
- Cardiac Rehabilitation
- Cardiac Testing
- Cardiovascular Procedures
- Chemotherapy
- 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 Genera Surgery

- Genetic/Pharmacogenetic Testing/Molecular Diagnostics
- Genitourinary Procedures
- 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
- Long Term Acute Care Hospital (LTACH)
- Nuclear Cardiac/Radiology Studies
- Nutritional Products/Services
- Nutritional Therapy
- Ophthalmology Procedures
- Orthopedic Procedures
- Outpatient Procedures, surgeries, services
- Pain Management Services/ injections

- Parenteral and Enteral Therapy
- Pulmonary Rehabilitation
- Radiation Treatment
- Reconstructive/potentially cosmetic procedures
- Second Opinions (only for non- plan providers)
- Sleep Studies
- Surgical procedures done in inpatient or ambulatory care/outpatient settings
- Transplant and related services
- Ultrasounds
- 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)
- Wound Care
- Products/Procedures (Prior Approval required for Provider Office or Outpatient Wound Center)

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

- Alternative/Complementary Treatment/Therapy
- Artificial Heart Transplant
- Category III codes
- Clinical Trials and/or Studies
- 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 (unless otherwise stated)
- Experimental or Investigational

- Food or Dietary Supplements
- Hearing Care (unless otherwise stated)
- Infertility/Surrogacy Treatment/Procedures
- Non-FDA Approved Laboratory Tests
- Over-the-Counter medications/supplies (unless otherwise stated)
- Refractive Surgery
- Reversing Sterility
- Routine Circumcisions
- Routine Foot Care
- S-codes once CMS designates alternate code
- Spinal Decompression Devices
- Temporomandibular Joint Syndrome (TMJ) treatment service

# To submit authorization requests:

- Portal: Provider.HealthOptions.org
- Fax: (877) 314-5693
- Phone: (855) 542-0880

Please use phone line for urgent requests only. Urgent requests are based on clinical presentations that could seriously jeopardize the Member's life or health, ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.

Express Scripts accepts PA requests through the following methods:

Electronic PA (ePA): www.esrx.com/pa

- Phone (PA line): (800) 753-2851
- Fax: (877) 329-3760

# 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 on our website for any substantive changes.  Providers are expected to check the website periodically for updates to authorization requirements. Prior Approval documents and forms are posted by November 1st for each subsequent year.

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 Providers@ HealthOptions.org.

# Member Requirements

Members are responsible to obtain Prior Approval for out of network services.

Members seeking services at an out-of-network provider should call Member Services at 855-542-0880 if they have any questions about authorization requirements.

# 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.

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all inclusive and is  subject to change without notice. Providers will receive a 60-day notice of any substantive changes.
All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.
Effective 1/1/2021.

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### 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. Services are subject to applicable claim edits.

### Inpatient Admissions and Observation Stays

Health Options will perform Medical Necessity review for the entire stay.
Notification is required within 48 hours (or by noon on the first BD after the weekend) even if the patient is already discharged.

Observation stays are limited to 48 hours at which time the member is admitted or discharged to a lower level of care.

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. Approvals do not include experimental or investigational services or services completely unrelated to the admission.

Health Options will review the Admission/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 for any service or procedure provided during the admission, the applicable 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 when an extended stay is anticipated.**

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### 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.

Health Options reserves the right to audit clinical records to support medical necessity of rendered services.

### Routine Pre-Service Authorization Requests

**Routine services that require Prior Approval should be submitted before the service is rendered and must be submitted within 10 BD of the date of service to be eligible for medical necessity review.**

Routine Pre-Service requests will generally be processed within 72 hours or two business days, whichever is earliest, upon receipt of all medically necessary information.

Urgent Pre-Service requests will generally be processed within one calendar day of receipt of all necessary information.

### Post-Service Authorization Requests

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

Medical necessity review is based on submitted information. Providing all necessary information facilitates timely decisions.

### 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 95%.

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 substantiate medical necessity.**

Guidelines (exceptions apply) for Medical Necessity decision turnaround times are based on receipt of all necessary information and generally meet the following timeframes:

- 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 – processed within one calendar day of receipt of all necessary information.

- Routine Pre-Service - 72 hours or two business days, whichever is earliest, upon receipt of all medically necessary information. "

- 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 (day zero (the following day = day one)