Healthcare Resources NW

OPERATIONS POLICY

SECTION: Care Management

SUBJECT: Referral/Preauthorization Determination for Medicare Advantage Lines of Business.

POLICY:

Care Management (CM) is committed through utilization management to authorize approval or denial of healthcare services in a timely and cost-effective manner, in an environment, which is consistent with professional, legal, contractual, and accreditation guidelines.

DEFINITIONS:

Medical Necessary - Health care services, supplies, or drugs needed for the prevention, diagnosis, or treatment of sickness, injury or illness that are all of the following as determined In accordance with **Generally Accepted Standards of Medical Practice:**

- Most appropriate, in terms of type, frequency, extent, site and duration
- Considered effective for sickness, injury, or illness not mainly for member convenience or that of the doctor or other health care provider and
- Meets but does not exceed the member's medical need,
- And is at least as beneficial as an existing and available medically appropriate alternative, and furnished in the most cost-effective manner that may be provided safely and effectively.

Generally Accepted Standards of Medical Practice - Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

GENERAL INFORMATION:

A Quick Reference Guide is created to assist Healthcare Resource NW (HRNW) participating providers to easily identify when a referral or preauthorization is typically required. This Quick Reference Guide is not all-inclusive and providers seeking to provide service to HRNW Members are encouraged to also review this Policy 700 prior to providing services to any HRNW Member. The Quick Reference Guide is maintained on the HRNW website:

www.healthcareresourcesnw.com

1. **Members are required to obtain services from participating (par) Providers unless non-participating (non-par) services have been pre-approved by the Care Management department. All services received must be referred and preauthorized, unless specifically stated otherwise in the Member's benefit plan or as listed on the Quick Reference Guide.** Members and Providers are encouraged to contact the Care Management department when unsure of referral and pre-authorization requirements. **There is no benefit for Member self-referral.**

2. Failure to obtain pre-authorization for services that requires authorization could result in payment reduction for the Provider and benefit reductions for the Member.

3. **Preauthorization Process:** The terms referral, prior authorization and preauthorization refer to the preauthorization process. A referral is a submitted request for services to pre-determine the services requested meet medical necessity for benefit coverage. A preauthorization is a notification the requested services are approved or denied. **Preauthorization determination is only effective for coverage within a specified time frame and only when Member retains Health Plan eligibility.**
4. **Utilization Management** (UM) reviews, guides and monitors the utilization of medical services. Once an outpatient preauthorization has a final determination the authorization is not reopened except for HRNW clerical error or in conjunction with Health Plan appeal or reconsideration. If further procedures or revisions are necessary, a new referral is required. **Referral Modification is only permitted for dates of service adjustment** per the judgement of HRNW UM review.

5. An authorization determination notification is provided per Health Plan **turnaround-times** to the Member, PCP and Treating/Supplying Provider/Facility as follows:
    a. Member will be notified in writing. In addition for a *medically urgent* expedited/ urgent referral, up to two verbal documented attempts will be made to provide notification. The PCP office staff may be requested to assist in notifying the Member. Written documentation from the PCP office staff, of their notification to the Member is to be documented/scanned in HRNW's Medical Management System.
    b. PCP and Treating Specialist, Facility or supplying Provider notification uses at least one of the following methods: written, verbal, EMR or reports.

6. **Emergency medical care** should be provided without waiting for authorization, as it does not require an authorization. If non-par inpatient admission follows ED stabilization, an inpatient referral is requested within 48 hours, or as soon as possible thereafter.

7. **No referral is required for Emergency Convenient/Urgent Care,** Emergency Department, or when a Member is admitted to a par facility.

8. **Inpatient authorizations** relate to provided services while a patient is admitted to a hospital or skilled nursing facility. Medicare Advantage (MA) covers benefited/ approved inpatient services under **Medicare Part A.**
    a. When a Member is admitted inpatient to a non-par facility from the ED, the Member/Provider is to contact HRNW within 48 hours of initial treatment or as soon as possible thereafter.
    b. Notification for non-par inpatient facility requires a written or verbal approval notice, which will include a reference number and, the number of days, approved.
    c. For par inpatient hospital facilities, no authorization approval is required.
    d. Skilled nursing facility services requires a pre-authorization approval
    e. For inpatient hospital or skilled nursing facility, HRNW reserves the right to redirect care to a par facility.
    f. During inpatient services, the hospitalist team serves as the PCP. Upon discharge the health plan assigned PCP directs the Members general medical care.

9. **Outpatient authorizations** relate to provided service <u>while a patient is not confined to a facility</u>. Outpatient services include, but are not limited to, office visits, lab, pathology and diagnostics, home health services, durable medical equipment, etc. MA covers benefited/approved outpatient services under **Medicare Part B**.

10. **Preventative screening** includes well care services such as Screening Mammograms and Colonoscopy. Mammogram (including Provider interpretation) is a covered benefit for all women aged 40 and over and does not require Provider prescription or referral. Medicare Advantage Members must see a women's healthcare specialist within the HRNW Specialist panel and use a par Mammogram Provider.

11. **Complete Health Improvement Program (CHIP)** is a 10 week, video-based intensive lifestyle improvement program which can dramatically reduce health risks associated with heart disease, hypertension, diabetes and obesity. Members who have a diagnosis of any of the following: Congestive Heart Failure (CHF), Diabetes, Obesity, Renal Failure may access this one time, life time benefit max with an approved authorization.

12. **Vaccine** - Members may receive influenza (flu) vaccine without imposing cost sharing by the Member, regardless of location in which it is administered. Pneumonia and Hepatitis B vaccinations should be received from a Primary Care Provider (PCP) or par Providers.

13. **Kidney Dialysis** does not require a referral for chronic (non-acute) with a diagnosis of End Stage Renal Disease (ESRD).

14. **Chemotherapy and High Cost Injectable** Medications: Requests submitted must include the appropriate dosage, CPT, HCPC and ICD-10 codes

15. **Investigational and experimental (E/I) services** are to be managed by Medicare instead of the Health Plan. Please consult with the Health Plan and Healthcare Resources NW (HRNW) Care Management Team for clarification. The Health Plan may cover one (1) specialist referral to determine if Member is a candidate for a Medicare approved clinical trial or set of trails. HRNW will coordinate with the Health Plan to review coverage decisions for E/I services for members with life threatening or seriously debilitation conditions.

16. Members have the right to a **second opinion** as part of the UM process.

17. HRNW does not deny coverage based on a condition being pre-existing.

18. Unless a provided service is a facility concurrent review service, once a service has been provided and/or billed, it is a **Retrospective (Retro) Service**. A Retro service it is no longer considered a Care Management Utilization Management (UM) process. In these circumstances, Care Management will collaborate with Claims, as indicated. The Provider/Members are expected to contact the Claims Department.

GETTING STARTED FOR A REFERRAL:

1. PCP refers Member to a par specialist when the medical need is beyond their scope.

2. Services are required by the Health Plan to be provided by a par specialist

3. The PCP initiates the referral to par specialist

4. A specialist may not refer to another specialist outside of their respective Table without a referral via the PCP and a pre-authorization from HRNW as outlined in the Quick Reference Guide Table 3

5. If a Member wants to see a non-par specialist, and wants their Health Plan coverage to apply, a referral from their PCP and a HRNW pre-authorization approval is required prior to seeing the non-par specialist. In most cases services are redirected to a par specialist.

REFERRAL SUBMISSION & STATUS:

When submitting a referral form, it is be filled out as completely as possible. Include patient name, PCP, diagnosis and the reason(s) why the requested care is necessary. Include appropriate additional documentation for injectable drugs including dosage/ units, any pertinent progress note(s) x-ray / lab / pathology reports, operative note. Referrals may also be received by EMR accessible to CM staff, to assist in making the determination.

1. Provider options to submit a referral for a preauthorization request:

    - FAX: Use the request for authorization form provided by HRNW. Complete and submit the form via fax to 1-503-251-6877

    - Phone (this option may still require submission of documentation necessary for determination): Call in your request to 1-877-261-6991

    - Electronic Medical Records, such as EPIC when this option has been pre-arranged with HRNW.

2. Members or the Member Appointed Representative is strongly encouraged to submit their request for preauthorization of services through their PCP. When a request is from other than the Member or the Member's treating Provider a CMS Appointment of Representative (AOR) Form or Power of Attorney Form must be on file with HRNW before the referral is accepted for processing.

3. To ensure consistency of supporting documentation for reviews and to ensure the collection of relevant medical record information is not overly burdensome to the Member, Provider or staff.

4. The following elements of the medical record are the minimum to be available in order to support a medical necessity determination:
    a. Relevant clinical records (and hospital records if applicable)
    b. Injectable drug and dosage, if applicable
    c. History of the presenting problem
    d. Recent clinical exam as pertaining to authorization requested
    e. Applicable diagnostic test results
    f. Consultation, if applicable

    If not all of the above elements are received with the initial referral the first request for additional information from the provider will be made with the intent to meet the CMS goal of two calendar days of original receipt of referral request.

5. HRNW utilizes appropriate licensed health professional to supervise medical necessity review decisions. Medical Directors or Board Certified Provider

consultants are used to review and assist in making Medical necessity determination and for all cases that do not meet approval criteria.

6. Non-clinical staff may collect data for referral review and may authorize services for which there are explicit criteria.

7. Criteria for UM decision making is based on medical necessity, appropriateness of care, Health Plan eligibility and coverage, CMS criteria: a. National Coverage Determination (NCD), b. Local Coverage Determination (LCD), c. Local Coverage Medical Policy Article, d. Medicare Benefit Policy Manual, Health Plan criteria (e.g. Certificate of Coverage or Summary of Benefits, Medical Policy), Evidence based criteria such as MCG and InterQual. CM reviews the referral in order to assure there is documented evidence to submit to HRNW's Chief Medical Officer (CMO) (referred to as Medical Director in some health plans) for the review.

8. In certain circumstances, decisions about care or services could be considered either covered or not covered. Decisions are based on the needs of the individual Member and the characteristics of the local delivery system.

9. Decisions about dental surgical procedure that occur within or adjacent to the oral cavity or sinuses are reviewed based on member's medical benefit coverage.

10. Should par Providers be unavailable or inadequate to meet a Member's medical needs for specialty care, HRNW will facilitate non-Par Providers to provide the benefited care meeting medical necessity criteria.

11. Referral processing time will meet all regulatory and contracted Health Plan mandates for the amount of time allowed to process the referral. According to Center for Medicaid and Medicare Services (CMS) guidelines:
    a. Standard or Routine request will be processed in no more than 14 days from the time the request is received until the decision is mailed to the Member.
    b. Urgent/Expedited request has a 72 hour requirement from the time the request is received until a decision is received by the Member. Unless the CMS definition for Medically Urgent/Expedited is met, an urgent request may be downgraded to a Standard request.

       "An urgent or expedited review process is for cases in which the standard time or time sensitive time frame for review could seriously jeopardize the life or health of a Member or the Member's ability to regain maximum functioning."

    c. Urgent/Emergent and Time Sensitive referral requests may be handled by phone call 1-877-261-6991, or Fax, 503-251-6877. Every attempt will be made to make an immediate determination. CM staff will load the authorization. The determination will be documented. All urgent/emergent referral request determinations generate a written notice as well as a phone

notice (at least two phone attempts to reach the Member. If unsuccessful Provider assistance will be sought to verbally notify the Member).Time sensitive determination notifications use EMR and or phone notification.

d. When the status of a referral request is not indicated by the requestor the status will default to Standard, unless there are indicators otherwise.

12. HRNW website maintains the list of par providers under the “For Providers” option. The user selects Medicare Advantage HMO and scrolls to Participating Providers.
www.healthcareresourcesnw.com

13. Questions regarding the status of a referral, should be directed to the CM staff, by calling 1-877-261-6991.

14. When Member’s coverage terminates, outpatient approved authorization shall be binding for five days. In circumstances where Member coverage is going to terminate, authorization shall be binding for the period of time specified by HRNW at the time the prior authorization is issued.

DENIALS:

1. A service authorization request with a denial determination will be processed according to the Health Plan and HRNW policy and procedure.

2. A denial of requested service is indicated when there are no clinical basis to support an approval, or medical necessity cannot be established, or there is no benefit for the service.

3. A denial of request for services determination is made by the Medical Director or designated board certified physician provider.

4. Denials for requested services will include a letter to the Member and the requesting Provider or facility, explaining the reason for the denial (the denial letter reason must align with the Medical Directors stated denial reason), suggesting an alternative treatment plan, and informing them of the Member’s Health Plan appeal process.

5. The Medical Director is available by phone or by appointment for peer to peer discussion of determinations. If the Provider is unable to keep the peer to peer appointment at the agreed upon time the Denial remains in effect. The Provider may schedule a new peer to peer appointment if desired.

6. Upon request, Providers may obtain oral and/or written utilization management criteria relating to the specific referral in question. These criteria will apply only to the specific issue being approved/denied.

Effective: October 1996
Reviewed: 5/10, 5/11, 12/13
Revised: 5/96, 9/96, 4/97, 6/97, 1/99, 2/00, 3/03, 6/03, 4/04, 5/05, 3/06, 4/07, 6/08, 5/09, 9/09, 3/10, 10/10, 11/10, 3/11, 2/12, 3/12, 7/12, 01/13, 5/13, 8/13, 12/13, 3/14, 10/14, 12/14, 3/15, 7/15, 8/15, 10/15, 12/15, 5/16, 10/16, 2/17
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