Chapter 6: Medical Authorizations and Referrals

Overview

Health Choice Insurance Co. has confidence that Primary Care Physicians are capable of providing the majority of medically necessary healthcare services to the patients who present to them. However, should the need arise for medically necessary specialty services, the Health Choice Insurance Co. Chief Medical Officer, and/or Medical Director(s) or their designees make medical necessity determinations based upon nationally recognized, evidence-based standards of care.

Accurate and prompt medical necessity determinations depend upon the comprehensive content and the quality of medical documentation that Health Choice Insurance Co. (or its delegated entities) receives with each request. Health Choice Insurance Co. is committed to making the referral and prior authorization processes as efficient and simple as possible; however, the requesting provider should make a best effort to submit requests in a manner which can facilitate an effective review process.

Medical and Pharmacy Prior Authorizations

For a complete listing of services which require Prior Authorization please refer to the Health Choice Insurance Co. Prior Authorization Guidelines. http://www.healthchoiceessential.com/providers/pa_guidelines. The Member Evidence of Coverage (EOC) can also serve as a reference guide and answer many questions which may arise but which are not directly referred to in the chapter text.

Please follow these key steps when requesting a medically necessary prior authorization:

1. Offices should legibly complete all necessary fields of the most current Health Choice Insurance Co. Medical Services Prior Authorization form. The most current Medical Services Prior Authorization form is available through your Health Choice Insurance Co. Provider Service Representative and can be accessed on-line at http://www.healthchoiceessential.com/providers/forms.aspx
2. Please include accurate ICD-10 codes which support the request, and must provide specific CPT codes, HCPCS codes, and J-codes.
3. Please include ALL necessary documentation to support medical necessity in order to avoid unnecessary denials or inappropriate delays in the medical review/approval process.
4. Offices should clearly indicate in the check boxes provided on the Medical Services Prior Authorization form whether the request is “Standard” or “Expedited” (see below for details.) Offices must not abuse “Expedited”

service requests as inappropriate "Expedited" requests result in slower response times for truly urgent medical authorizations from all network providers. Expedited means a request for which a provider indicates that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

5. Please fax the Medical Services Prior Authorization (24 hours a day/7 days per week) to the Health Choice Insurance fax number. The office should confirm the tax receipt and this record should be kept for your documentation.

-Health Choice Insurance Co. Medical PA Fax Line 1-855-432-2494

-Health Choice Insurance Co. Pharmacy PA Fax Line 1-855-432-2495

NOTE:

-Receipt of an authorization from Health Choice Insurance Co. **does not -** guarantee payment of services. The claim must be billed correctly and timely.

-The member must be eligible on the date of service.

-The service must be covered at the time the service is rendered.

-Only one Medical/Pharmacy service may be requested per PA form.

-ALL Out of Network Providers (OON) require prior authorization. OON Providers should not be requested unless there is a compelling medical necessity basis.

-Health Choice Insurance Co. does not perform prior authorization for Emergency Services.

-OB Ultrasound Authorizations – please see Chapter 16, Women's and Children's Services

Time Frames for Health Plan Prior Authorization Review

-"Standard": **Up to 14 calendar days –** Standard means a request for which Health Choice Insurance Co. must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days if the member or provider requests an extension or if Health Choice Insurance Co. justifies a need for additional information and delay is in the enrollee's best interest.

-"**Expedited": 72 hours from receipt of request –** Expedited means a request for which a provider indicates or Health Choice Insurance Co. determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Health Choice must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, no later than 72 hours following the receipt of

the authorization request, with possible extension* of up to 14 days if the member or provider requests an extension or if Health Choice Insurance Co. justifies a need for additional information and the delay is in the enrollee's best interest.

Pre-Service Denials

Members will be notified of a denial of service request within 72 hours for Expedited requests, and within 14 *calendar* days for Standard request. For more information about what a member can do if they receive an NOA, please see Chapter 15 *Claims Disputes and Member Appeals.*

Written information which communicates a denial of service will also be sent to the requesting Provider (or their designee). Provider denial letters are sent to the Physician or Facility who initiated the request for prior authorization and will contain varying degrees of detail in order to explain the basis for denial.

Special considerations and information regarding Prior Authorizations and Referrals

-The Primary Care Physician/Provider (PCP) must initiate the referral process (specialists should not generally refer directly to other specialists).

-Health Choice Insurance Co. members should be instructed not to self-refer to specialists.

-Health Choice Insurance Co. will provide notice of approval/denial within the allowable time frames via fax and/or phone to the requesting provider where a prior authorization is needed.

-If the service required prior authorization and an authorization was not approved, or if the member was ineligible at the time of service, the claim will be denied.

-The authorization number or denial will be noted in the member medical record.

-Prior Authorization approval number(s) should be provided by the requesting provider TO the specialist/facility/vendor PRIOR to the member's appointment.

-The specialist, facility or vendors are responsible to ensure that necessary authorizations have been issued prior to rendering service.

-The PCP (or ordering Provider) is responsible to facilitate coordination of care and assist/alert the member to make the necessary appointments for approved services.

-When difficulty arises in coordinating and/or facilitating care, the referring provider should contact the plan for additional assistance.

-Authorization is NOT a guarantee of payment for services.

-Authorizations are valid for 90 days unless otherwise noted.

-Contracted health professionals, hospitals, and other providers are required to comply with Health Choice Insurance Co. Prior Authorization policies and procedures.

Retrospective Authorizations

Health Choice Insurance Co. requires that Prior Authorization (PA) be obtained for some non- emergent/non-urgent services, as defined by this Chapter and the Member EOC. Health Choice Insurance Co. does not generally entertain requests for "retro" authorizations, as these are, by definition, contradictory. It is the responsibility of the provider or facility rendering care to verify insurance eligibility as well as benefit coverage and/or authorization requirement/status.

Providers/facilities have the right to file a Claims Dispute if a claim is denied (see Chapter 15 Claim Disputes and Member Appeals). Simply, if the Provider submits a claim which is denied for no PA being obtained, the claim can be grieved along with documentation of medical necessity and a basis for why PA was not obtained.

Health Choice Insurance Co. uses the following protocol to resolve informal appeals regarding authorizations:

1. The requesting provider may resubmit a new PA request with new/additional information pertinent to the original non-authorized request to the Prior Authorization Department.
   Please note: *Requests should only be resubmitted to the Health Choice Insurance Co. PA Department IF new and/or additional, pertinent information is being provided with the resubmission.*
2. The original information (denial packet) will be retrieved from storage when possible and combined with the current request which contains new/additional information, and will be presented to the Health Choice Insurance Co. Chief Medical Officer, Medical Directory, or their designee for reconsideration.
3. If no new and/or additional information is received, the resubmitted request will be "Cancelled" (C) and the office notified by telephone or FAX. New and/or additional information is needed to constitute a new PA request. If the member wishes to file a formal appeal on a denied authorization, please refer them to their Health Choice Grievance and Appeals Packet, Member Services, or please see Chapter 15 in this provider manual.

Hospital Services – Inpatient and Outpatient

All hospital admissions, including Acute, Observation, Rehabilitation, Long Term Care Skilled Nursing Facilities and Hospice require prior authorization.

All facilities must notify Health Choice Insurance Co. and obtain an authorization prior to, or at the time of, ALL admissions. Plan authorization and/or notification is accepted and approved by the Health Choice Insurance Co. Medical Services PA

Department.

In the event that acute inpatient hospitalization services delivered are to evaluate and stabilize an Emergency medical condition, concurrent plan notification/authorization is not required for payment for medically necessary covered services. However, the plan must be notified of emergent inpatient services within 48 hours of emergent member presentation. Health Choice Insurance Co. strongly recommends that plan notification from the facility occur as quickly as possible to help guarantee full coverage of medical services rendered.

Any patient that has been medically stabilized and still requires inpatient admission must be transferred to an in-network facility. This transfer process can be initiated by calling the transfer center at 855-500-2305.

For pre-planned, medically reviewed and/or prior-authorized admissions, the facility must call Health Choice Insurance Co. at the time of admission to activate the authorization number when the member presents for admission to the facility.

All outpatient procedures must be performed at an in-network Ambulatory Surgical Center (ASC). Claims from locations other than an ASC will not be paid without an authorization - Health Choice Insurance Co. will entertain Prior Authorization requests for "medical necessity exceptions" where the Provider believes a case must be performed in the hospital outpatient setting.

NOTE: Health Choice Insurance Co. does not have coordination of benefits with any other commercial carrier.

Health Choice Insurance Co. – Ophthalmology and Optometry – Special Coverage Instructions

Health Choice Insurance Co. covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility. Please see the Pediatric Vision section of the Evidence of Coverage for specific vision benefits and limitations.

Health Choice Insurance Co. has a statewide contract with Nationwide Vision to provide covered benefits as described in the Pediatric Vision section of the Evidence of Coverage, within their scope of practice and as defined by the Arizona State Board of Optometry.

Durable Medical Equipment and Enteral Therapy

Preferred Homecare is the statewide contracted service provider for Health Choice Insurance Co. Requests for Durable Medical Equipment (DME) or enterals are to be sent directly to Preferred Homecare who will coordinate with the requesting provider in obtaining any necessary prior authorization. Medical records documenting the medical

necessity of the request must also be provided in addition to a current, signed doctor's order(s) prescription.

Contact Information for Preferred Home Care:

- Main Office Phone Number: 480-446-9010
  800-636-2123
- Main Fax Number 480-446-7695

Orthotics Prosthetics

Health Choice Insurance Co. has several contracted orthotics and prosthetic providers in the geographical areas we serve. Requests for orthotics/prosthetics which are determined medically necessary by the physician/provider are to be sent directly to the contracted orthotics/prosthetics provider you select with supporting medical documentation and a current signed physician order(s)/prescription. It is the responsibility of the orthotics/prosthetics provider to obtain Prior Authorization and to coordinate care delivery, as necessary with the referring/requesting Provider.

Please see the Evidence of Coverage for specific benefits and limitations.

Pharmacy Authorizations

Refer to Chapter 17: Pharmacy and Drug Formulary.

Family Planning Services

Please refer to the Member Evidence of Coverage.