



### **Referrals or Prior Authorizations:**

A referral or prior authorization is a request by a PCP or a participating specialist for a member to be evaluated and/or treated by a participating specialty physician and/or facility. The Plan uses two types of forms and processes:

#### **1. Quick Authorization Form (QAF):**

For services included on the Plan's Quick Authorization Form (QAF) a referral is NOT required.

Primary Care Physicians (PCP's) can refer a member to a participating specialist and to many frequently requested services and procedures at free-standing facilities with the Simply Healthcare Plans Quick Authorization Form (QAF) without contacting the health plan for prior authorization. **Communication with the Plan prior to the provision of care is not necessary when using the QAF.** However, the PCP or specialist ordering/requesting the consultation or test is required to fax or mail a copy of the completed QAF to the participating provider or facility that will be providing the service(s) or to give a copy to the member so that it is presented at the time of the service.

#### **IMPORTANT NOTE: Services that DO NOT Require Prior Authorization or QAF:**

- Family Planning
- Participating Office/free standing laboratory tests at labs consistent with CLIA guidelines
- Emergent transportation services
- Urgent or emergent care at participating Urgent Care centers or any Emergency Room
- County Health Departments (CHD)
- Federally Qualified Health Centers
- Rural Health Clinics and federally funded migrant health centers when providing:
  - Vaccines
  - STD diagnosis/treatment
  - Rabies diagnosis/immunization
  - Family planning services and related pharmaceuticals
  - School health services and urgent services

\*NOTE: If the member receives Family Planning Services from a non-network Medicaid provider, the Plan will reimburse the provider at the Medicaid reimbursement rate, unless another payment rate is negotiated.

## **2. Prior Authorizations:**

Prior authorization (pre-service request) allows for the use of quality, cost-efficient covered health care services and helps to ensure that effective transition of care planning is done so that members receive the most appropriate level of care in the most appropriate setting. Prior authorization must be obtained for all services not included on the Quick Authorization Form (QAF). The Plan's Utilization Management (UM) Department evaluates requests for services/procedures and makes determinations that consider medical necessity, covered benefits, and appropriateness, based on approved utilization criteria (McKesson InterQual) and evidence-based, nationally recognized clinical guidelines. Only a Medical Director may issue an adverse determination, with the exception of denials due to benefit issues. Adverse determinations include partial or total denial of requested services.

Prior authorization requests are made through the Plan's UM Pre-Certification Department using the Plan's Prior Authorization Form.

Providers may submit authorization requests as follows:

- Fax the completed Referral & Authorization Form to the UM Pre-Certification Department at Fax number **1-800-283-2117**.
- Call the UM Pre-Certification Telephone Queue at **1-877-915-0551**, Option 2. All information required on the Referral & Authorization Form must be provided verbally. A follow-up fax with supporting documentation will be required.

Additional information that must be provided with an authorization request includes:

- Member demographic information (i.e. name, sex, DOB, Plan Member Number)
- Requesting provider information (i.e. name, Plan Provider Number, phone number, fax number, contact person)
- Referred-to specialist/facility information (i.e. name, Plan Provider Number, address, phone number, fax number, and identification if PAR (Plan participating provider/facility) or Non-PAR (not a Plan participating provider/facility))
- Diagnoses for authorization request, including ICD-10 code(s)
- CPT/HCPCS code(s) and description of requested procedure(s)/ service(s)
- Number of visits requested, if applicable
- Frequency and duration of visits, if applicable
- Desired initial date of service
- Pertinent medical history and treatment, laboratory and/or radiological data, physical examinations/referrals that support the medical necessity for the requested service(s)

Routine (not stat/urgent) requests are processed within fourteen (14) calendar days of the Plan receiving the authorization request and supporting clinical information. Stat/urgent requests are processed within seventy-two (72) hours of the Plan receiving the request.

**NOTE:** Stat/urgent requests must meet the following defined medical criteria: Any condition where failure to issue an immediate response may result in an irreversible and significant adverse outcome for health and/or function. Stat/urgent authorization

requests should be **CALLED IN** to the Plan's Pre-Certification Authorization Telephone Queue at **1-877-915-0551**, Option 2 and **NOT** faxed, and the caller should identify the request as "Stat/urgent".

An authorization number will be provided, via fax, to the PCP, specialist and other provider(s) that will provide services to the member, when the request is completed and approved.

Requests that do not meet medical necessity, based upon approved criteria, are reviewed by the Medical Director for a final determination. The Medical Director may conduct a peer-to-peer discussion with the requesting provider, if indicated.

All of the following procedures and services require Prior Authorization and must be provided in a Plan participating facility:

- Inpatient and observation admissions
- Admission to any rehabilitation and skilled nursing facility
- All surgical procedures, inpatient or outpatient
- Abortions, Hysterectomies, sterilization procedures
- Cosmetic or Reconstructive Surgery, including but not limited to:
  - Breast reconstruction or reduction
  - Blepharoplasty
  - Venous procedures
  - Sclerotherapy
- Services and items:
  - Allergy (immunotherapy),
  - Ambulance transportation (non-emergent)
  - Amniocentesis
  - Cardiac and pulmonary rehabilitation programs
  - Circumcisions after 12 weeks of age
  - Court-ordered services
  - Chemotherapy
  - Dialysis
  - DME, including apnea monitors and bili-blankets
  - Upper endoscopies at colonoscopies at hospitals
  - Genetic testing
  - Gamma Knife, Cyberknife
  - Hearing aids
  - Home Health Services
  - Hospice care
  - Hyperbaric Oxygen Therapy (HBO)
  - Investigational and experimental procedures and treatments
  - IV Infusions
  - Laboratory services
  - Lithotripsy
  - Mental Health
  - Nutritional counseling
  - MRI's, MRA's
  - Oral Surgery
  - Oxygen therapy and equipment
  - Out-of-Network Services

- Pain Management and or Pain Injections
- PET Scans
- Prenatal care
- Orthotics and Prosthetics, including Cranial Orthotics
- Physical, Occupational and Speech Therapy
- Radiation therapy
- SPECT scans
- Transplants and pre and post-transplant evaluations
- Wound Care and wound vacuums
- Drugs that require pre-authorization
- Any services or procedures not listed on the Quick Authorization Form (QAF) (unless the service is only available in a non-participating facility)

No provider or any other individual or Plan employee or associate is rewarded for issuing denials of coverage or care. Financial incentives are never used to encourage decisions that would result in underutilization nor are incentives to create barriers to care and services.