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Medical Authorizations & Notifications

OVERVIEW

Health Choice 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.

Health Choice 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 complete an effective review process. Please keep the following key points in mind when requesting a medically necessary prior authorization:

For a complete listing of services which require Prior Authorization please refer to Exhibit 6.1: Health Choice Generations Prior Authorization Grid. The guidelines can also serve as reference guide and answer many questions which may arise but are not directly referred to in this chapter.

THE FOLLOWING DIRECTIVES APPLY TO ALL HEALTH CHOICE GENERATIONS PRIOR AUTHORIZATIONS

- 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 Generations does not perform prior Authorization for Emergency Services.
- Health Choice Generations does not pay for experimental and/or investigational services.

PLEASE FOLLOW THESE STEPS WHEN REQUESTING A MEDICAL NECESSARY PRIOR AUTHORIZATION

1. Offices must legibly complete all necessary fields of the most current Health Choice Generations Prior Authorization Request Form. The most current Health Choice PA forms can be found on our website: www.hcgenerations.com under commonly used forms and are included in the Provider Manual as an exhibit to this chapter (Exhibit 6.2 Medical Prior Authorization Form).
2. Offices should include accurate ICD-10 codes which support the request, and must

provide specific CPT codes, HCPCS codes, and J-codes.

3. Offices should only request prior authorization for services listed on the Health Choice Generations Prior Authorization Grid.
4. Please include ALL necessary documentation to support medical necessity in order to avoid unnecessary denials or inappropriate delays in the medical review/approval process.
5. Please clearly indicate in the check boxes provided on the Health Choice Generations prior authorization form whether the request is “Standard” or “Expedited” (see below for details).
6. Offices can fax the Health Choice Generations Prior Authorization Request Form (24 hours a day/7 days per week) to the appropriate Health Choice fax number. Health Choice has designated fax numbers for Health Choice Medical requests and Health Choice Pharmacy requests. The office should confirm the fax receipt and this record should be kept for your documentation.
 - a. Health Choice Generations Medical PA Fax Line (877) 424(Health Choice Generations)-5680
 - b. Health Choice Generations Pharmacy PA Fax Line (877) 424(Health Choice Generations)-5690

7. **eviCore Health Solutions** - All “high-tech” radiology services (MRI, MRA, CT and PET), as well as obstetrical ultrasounds, require prior authorization, nuclear cardiac stress testing, echocardiography, and heart catheterizations also require prior authorization. The full listing of service codes are identified in the PA Grid Exhibit 6.1. Prior authorization for these services must be obtained through the eviCore on-line web portal: (<http://www.evicore.com>), by phone (888) 693-3211 or by fax (888) 693-3210.

The eviCore prior authorization forms for each type of service request are available on the web portal and can also be requested by calling eviCore.

NOTE - ALL eviCore expedited requests, or requests for multiple (recurring) units of an Obstetrical test, MUST be performed by phone: (888) 693-3211.

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

Standard: Within 14 calendar days - “Under CFR 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. The requesting provider is responsible for communicating the procedure approval to the member.

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. The requesting provider is responsible for communicating the procedure approval to the member.

SUPPORTING DOCUMENTATION – PRIOR AUTHORIZATION

Documentation of medical necessity must accompany all requests for prior authorization. For most PA requests, supporting documentation should include:

- Current diagnosis and treatment already provided by the PCP/requesting Provider;
- All pertinent medical history and physical examination findings;
- Diagnostic imaging and laboratory reports (if applicable);
- Indications for the procedure or service;
- Alternative treatments, risks and benefits (including the indication of such discussions with patient);
- For Out-Of-Network (OON) providers/facilities/ services, and/or Non-Formulary (NF) medication requests, specific information which explains the medical necessity for an OON or NF service is required. A PA is required in order for any service to be covered at OON providers/facilities.

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 **Health Choice Generations Organization Determination (Prior Authorization) Request Form** and fax it along with ALL 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.
- Health Choice 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 90 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.
- Health Choice Generations does not prohibit providers from advocating on behalf of members within the utilization management process.
- Providers are responsible for informing the member that the procedure has been authorized.
- Health Choice Arizona Medical Directors and clinical staff are available to discuss the review determination with the attending physicians or other ordering providers.

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 Grid (Exhibit 6.1) 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 obtained 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 Health Choice Generations website has an updated listing of contracted providers at www.healthchoicegenerations.com.

HOSPITAL SERVICES

Acute Inpatient Admissions

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

Health Choice 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 Health Choice Generations Utilization Review staff as determined by the medical necessity and intensity of service. Health Choice Generations Utilization Review staff will assist in coordinating services identified for discharge planning, as well as required follow up post discharge.

Outpatient Services

Select ambulatory and outpatient procedures require authorization. Providers should refer to the Health Choice Generations Prior Authorization Grid (Exhibit 6.1) to determine which services require prior authorization.

SUPPORTING DOCUMENTATION- ORGANIZATION DETERMINATION

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 providers/facilities, non-formulary medication or service is required.

CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines (CPG's) designed to support practitioners in developing treatment regimens 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 Health Choice 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.

Health Choice Generations clinical practice guidelines are available on the website at www.hcgenerations.com, under “Providers” and then “Provider Information Link”.

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 Claims Disputes, Member Appeals and Member Grievances Chapter 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.

PRIMARY CARE OBSTETRICIAN RESPONSIBILITY (PCO)

The PCO must notify Health Choice Generations of each pregnant woman at the beginning of her prenatal care (initial visit) by faxing a completed Maternal Risk Assessment for Total OB Authorization form. This Risk Assessment form is a critical component of coordinated care between Health Choice Generations and the Obstetrician or Maternal Fetal Medicine provider and MUST be completed and submitted promptly after the member’s first visit. A copy of the member’s ACOG notes may be submitted in lieu of the clinical documentation requested on the Maternal Risk Assessment form as long as all of the requested information is included in the notes. The Maternal Risk Assessment form should be faxed to Health Choice Generations at (480)760-4762. Upon receipt of the Maternal Risk Assessment form, the Maternal Child Health Department will issue a Total OB Prior Authorization number to the PCO. The PCO will use this number for all professional services related to the pregnancy. See Exhibit 3.6.12 for a copy of the Maternal Risk Assessment for Total OB Authorization form.

Reimbursement for Obstetrical services provided through the term of the pregnancy is dictated by the “Total OB pack” or the provider’s contract.

OB ULTRASOUND

Your total OB package authorization number can be used to bill for the two (2) routine OB ultrasounds included in the TOB. Your office does not need to obtain authorization numbers from eviCore for those two (2) OB ultrasounds. CPT codes that can be used as routine OB ultrasounds are 76801/76802, 76805/76810, 76813/76814, 76815, 76816, and 76817. Please note that any additional OB ultrasounds will require authorization by eviCore. If you have a pregnant member who presents with symptoms indicating an urgent or emergent need for an ultrasound, you may proceed with the ultrasound.

Remember, you will need to contact eviCore within three (3) business days for an authorization of the ultrasound.

eviCore contact information:

Phone number: (888) 693-3211

Fax number: (888) 693-3210

Provider Portal: <https://www.evicore.com/pages/providerlogin.aspx>

eviCore Clinical Guidelines are available at:

<https://www.evicore.com/resources/Pages/Providers.aspx>

EDUCATION FOR PREGNANT WOMEN

During your patient's pregnancy, be sure to document any and all education done by you and your staff. Important topics to discuss with your patients include proper nutrition, breast feeding, smoking cessation, physiology of pregnancy, labor and delivery process, warning signs, drug and alcohol avoidance, postpartum depression and family planning options.

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.

PRIOR AUTHORIZATION AND REFERRALS

It is the responsibility of the PCO to obtain prior authorization for services not related to the pregnancy, i.e. if you have to refer the member out, and for services related to pregnancy but not included in the TOB authorization. In the event that a PCO feels the member needs to be referred to a Maternal Fetal medicine Doctor, it is the responsibility of the PCO to contact the Maternal Fetal medicine Doctor's office, discuss the member's condition and set up the initial appointment.

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 postpartum check in order for Health Choice Generations to identify these critical obstetrical appointments.

OPHTHALMOLOGY/OPTOMETRY

The following services are covered through Health Choice Generations (See Health Choice 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. One pair of eye glasses or contacts per year (\$225 limit)
3. Medicare covered eye exam for the diagnosis and treatment for diseases and conditions of the eye.
4. 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.
5. 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.

Preferred Homecare is the preferred provider of these services for Health Choice Generations. Requests for Durable Medical Equipment (DME) or Infusion/Enterals are to be sent directly to Preferred 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 Arizona has several contracted orthotics and prosthetic providers in the geographical areas we serve. Requests for customized orthotics/prosthetics must be sent to Health Choice by the requesting physician/provider on a prior authorization form with the supporting clinical documentation.

PHARMACY AUTHORIZATIONS

Physicians are required to use the Health Choice Generations Drug Formulary when prescribing medications for Health Choice Generations members. *Refer to Chapter 10: Prescription Benefits and Drug Formulary.*

If the patient requires medication which is listed as “prior approval required” the physician must request prior authorization using the current **Health Choice Generations Pharmacy Medication Prior Authorization Form/Exception Request Form (Exhibit 17.1)** along with appropriate documentation to support the request. Providers should also note references to step therapy (ST) edits, quantity limits (QLL), and maximum dispensing limits (MDL) prior to requesting PA.

Health Choice Generations Formulary is available on the web site at www.healthchoicegenerations.com. Note: if you do not have internet access, contact your Provider Services Representative to arrange for a paper copy to be delivered.

SPECIALTY MEDICATION PROGRAM

Health Choice 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 Exhibit 17.2, Specialty Drug List for the list of medications and Chapter 10 for instructions on how to order these special medications, or contact the Health Choice Generations Pharmacy department for additional assistance.

BEHAVIORAL HEALTH PROGRAM

Health Choice 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 **Health Choice Generations Pharmacy Medication Prior Authorization Form/Exception Request Form** and submit appropriate documentation to support the request. See Exhibit 17.1

Medicaid Behavioral Health benefits are provided by Regional Behavioral Health Authorities. For further assistance regarding Behavioral Health Services, call Health Choice Generations at (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 turnaround 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. The specialist should verify the member’s eligibility on the date of service. 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. Health Choice Generations reserves the right to grant retrospective authorizations in rare circumstances, Health Choice 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 Health Choice Generations policies and procedures in attaining PA prior to any non-emergent or urgent service.

CASE MANAGEMENT

Health Choice Generations will assist in managing the care of members with chronic or disabling conditions that can benefit from care coordination and assistance. Health Choice Generations providers shall assist and cooperate with Health Choice Generations case management programs. Health Choice 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 Health Choice 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 Health Choice Generations Case Management program by filling out a case management referral form (Exhibit 5.1) and attaching any pertinent medical documentation and faxing it to (480) 317-3358 or (800) 323-9652. Providers may also contact the Case Management Department via phone to refer a member by calling (800) 230-6044 Monday-Friday 8am – 5pm.