POLICY NUMBER	41-UM-AUTH 600
POLICY TITLE	Service Authorization Request
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DEPARTMENT	Utilization Management
ORGANIZATION (S)	CCHP
LINES OF BUSINESS	All

Purpose

To outline the process for reviewing prior authorization requests.

Policy

It is our policy to assure that culturally competent quality care is provided to all members and that authorization decisions are made within the established timeframes. We maintain a panel of credentialed physicians to provide such care.

Definitions

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Procedure

A Service Authorization Form (SAF - Attach A) is used by the physician when referring a member to another provider. The primary care physician (PCP) determines the medical necessity and appropriateness for the referral and controls all referrals to specialists, both contracted and non-contracted physicians. The PCP refers members to non-contracted physicians when providers in the medical group cannot provide the service. CCHP will ensure that members have access to covered services that are not available from plan providers. Referrals to non-plan providers require health plan authorization.

Certain requests for senior members are considered to be expedited initial determinations and are governed by certain criteria established by the Centers for Medicare and Medicaid Services (CMS) (see below).

In Network Women's health services (access to OB/GYN providers) do not require a referral for routine or preventive health services including mammography from a participating gynecologist or other qualified health care provider.

Members may self-refer in network for an annual flu vaccine injection.

The PCP may refer a member directly to an in network specialist, for medically necessary care, for up to four visits without authorization by the health plan. If the member has a life threatening, degenerative or disabling condition, extending referrals to specialists beyond the four visits for the purpose of coordinating care may be subject to review that may include a treatment plan evaluation with coordination efforts among the PCP, specialist and Medical Director/CMO.

The physician may request authorization for health care services via one of the following methods:

- Provider Portal- https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx?bc=250fdc7b-5144-44f4-88d9-d86b841d9ebf&serviceid=0ec2e499-26cd-4333-bb08-f97ffc1b75de
- Fax- The physician completes, signs the SAF and faxes to the UM Department at 1-415-398-3669;
- Mail- The physician completes, signs the SAF and mails to the UM Department:
  445 Grant Avenue, Suite 700
  San Francisco, CA 94108
- Telephone- The physician calls the UM hotline at 1-877-208-4959 to request authorization for health care services.

The Utilization Management Nurse Reviewer may authorize a verbal request from a physician by entering the data into the authorization application and noting that she/he had spoken with the physician.

Prior authorization is required for:

- Ambulatory surgery in hospitals
- Ambulatory surgery at Chinese Hospital which exceed $500.00 allowable based upon Medicare reimbursement
- PCP referrals in excess of four visits to specialist physicians.
- Elective hospitalizations
- Tertiary providers (eg UCSF, Sutter, Stanford, Lucile Packard Children's, Bay Children's)
- Out of plan providers
- Ambulatory Therapy
- Treatment plan for course of care at all facilities (eg chemotherapy, radiation therapy, renal dialysis)
- Outpatient procedures in physician offices which exceed $500.00 allowable (based upon Medicare reimbursement)
- Genetic testing
- CCHP will perform random audits including clinical reviews of specialist claims billed with 99204, 99205, 99214 and 99215 even if they were pre-authorized.

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Prior authorization is not required for:

- In-network outpatient mental health services performed in Place of Service (POS) 11 (office visits)
- In-network pregnancy related services including medically necessary prenatal tests as referenced in nationally recognized evidence based guidelines such as ACOG and MCGs Vol 22 , 2018 which may include amniocentesis, outpatient ultrasounds, fetal testing, stress & non-stress testing. (Genetic testing still requires prior authorization)
- The screening, prevention, testing, diagnosis and treatment of the human immunodeficiency virus (HIV)
- In-network Physical Therapy: A therapist may perform the PT evaluation and 6 follow-up sessions. For additional services, a Service Authorization Form (SAF) must be submitted.
- In-network Acupuncture Therapy: In-network acupuncturist may perform up to 18 acupuncture sessions per calendar year without prior authorization. For additional services, prior authorization is required.

Retroactive Authorizations:

For services requiring authorization or modification of an existing treatment plan, the request must be submitted prior to render the service to 1) verify medical necessity, 2) verify the service requested is a covered benefit, 3) verify member eligibility and enrollment, and 4) verify the provider and location of service is in network. Requests for retroactive authorization shall not be approved for any elective and non-emergent services. Claims received for elective and non-emergent services without the required prior authorization by the Utilization Management Department will be denied.

The Utilization Management Coordinators are responsible for:

- Verifying member's eligibility and line of business
- Entering the request into the utilization management software system
- Requesting additional information as necessary
- Forwarding SAF to the UM Nurse Reviewer
- Returning the request to the provider once authorization has been given

The Utilization Management Nurse Reviewers are responsible for:

- Assuring that the provider is a member of the referral panel
- If the provider is not a member of the referral panel, contacting the PCP for clarification
- Applying medical criteria or guidelines as appropriate

- Referring potentially denied cases to the Medical Director or senior physician for a decision
- Assuring that the service approved is specified
- Signing the approved authorization requests

Any notes regarding the SAF, such as reasons for pending, discussions with the provider, and referrals to the physician advisor shall be documented in the authorization application by the UM Nurse Reviewer.

Authorizations will be effective for 90 days unless otherwise noted. Authorizations for treatment shall not be rescinded after the provider renders the service in good faith pursuant to the authorization, even if the member is later found to be ineligible at the time the service was rendered, and claims submitted against the authorization shall be adjudicated in compliance with standard claims paying policies and procedures. This shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan.

SAFs submitted for services that do not require authorization will be returned to the provider with a note that prior authorization is not required.

Commercial members in plans other than CCHP shall receive notice of approval of the request. For denials of services refer to policy # DEN 100.

Expedited Initial Determinations for Senior Program Members

Medicare Advantage Organizations must promptly decide whether to expedite an organization determination based upon regulatory requirements. Requests for an expedited organization determination for medical services may be made in writing or orally by:

- An enrollee, or an authorized representative of the enrollee; or
- A physician regardless of whether the physician is affiliated with CCHP.

If the requesting individual asks that the authorization be handled as an urgent request then the decision must be made within 72 hours of receipt even if additional information is needed except in instances as noted below. There may also be instances when the UM Nurse Reviewer determines that the decision must be made expeditiously such as when a procedure is scheduled within 72 hours of the request. These requests are considered "time-sensitive" which is defined by CMS as "involving a situation in which the time frame for the regular authorization process of 14 calendar days could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum function."

Upon receipt of an authorization request marked urgent, the UM Coordinator shall enter the demographic information into the authorization application and alert the UM Nurse Reviewer that the request appears to meet the definition of an expedited determination.

A request is considered to require expedition when applying the standard timeframes (14 days) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function or if the physician indicates that applying the standard timeframe could seriously jeopardize the life or health of the member. The UM Nurse Reviewer may take an oral request and enter the information directly into the authorization application**.**

- Member notification of favorable expedited determinations:

When a request for an expedited initial determination is received, the member must be notified of the determination as expeditiously as the member's health requires, but no later than 72 hours after receiving the request. The UM Coordinator shall be responsible for notifying the member that an expedited request has been approved.

- Member notification of expedited extension needed for additional information:

If the request cannot be acted upon within 72 hours because additional information is needed, the member must be notified in writing no later than 72 hours after receiving the request. The written notice must include the reasons for the delay and inform the member of their right to file an expedited grievance if they disagree with the extension. The member may request an extension of 14 days or there must be documentation that the need for additional information and delay is in the best interest of the member. For example, additional time of up to 14 calendar days may be used if additional information or tests are needed.

- Member notification of determination not to expedite:

If the request does not meet the expedited criteria, it will be processed under the standard timeframe. The member will be notified in writing of decision not to expedite within 72 hours of receipt of the request. Such notice must include the member's right to file an expedited grievance if they disagree with the decision to process the request within the standard timeframe.

- Member notification of denial, or when a request is approved with modifications:

Refer to policy # UM-DEN 100, "Denial Process."

The Medical Director, a licensed doctor of medicine or doctor of osteopathic medicine, shall always be available to the UM Nurse Reviewer. The Director of Clinical Services, a nurse, shall assure compliance with this policy through the monitoring of the turn-around time of SAF processing in general and urgent requests in particular. The results of this monitoring shall be reported quarterly to the QI Committee.

Attachments

A: Service Authorization Request Form

B: List of MH_SUD Services Require PA

Regulatory Reference

California Health and Safety Code Section 1367.01(i).

(i) A health care service plan shall maintain telephone access for providers to request authorization for health care services.

CCHP Health Plan

SERVICE AUTHORIZATION FORM

This form must be completed in its entirety. Failure to do so may delay processing and result in service denial.

Fax to CCHP at (415) 398-3669

All out of network, UCSF Medical Group, Stanford Hospital and Clinics, Lucile Packard Children's Medical Group and Sutter Pacific Medical Foundation Providers must be pre-authorized before service is provided.

Member Information

☐ Commercial ☐ Senior ☐ Senior Select
☐ Covered California ☐ Senior Value

First Name: Member ID#:

Last Name: Date of Birth: Gender: ☐ **M** ☐ **F**

Check only one request type:

☐ Urgent Request ☐ Non-Urgent Request ☐ Standing Referral ☐ Retroactive DOS:_____

Check only one service type:

☐ Consultation ☐ Follow-up ☐ Outpatient ☐ Inpatient
☐ Diagnostic ☐ DME ☐ Home Health ☐ Other: _____

Description of Requested Service	**CPT/HCPCS/NDC**	**Unit(s) Requested**	Health Plan Use Only Unit(s) Approved
1.			
2.			
3.			
4.			
5.			

Diagnosis:	Diagnosis:
ICD-10:	ICD-10:

Medical Justification/Necessity: Please attach progress notes or supporting documentation (e.g. labs, X-ray)

Service Provider Information

First Name: Telephone #: ( )

Last Name: Fax #: ( )

Email:

Address: City: Zip Code:

Note: This member was referred to you by an in-network provider. If more visits or treatment is needed, please complete a Service Authorization Form and fax it to CCHP. Provider must check eligibility within two (2) business days prior to services. All providers of services to this patient agree to accept Jade Health Care and/or CCHP rates as payment in full. For web-based inquiry, please visit www.cchphealthplan.com > For Providers > Eligibility Inquiry > Web Based Inquiry.

Requesting Provider Information

First Name: Telephone #: ( )

Last Name: Fax #: ( )

Signature: **Date:**

Health Plan Use Only	Authorization #:
Received Date:	☐ Approved ☐ Denied ☐ Modified
Received/Processed By:	Decision by:
Returned Date	Decision Date:
Case #:	From: To:

To the best acknowledgement, I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review and I have the current relevant experience and/or knowledge to render a determination for the case under review. Initials___

General Information

This authorization does not authorize the provision of services in excess of those benefits currently provided under the member's service agreement for services to be covered. The member must be enrolled at the time the service is provided.

Referrals to Sutter Pacific Medical Foundation, Stanford Hospital and Clinics, Lucile Packard Children's Medical Group or UCSF Medical Center for tertiary care services will require pre-authorization. A Service Authorization Form (SAF) is required.

To The Provider

1. This authorization is limited to the care and/or treatment for the stated diagnosis or problem. If care or treatment other than/in addition to that which is authorized herein is required (including hospital or other institutional care or consultation) by non-Jade Health Care or non-CCHP physicians, additional authorization is needed prior to obtaining or rendering such care or treatment unless it is emergent. Any additional services requiring authorization must be requested with a completed and signed Service Authorization Form (SAF) and faxing it to the CCHP Utilization Management Department at (415) 398-3669.

2. CCHP providers may refer to Jade Health Care and/or CCHP physicians for up to four (4) visits in a calendar year for the same diagnosis. Any additional visits (≥5) require authorization with a SAF and faxing it to the CCHP Utilization Management Department at (415) 398-3669. This Prior Authorization Rule does not apply to Behavioral Health services.

3. No Prior Authorization is needed for in-network outpatient mental health services performed in office setting (Place of Service 11). PCP referral is required.

4. Unless otherwise indicated this referral is valid for the calendar year only. If an extension is needed, contact the referring physician or the CCHP Utilization Management Department at (877) 208-4959 for additional information.

5. The member has agreed to receive referral services from Jade Health Care or CCHP. The health professional accepting this member agrees to seek payment of covered services only from the medical group or plan and agrees not to bill the member.

6. If there is any question concerning this authorization, please call Utilization Management at (877) 208-4959.

CCHP Health Plan

List of MH/SUD Inpatient and Outpatient Services Requiring Prior Authorization

Inpatient services:

- Psychiatric inpatient hospital care
- Inpatient hospitalization for acute stabilization
- Skilled nursing facility services for post-acute care

Outpatient services:

- Speech therapy
- Occupational therapy
- Physical therapy
- Intensive outpatient psychotherapy
- Residential treatment
- Detoxification programs/treatments
- Outpatient day treatment

- Inpatient/Outpatient services provided by non-contracted provider