

## Section 6

### Medical Prior Authorization and Referrals

#### Key Reminders

HC Generations is confident that our Primary Care Physicians are capable of providing the majority of medically necessary services to the patients who present to them. However, should the need arise for medically necessary specialty services, Health Choice Arizona, Inc.'s Chief Medical Officer, Medical Director(s), or their designees make determinations of medical necessity based on nationally recognized, evidence-based standards of care. Accurate and prompt determinations of medical necessity depend upon the comprehensive content and the quality of medical documentation received with each request.

HC Generations is committed to making the prior authorization process as efficient and simple as possible; however a requesting provider should make a best effort to submit requests in a manner which can expedite an effective review process. Please keep the following key points in mind when requesting a medically necessary prior authorization:

Current HC Generations Prior Authorization Forms and Prior Authorization Requirements are located on the website at:

Web Address: [www.hcgenerations.com](http://www.hcgenerations.com)- Select Provider, then Commonly Used Forms

1. The busiest Coverage Determination days are Tuesday and Fridays, from 9:00 AM to 3:00 PM.
2. Offices must legibly complete all fields of the most **Current** "HC Generations Prior Authorization Request Form" (including the ICD-9 or CPT codes). *See Section 6, Exhibit 1-1*  
**Note:** HC Generations reserves the right to deny prior authorizations which are submitted on expired PA forms.
3. Fax the forms to HC Generations 24 hours a day, 7 days a week to 1-888-291-4542 and *confirm fax receipt*.
4. Offices must include all relevant documentation to support medical necessity in order to avoid unnecessary denials or inappropriate delays in approval.
5. Please indicate clearly if the request meets for "Standard" or "Expedited" review (see below). Please do not abuse Expedited (within 72 hours) requests.

**Inappropriate "Expedited" requests may be down graded to "Standard" by HC Generations. A letter will be sent out to the member and provider regarding the change in request status.**

#### **TIME FRAME FOR APPROVALS (AS DEFINED BY THE MEDICARE MANAGED CARE**

**Standard:** Within 14 calendar days - "Under CRF 438.210, "Standard" means a request for which a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest.

**Expedited:** Within 72 hours – “Under 42 CFR 438.210, “Expedited” means a request for which a provider indicates or a Contractor 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. The Contractor 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 the Contractor justifies a need for additional information and the delay is in the enrollee’s best interest.

**Note:** Above time frames reflected do not begin until all documentation is received. Contracted providers, as a requirement of their contract with HC Generations, **MUST** submit all necessary documentation with a Prior Authorization request in order for the Plan to make an informed, accurate, and timely determination of medical necessity. Non-contracted providers may not/do not have knowledge of plan policies, procedures and/or requirements and may not be held to the same standards as contracted providers. For these reasons, non-contacted providers may be more likely to require use of a 14 day extension.

### **Organization Determination Process**

- The PCP must determine if a service requires organization determination process.
- The PCP should initiate the referral process; Specialists should not generally refer directly to other specialists;
- Members should not be permitted to self-refer to specialists without direct intervention of the PCP.
- The PCP must complete the **current HC Generations Organization Determination Request Form** and fax it along with documents to support medical necessity.
- The PCP must facilitate care and/or alert the member to make the necessary appointments.
- When difficulty in coordinating and/or facilitating care exists, the referring provider must contact the plan for assistance.
- HC Generations will contact the Primary Care Physician (or consulting physician) with the authorization number via fax/phone upon approval.
- The PCP should document the authorization number in member’s medical record.
- Authorizations are valid for 180 days, and are contingent upon continued member eligibility. *Unless indicated otherwise on the prior authorization form that is faxed back to the provider. Provider offices are responsible for confirming current member eligibility prior to service.*
- Contracted and non-contracted health professionals, hospitals, and other providers are required to comply with prior authorization policies and procedures. Noncompliance may result in delay or denial of reimbursement.
- HC Generations does not prohibit providers from advocating on behalf of members within the utilization management process.

**Note:** Receipt of authorization **DOES NOT** guarantee payment of services. If the claim is billed incorrectly, or the member was not eligible on the date of service, the claim may be denied.

### **Referrals to Specialists**

Please check the Prior Authorization list to verify which specialties and services require medical review and a prior authorization number prior to referring a member to the specialist office or facility. If a Prior Authorization number is required, please ensure this number has been attained and the specialist/facility has the number prior to the member's appointment. Please verify that the provider/facility you are referring to is in-network except where out-of-network (O.O.N.) authorization had been obtained. The HC Generations website has an updated listing of contracted providers at [www.hcgenerations.com](http://www.hcgenerations.com).

## **Hospital Services**

### **Acute Inpatient Admissions**

All elective and emergent admissions require prior authorization and/or notification for all HC Generations admissions. Admissions must be called into the HC Generations Organization Determination line at: 1-800-322-8670.

HC Generations Utilization Review staff will coordinate the admission plan of care with the attending physician, as well as hospital case management staff. Continued stay review will be conducted by HC Generations Utilization Review staff as determined by the medical necessity and intensity of service. HC Generations Utilization Review staff will assist in coordinating services identified for discharge planning, as well as required follow up post discharge.

### **Supporting Documentation**

Documentation of medical necessity must accompany all requests for organization determination. For most requests, supporting documentation should include:

- Current diagnosis and treatment by PCP;
- Pertinent medical history and physical examination findings;
- Diagnostic imaging and laboratory reports (if applicable);
- Indications for the procedure or service;
- Failure of conservative treatment;
- Alternative treatments, risks and benefits (including the indication of such discussions with patient)
- For out-of-network (O.O.N) providers/facilities, O.O.N services, and non-formulary medication requests, specific information which explains the medical necessity for an O.O.N or non-formulary service is required. An authorization is required for any service coverage when going to O.O.N. providers/facilities.

### **Clinical Practice Guidelines**

Clinical Practice Guidelines (CPG's) designed to support practitioners in developing treatment regimes that conform to current standards and national guidelines and ensure consistency in chronic disease management. To ultimately and further utilize CPG's in meeting the Chronic Care Improvement Program standards.

Clinical Practice Guidelines which have sound scientific basis such as clinical literature and expert consensus, are utilized to assess the appropriateness of specific healthcare decisions on outcomes of

care, and may reduce inter-practitioner variation in diagnosis and treatment. They are guidelines, and as such, allow for individual medical necessity determinations and may not interfere with or cause delays in service or otherwise preclude delivery of health care services which providers, through their education, experience and assessment of enrollee's need, deem medically necessary for the individual HC Generations enrollees. Health Choice Generations adopts CPGs for acute, chronic and behavioral health care that are relevant to the member population. These are adopted for the purpose of improving health care and reducing unnecessary variations in care.

HC Generations clinical practice guidelines are available on the website at:

Web Address: [www.hcgenerations.com](http://www.hcgenerations.com)

Select: Provider then Provider Resources and Links

### **Authorization Denials**

CMS rules and regulations mandate that all members must be notified of a denial of medical coverage request within 72 hours for expedited requests, and within 14 calendar days for standard request. When a denial is issued, the health plan must inform the member of the denial of medical coverage and the reason for denial. The Denial of Medical Coverage (NDMC) letter also contains information regarding the members appeal rights. Information regarding the denial of service will be returned to the physician (or their designee) who requested the authorization. Details of the denial language sent to the member may be less technical and/or less sophisticated, and at a lower reading grade level than language sent to the requesting provider. (Please see Appeals and Grievance Section 9 for additional information).

Please note: There are no specific rewards offered to practitioners or other individuals for issuing denials of coverage or service care.

### **Obstetrical Package**

HC Generations will issue a Total OB authorization with the completion of the Pregnancy Risk Assessment form this form must be completed by the obstetrician at the time of the member's first visit. Refer to Chapter 16 of the Health Choice Arizona Provider Manual titled: **Women's and Children's Services and Dental Benefits**. This section further identifies services that are covered under the Obstetrical Global Authorization Package. Reimbursement for Obstetrical services provided through the term of the pregnancy is dictated by the "OB pack". During the pregnancy period, the member is reassigned to the OB provider as their "Primary Care" provider, during which time the Obstetrician (OB) is responsible for directing all medical care for the member.

**Note:** Contracted OB providers are required to meet minimum appointment availability standards, should make a best effort to expedite early entry into prenatal care for all members in any trimester, and see all post partum visits within 6 weeks of delivery. Providers are also required to bill FFS for both the initial member appointment and the part partum check in order for HC Generations to identify these critical obstetrical appointments.

### **Ophthalmology**

The following services are covered through HC Generations (See HC Generations Organization Determination requirements on the website for a list of services requiring authorization):

1. Routine eye exam, limited to one exam every year.

2. Medicare covered eye exam for the diagnosis and treatment for diseases and conditions of the eye.
3. For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older; glaucoma screenings once per year are covered.
4. One pair of eye glasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames and replacements needed after a cataract removal without lens implant.

### **Durable Medical Equipment**

Preferred Homecare is the sole provider of these services for Health Choice Generations. Requests for durable medical equipment (DME) are to be sent directly to the Preferred Homecare. Preferred Homecare is responsible for obtaining authorization through the organization determination process if it is required prior to rendering services. Medical records documenting the medical necessity of the request must also be sent along with the signed doctor's orders/prescription.

Contact Information for Preferred Homecare:

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

### **Infusion/Enteral Therapy**

Requests for infusion therapy are sent directly to Preferred Homecare, which is the primary contracted provider for these services with Health Choice Generations to obtain authorization through the Organization Determination Process prior to rendering services. Medical records documenting the medical necessity of the request must also be sent along with the signed doctor's orders/prescription.

### **Orthotics/Prosthetics**

Requests for orthotics/prosthetics are to be sent directly to Preferred Homecare, which is the primary contracted provider for these services with Health Choice Generations to obtain authorization through the Organization Determination Process prior to rendering services. Medical records documenting the medical necessity of the request must also be sent along with the signed doctor's orders/prescription.

### **Pharmacy Authorizations**

Physicians are required to use the HC Generations Drug Formulary when prescribing medications for HC Generations members. *Refer to Chapter 21 Section 10. Prescription Benefits and [www.hcgenerations.com](http://www.hcgenerations.com) for the HC Generations Formulary.*

If the patient requires medication is listed as "prior approval required" the physician must request prior authorization using the current **HC Generations Organization Determination Request Form** along with appropriate documentation to support request. Providers should also note references to step therapy (ST) edits, quantity limits (QLL), and maximum dispensing limits (MDL) prior to requesting PA.

HC Generations Formulary is only available on the website.

Web Address: [www.hcgenerations.com](http://www.hcgenerations.com)

Select: Medicare Part D Plans

Note: if you do not have internet access, contact your Network Services Representative to arrange for a CD or assistance.

### **Download Formulary to a PDA**

Providers may also download the formulary to a PDA for their convenience and ease of use by taking either of the two following steps:

1. If the user has Internet access from his PDA (i.e Palm), then the user can access the HC Generations website(s), go to the Formulary page, and download the PDF.
2. The user can access the HC Generations website(s) via any personal computer, download the PDF, link the PDA to the computer, and then transfer the PDF over to the PDA.

**Note:** Either technique requires the user to have Adobe Reader loaded on the PDA, which has generally been a free program accessed at the following web site:

[http://www.adobe.com/products/acrobat/readstep2\\_mobile.html](http://www.adobe.com/products/acrobat/readstep2_mobile.html)

### **Specialty Medication Program**

HC Generations has instituted a special program with our pharmacy benefit manager for certain specialty medications. Examples of such medications are those used to treat multiple sclerosis, rheumatoid arthritis and chronic hepatitis. Please refer to Chapter 17 for the list of medications and instructions on how to order these special medications, or contact the HC Generations Pharmacy department for additional assistance.

### **Behavioral Health Program**

HC Generations has formulary medications available to treat identified Behavioral Health Disorders.

If the patient requires a behavioral health medication that is listed as “Prior Authorization Required”, “Step Therapy” and/or “Quantity Limits” the physician must request prior authorization using the **current HC Generations Behavioral Health Medication Prior Authorization Request Form** and submit appropriate documentation to support the request. *See Section 6, Exhibit 1-2*

HC Generations contracts with the Regional Behavioral Health Authorities (RBHA) to provide Behavioral Health services for our members. No prior authorization is needed for members to seek outpatient behavioral health services. Members may self refer themselves for services by contacting the RBHA responsible for the county they reside in and/or the provider may make a referral to the RBHA. For further assistance regarding Behavioral Health Services, call Health Choice Generations at 1-800-656-8991.

### **Referrals to Specialists**

Please check the Prior Authorization list to verify which specialties require medical review and a prior authorization number prior to referring a member to the specialist office. It is the responsibility

of the referring provider to ensure that any necessary authorizations have been obtained within the allowable authorization turn around time frames prior to a scheduled Specialist appointment. If a Prior Authorization number is required, please provide a copy of this authorization number directly to the Specialist in advance of the scheduled appointment to ensure services are provided timely on the scheduled date of service. The specialist and the PCP should retain a copy of the referral authorization in the member medical record.

### **Specialist Protocol**

The specialist is responsible to ensure that necessary authorizations have been issued (if the service requires authorization) prior to rendering service. Where referrals are required for member's consultations and/or billing, these requirements must be met in order to receive proper reimbursement. In addition, the specialist must verify the member's eligibility on the date of service HC Generations Member Services Department at 1-800-656-8991. 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.

### **Retrospective Prior Authorization**

It is the policy of Health Choice Arizona, Inc. (HCA) that retrospective authorization requests (a request for authorization after services which require authorization have been rendered) will NOT be provided. HC Generations reserves the right to grant retrospective authorizations in rare circumstances, HC Generations offers an appeal and grievance process per CMS guidelines should the provider disagree with a retrospective denial of service, however providers must adhere to HC Generations policies and procedures in attaining PA prior to any non-emergent or urgent service.

### **Case Management**

HC Generations will assist in managing the care of members with chronic or disabling conditions that can benefit from care coordination and assistance. HC Generations providers shall assist and cooperate with HC Generations case management programs. HC Generations case management programs will include the following key areas;

- Identifies individuals with complex or serious medical conditions.
- Establish and implement a Case Management plan that is appropriate to the members' specific needs and medical condition(s).
- Assessment of the member's physical, psychological, social environment, financial, and functional status as well as the family, community and institutional support systems.
- Includes an adequate number of direct access visits to specialists.
- Ensures coordination among providers.
- Considers the beneficiary's input.

The HC Generations Case Management program promotes quality and utilization management by:

- Defining and tracking quality and performance indicators.
- Implementing measures that contribute to improving quality of care and cost effective management of targeted conditions.
- Encouraging preventive care strategies to keep members healthy.
- Promoting member education and behavioral modifications that improve health outcomes.
- Educating members on available community resources.

- Monitoring outcomes and programs effectiveness.

Providers may enroll members into the HC Generations Case Management program by filling out a case management referral form and attaching any pertinent medical documentation and faxing it to: (480) 317-3358 or 1(800) 323-9652.

*Refer to Exhibit 5-1 HC Generations Case Management Form*