



Overview

NOTIFICATION & PRIOR APPROVAL GUIDE

2022



Services Categories That Generally Require Prior Approval (PA)/ Medical Necessity Review

Service noted with an * require Notification (see Prior Approval form(s) for Notification timeframes).

Services noted with an ** require Notification but are generally not subject to medical necessity review.

- Acute Care Hospital Admissions* From ED, Elective, Scheduled
- Acute Rehabilitation Admission*
- Advanced Diagnostic Imaging
- Allergy Testing
- Ambulance (Non-Emergency- Ground, Air, Water)
- Behavioral Health Services
- Cardiac Diagnostic Testing
- Cardiovascular Procedures
- Chemotherapy
- Clinical Trial and/or Study associated services
- Colonoscopies
- Crisis Evaluation**
- Dental and Orthognathic related services
- Dialysis (End Stage Renal Disease-ESRD)
- Durable Medical Equipment (DME)
- ENT services/procedures
- Gastroenterology services and General Surgery
- Gender Affirming Surgery
- Genetic/Pharmacogenetic Testing/ Molecular Diagnostics
- Genitourinary Procedures
- Home Health Services*
- Home Infusion Therapy*
- Hospice/Hospice Respite Care
- Infusion/Injection (non-pharmacy issued-drugs & biologicals)
- In-Home Biometric Monitoring
- Long Term Acute Care Hospital (LTACH)
- Nuclear Cardiac/Radiology Studies
- Nutritional Products/Services
- Nutritional Therapy
- OB Admissions**
- Observation (overnight whether or not Member uses a bed)*
- Ophthalmology Procedures
- Orthopedic Procedures
- Outpatient Procedures, Surgeries and Services
- Pain Management Services/injections
- Parenteral and Enteral Therapy
- Radiation Treatment
- Reconstructive/Potentially Cosmetic Procedures
- Second Opinions (only for non- plan providers)
- Skilled Nursing Facility*
- Sleep Studies
- Surgical procedures (all elective: ambulatory, inpatient, and outpatient settings)
- Transfer from one Acute Care Facility (ACF) to another ACF
- Transfer to Hospice
- Transplant and related services
- Ultrasounds
First four (4) low risk OB US**
- Unlisted CPT codes (regardless of place of service)
- Urgent Care Center (UCC) Services
No PA to enter UCC but services that require PA, require PA in UCC
- Wound Care-Products/Procedures



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
- Newly released codes are non-covered pending further internal review- generally six months.
- Non-FDA-Approved Laboratory Tests
- Over-the-Counter medications/supplies (unless otherwise stated)
- Refractive Surgery
- Reversing Gender Affirming 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:

<ul style="list-style-type: none"> • Portal: Provider.HealthOptions.org • Fax: (877) 314-5693 • Phone: (855) 542-0880 <p>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.</p>	<p>Express Scripts accepts PA requests through the following methods:</p> <p>Electronic PA (ePA): www.esx.com/pa</p> <ul style="list-style-type: none"> • Phone (PA line): (800) 753-2851 • Fax: (877) 329-3760
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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 and review provider newsletter content 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

If a member is receiving services from an out-of-network provider and they are unsure if the service or procedure requires Prior Approval or Notification, please call Member Services. The member's timely phone call to Member Services satisfies their notification responsibility. If we have not received required clinical information from the out-of-network provider, Health Options will attempt to contact the provider to obtain the necessary information.

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.

Emergency Department

No Prior Approval is required for services performed in a hospital Emergency Department, but services are subject to applicable claim edits.

Inpatient Admissions and Observation Stay

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
- Advanced Diagnostic Imaging

If medical necessity is not met for any service or procedure provided during the observation/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.



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 10BD 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 may apply) for Medical Necessity decision turnaround times are based on receipt of all necessary information and generally meet the following timeframes:

- Urgent concurrent (ongoing care) review- one calendar day
- Routine concurrent concurrent (ongoing care) review- one business day
- Urgent Pre-Service- one business day
- Routine Pre-Service - 72 hours or two business days, whichever is earliest.
- Retrospective service – 30 calendar days

Our Medical Management 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 zero = day request is received
- Day one = day after the request is received