Policy

DEPARTMENT: Utilization Management	**POLICY#: UM- 004**
TITLE: Prior Authorization	**VERSION: 1.4**
APPROVED BY: Heidi Wold	**DATE:** 9/7/2022
DEPENDENCIES:	

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Purpose

To evaluate the appropriateness of a medical service based on criteria, medical necessity, and benefit coverage. Please review the current Prior Authorization List of medical services that require prior authorization. For certain services, providers are required to submit a prior authorization that outlines information important in helping LHP determine the appropriateness of care for LHP members seeking related services.

Definitions, Abbreviations, and Acronyms

Acronym	Meaning
Adverse Benefit Determination (Denial):	a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical appropriateness, OR b. The reduction, suspension, or termination of a previously authorized service, OR c. The denial, in whole or in part, of payment for a service, OR d. The failure to provide authorization in a timely manner, as defined by the and Centers for Medicare and Medicaid Services (CMS)
Appeal:	The right of the member or member's authorized health care representative to request reconsideration or redetermination of an authorization that resulted in denial.
Authorization Request:	The request for approval of a health care product or service such as a specific medical treatment, surgical procedure or diagnostic test
Auto-Approval:	Approval of a health care product or service based on established criteria determined appropriate by the Medical Director
Duplicate Request:	a. A request that is submitted by the same provider, for the same member, with the same International Classification of Diseases (ICD) diagnosis coding and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) coding within the appropriate appeal timeframe for the line of business OR b. A request that includes additional clinical documentation but is resubmitted by the same provider, for the same member, with the same ICD coding and CPT/HCPCS coding within the appropriate appeal timeframe for the line of business on a previously denied request, OR c. Any authorization request that includes wording within the request such as "reconsideration" or "review" or any other additional wording that would indicate the submitting provider office is requesting an additional review of an authorization request that has been previously reviewed with a recorded outcome determination.
Durable Medical Equipment (DME):	Items and supplies, both rented or owned, that provide therapeutic benefits to a member in need because of certain medical conditions and/or illness. DME must be able to withstand repeat use in the member's home.
Emergency Medical Condition:	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the

Acronym	Meaning
	health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction or any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.
Emergency Services:	Health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the member's condition is not likely to materially deteriorate from or during a member's discharge from a facility or transfer to another facility.
Expedited (Urgent) Request:	A request for a health care product or service where application of the time frame for making routine or non-life-threatening care determinations: a. Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state; or b. In the opinion of a practitioner with the knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is subject of the request.
Invalid Request:	An authorization request that is missing required data elements
Medically Appropriate:	Health services, items, or medical supplies that are: a. Recommended by a licensed health provider practicing within the scope of their license b. Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence c. Not solely for the convenience or preference of an LHP member, or a provider of the service item or medical supply d. The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to an LHP member in LHP judgement e. All covered services must be medically appropriate for the member, but not all medically appropriate services are covered services
Medically Necessary:	Health services and items that are required by a member to address one or more of the following: a. The prevention, diagnosis, or treatment of a member's disease, condition, or disorder that results in health impairments or a disability b. The ability for a member to achieve age-appropriate growth and development

Acronym	Meaning
	c. The ability for a member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or d. the opportunity for a member receiving Long Term Services & Supports (LTSS) to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice e. A medically necessary service must also be medically appropriate. All covered services must be medically necessary but not all medically necessary services are covered services
Post Stabilization Services:	Covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances to improve or resolve the member's condition.
Prior Authorization:	A pre-service request for evidence-based clinically appropriate health plan review and determination of health care services under the applicable benefit plan. Each line of business has a list of services that require authorization prior to the service being completed which is updated annually and posted to the health plan website. Contracted providers agree to be familiar with services that require prior authorization. Services that require prior authorization may include, but are not limited to, surgical services, diagnostic testing, items of DME, etc. Prior authorization is not required for urgent care or emergency services as defined herein.
Provider Administered Drug:	Medications that are infused or administered by a healthcare practitioner in an outpatient setting which may include a physician's office, infusion center or outpatient clinic.
Received Date	The date the request is received by the health plan. This date is counted as Day 0.
Retroactive "Retro" (Post-service) Request	A request for authorization of a health care product or service that has already been received.
Standard (Non-urgent Pre-service) Request	A request in advance for authorization of a health care product or service for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.
Urgent Care Services	Health services that are clinically appropriate and immediately required to prevent serious deterioration of a member's health that are a result of unforeseen illness or injury.
Valid New Request	An authorization request where all of the required data elements are present.

Policy

Longevity Health Plans (LHP) partially delegates Utilization Management Program, Prior Authorization, Grievance and Appeals functions to their contracted third party administrator (TPA), but remains accountable for those functions in their contracts with CMS. Each year LHP reviews TPA proposed policies and procedures for those delegated functions and determines efficacy/applicability for meeting the Health Plan programs and services, makes modifications as needed, then approves for final use by the TPA.

The TPA must submit all UM/PA and G and A policies and procedures to Longevity Health Plan by February of each year. The TPA is not authorized to change or alter any UM/PA policies and procedures without consent of the Health Plan (LHP). The TPA is required to administer the policies and procedures as approved by the Health Plan.

Procedures

1. Authorization Requests

a. Longevity Health Plan (LHP) classifies authorization requests as either expedited or standard. Authorization requests may also be reviewed for indications that the requested service has been scheduled
b. Requests are accepted in writing via fax, phone, electronic submission through the provider portal or by secure email. Contracted providers must submit requests via electronic submission using the provider portal, Provider Connect. Registration for Provider is required through Provider Portal.
c. All authorization requests are time/date noted upon receipt.
    i. Authorization requests received on weekends, on official LHP holidays, or on emergency closure days are to be processed using the received date/time indicated on the request regardless of if the request was technically received during a date/time which LHP was officially closed.
    ii. Appropriate maintenance of department date/timestamp equipment is the responsibility of department manager or designee.
d. All authorization requests are reviewed for member eligibility at the time of service.
e. The LHP Prior Authorization list is designed to eliminate barriers for members with chronic conditions and/or special health care needs.
f. All authorization requests are determined to be valid or invalid within two business days following receipt.
g. All authorization requests are reviewed for fraud, waste and abuse in accordance with LHP's Fraud, Waste and Abuse Program.
h. All authorization requests are processed according to the contractual state and/or federal regulations within the appropriate timeframes as specified in the table below.
    i. When there is failure to complete a final outcome determination with appropriate communications to the member and provider within the required timeframes, a Compliance Incident Report will be submitted, and the process failure will be immediately addressed with appropriate staff.
i. At no time will the full authorization process be applied to a request identified as a duplicate or invalid request.
j. Authorization requests received for LHP members who also have other coverage will be voided. Authorizations are not required by LHP when LHP is the member's secondary plan.

2. Retroactive authorization requests are accepted only if the request meets the exceptions and/ or extenuating circumstances. Qualifying requests are processed as a standard authorization request.

3. Expedited Authorization Requests

a. Utilization management staff determine within 24 hours of receiving an expedited request if the expedited requirements have been met.
b. All final outcome determinations to the member or the member's authorized representative will include the appropriate explanation of the member's rights to file an expedited appeal with the health plan.
c. Retroactive authorization requests will not be considered as expedited.

4. Invalid Requests

a. Utilization management staff are required to make a minimum of 3 documented attempts to obtain the missing data elements.
b. An extension letter will be sent if the information is not received in the appropriate time frame based on referral type.
c. If the information is not received after the above-mentioned attempts, the authorization request is then considered to be invalid. The requesting provider will be given final notification that the request is unable to be processed.

5. Outcome Determination

a. Longevity Health Plan does not use financial incentives to encourage over or underutilization. Decision making is based only on member eligibility and appropriateness of care and service.
b. Requesting providers are consulted for review of services when appropriate.
c. Completion of all medical review requirements will result in a documented outcome determination consisting of one of the following:

i. Authorized Services
    a. Approved
ii. Adverse Benefit Determination

    a. Denied
    b. Partially denied/partially approved
    c. For termination, suspension or reduction of previously approved covered services, written notification will be sent to the member at least 10 days before the planned action unless otherwise specifically authorized in contract. Notification will be sent to the member at least five days before the planned action when probable member fraud has been verified.
        a. Exception to this rule:
            i. LHP/TPA will mail a notice no later than the date of action if:
                1. The plan has factual information confirming the death of the member
                2. The plan receives a clear written statement signed by the member that:
                a. The member no longer wishes services; or
                b. Gives information that requires termination or reduction of services and indicates the member understands that this must be the result of supplying that information.
                3. The member has been admitted to an institution where the member is ineligible under the plan for further services.
                4. The member's whereabouts are unknown and the post office returns mail directed to the member indicating no forwarding address
                5. A change in the level of medical care is prescribed by the member's physician
                6. The notice involves an adverse benefit determination made with regard to preadmission screening requirements
                7. The date of action will occur in less than 10 days

d. All documents utilized and or generated as a result of an outcome determination will be retained within a secure electronic record system and/or in accordance with LHP's Data Storage and Destruction Policy.
e. PA is required for Companion care and benefit determination is based on Member DX, and demonstrated behaviors outlined in the Companion Benefit Assessment tool completed by the LHP NP and authorized by the member's LHP NP, PCP or LHP Telehealth provider

Prior Authorization: The purpose of prior authorization is to evaluate the appropriateness of a medical service based on criteria, medical necessity, and benefit coverage. Please review the current Prior Authorization List of medical services that require prior authorization. For certain services, providers are required to submit a prior authorization form that outlines information important in helping Longevity Health Plan (LHP) determine the appropriateness of care for LHP members seeking related services.

Precertification: LHP creates the Prior Authorization precertification/prior authorization list each year as part of the CMS bid Plan Benefit Product design process in conjunction with their Third Party Administrator (TPA). Ultimately the Health Plan approves the final list of Prior Auth items and revises each year. The TPA administers the Prior Auth list as designed and ensures all pre-certification and claims set up processes are in place to accurately administer the PA requirements.

In all instances prior auth determinations must be made considering any National or Local Coverage Determination Guidelines, Milliman Care Guidelines or Interqual Criteria and with consideration of the members goals of care. In the absence of LCDs/NCDs, Milliman Care Guideline or Interqual criteria LHP can make a determination to use an expert specialty physician to conduct the medical necessity review based on national practice guidelines, member's goals of care and other clinical considerations.

Services Type: The TPA shall be required to review all out of network provider prior auth request determinations for DME, Prosthetics, Long Term Acute Care Hospitals, and non-contracted Skilled Nursing Facilities. Services must be approved by the LHP Chief Clinical Officer OR designee before final approval is sent to the provider. All prior auth determinations must be made with consideration of the members medical condition, goals of care and in conjunction with the member's assigned NP/PA, PCP or Director of Clinical Quality and Operation.

In the instance where a referral requirement is on the Prior Authorization list for a service to be approved, the TPA must initiate a process to capture and document the referral is approved before paying the provider claim. Referrals can be generated from any provider but approval must come from the member's assigned LHP Health Plan NP/PA or PCP.

All non-contracted providers are required to obtain prior authorization for all non-emergent services rendered and must be reviewed and approved by the health plan.

Any prior auth request for amounts greater than $500 per request MUST be reviewed and approved by LHP Chief Clinical Officer or their designee.

Valid Prior Authorization Requests

A valid prior authorization request is defined as one where:

- The request is initiated by the primary care provider (PCP), treating specialist, or the treating provider
- The provider is part of the LHP Health Partners network
- The member is actively enrolled with LHP at the time of the service
- A physician prescription is included with a request for enteral formulas, infusion therapy, and DME
- Clinical documentation to support medical necessity is included

Review types

Pre-service review: Review of services/treatments prior to the service date is considered pre-service or prior authorization. Prior authorization requests account for the highest volume of requests reviewed in the department. These include planned inpatient hospitalizations or procedures, outpatient services and home health items, services and/or equipment.

Post-service(retroactive) review: The process of reviewing services or treatment after the date of service occurs is considered post-service review. Post-service review of services that require prior authorization is limited by exception reasons. If an exception is granted the same criteria and plan benefits and guidelines are applied to the request or case as would be applied for pre-service requests.

Concurrent review: A review to determine extending a previously approved, ongoing course of treatment or services. Concurrent reviews are typically associated with inpatient care, skilled nursing facility, residential behavioral health care, intensive outpatient behavioral health care and ongoing ambulatory care.

All member hospitalizations shall be reviewed concurrently for medical necessity. If a provider fails to provide requested medical necessity review data, their notification/authorization shall be pended (non-contracted) or administratively denied (contracted). Every attempt should be made to obtain follow up and discharge planning information from the hospital. Longevity Health Plan TPA is to follow their procedure to managing claims when authorizations are pended or administratively denied. Claims should not be paid until the medical necessity information is received and reviewed by Longevity Health Plan Compliance and Chief Clinical Officers, after review by the TPA designee medical officer.

Request types

Requests for services or items and decision notification time frames are consistent with applicable state and federal laws and regulations and accreditation standards. Detailed explanations and timelines are outlined in decision support tools and department policies and procedures.

- **Expedited:** When a service request is expedited, a provider is documenting that the member's health condition cannot wait the standard authorization time frame to receive a response.
- **Standard:** Each line of business has a regulatory time frame to process a standard request. When a request is incomplete or requires a more extensive review, additional time may be necessary to process the request. It is the responsibility of the plan to reach out a minimum of three times to request additional documentation and then refer to the plan medical director for follow-up.
- **Post-service/Retroactive:** A post-service or retroactive request may be reviewed up to one year past the date of service. Retroactive requests are processed within 14 days of receipt for all lines of business except Commercial Plans which are processed within two business days.

Notification process

Members may receive written notification of the authorization determination by mail. In addition, phone calls, faxes, letters, and e-mails are documented and maintained per regulatory requirements.

Prior authorization request processing timeline requirements:

Line	Expedited	Standard	Retroactive/Post-Service
MA	72 hours* Provider Administered Drugs are processed within 72 hours.	14 days* Provider Administered Drugs are processed within 72 hours.	14 days
Part B	24 hours	72 hours	N/A

Timeline Extension- May extend once for up to 14 calendar days with proper communication to member and to requesting provider. Provider Administered Drugs cannot be extended.
Note: No Physician signature required for expedition

Claims submitted without a Prior Authorization

Claims submitted for services that require an authorization from a contracted OR non-contracted provider will not be paid. The provider has the option to appeal and the TPA will follow the approved appeals process.

Inpatient Utilization Management -Precertification and Initial Notification of an Urgent/Emergent Admission

All providers are required to notify the Plan (TPA) when a member is requiring inpatient or observation services.

For elective services, members are expected to receive services from a contracted network provider. Elective procedures performed in an inpatient require pre-certification authorization. Elective procedures performed in an outpatient facility require precertification authorization. Select procedures performed in a provider office require pre-authorization (Per the Health Plan Prior Authorization List in the Provider Manual). Failure to receive prior authorization can result in non-payment.

For non-elective services transfers to an acute care facility (not plan directed) the provider is expected to notify Longevity Health Plan within 24 hours of arrival. Pre-certification or medical necessity review of the initial admission determinations must be made within 72 hours from receipt of the medical record information.

For providers requesting a hospital-to-hospital transfer for members needing services for either a higher level, lesser level of care, or to move to an in-network facility, must be authorized prior to the member transfer. Failure to do so could result in non-payment for the receiving hospital with one exception: the member requires urgently needed services and has not been stabilized at the sending facility.

Utilization management criteria

The plan's evidence of coverage (EOC) or plan document, use federal and state guidelines to determine benefits. Nationally recognized criteria, federal (CMS), state, internal practice guidelines and company developed clinical standards are used to determine clinical and medical appropriateness of services.

The criteria are selected, developed, approved and overseen by the LHP leadership team. The organization gives practitioners with clinical expertise in the area being reviewed, the opportunity to advise or comment on the

development or adoption of criteria. The LHP leadership team works closely with TPA to ensure clinical consistency and appropriateness of all criteria utilized by the TPA

Complete criteria sets are maintained electronically and are available for reference to authorized entities, providers and members upon request.

Evidence-based criteria

Longevity Health Plan performs utilization management using nationally recognized evidence-based guidelines from MCG Health and InterQual criteria. Care guidelines from MCG provide evidence-based medicine's best practices and care plan tools across the continuum of treatment, providing clinical decision support and documentation which enables efficient transitions between care settings. Eight of the largest United States health plans and nearly 1,900 hospitals use MCG Health's evidence-based guidelines and software. MCG Health's informed care strategies affect over 208 million covered lives.

Criteria examples

American Society of Addiction Medicine: https://www.asam.org/asam-criteria

- MCG CareWebQI 11.0.4 MCG Health: https://www.mcg.com/care-guidelines/care-guidelines/
- Longevity Health Plan use applicable content from:
    - Medicare National Coverage Determinations, Local Coverage Determinations, or Interqual as well as per the Medicare Benefit Policy Manual.
    - CMS Medicare National Coverage Determinations: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961
    - CMS Medicare Local Coverage Determinations: https://www.cms.gov/medicare/coverage/determinationprocess/LCDs
    - Medicare Benefit Policy Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

Denials / appeals

A denial is a decision to limit or deny authorization of a requested service or item that is published as requiring authorization from TPA utilization management. This is defined by Centers for Medicaid and Medicare (CMS) as an **adverse organizational determination**.

Whenever issuance of a denial is warranted, the member will receive notice in writing which is copied to the provider. The written notification of a denial of coverage is based upon medical appropriateness or benefit limitation and will include, but is not limited to:

- Reason for the adverse determination in terms specific to the member's condition.
- Description of the member's treatment interventions requested.
- Specific criteria deemed to be appropriate to apply to the specific request indicating (when appropriate and applicable) which portion of the criteria was not found to be met.
- Description of the member's appeal rights and how to initiate an appeal.

The chief medical officer or medical director is available to discuss the decision with the provider regarding an adverse determination. This is called a "peer-to-peer" consultation and may result in the decision being overturned. The intent is to provide an opportunity to discuss the details of a specific case for better understanding as to why the request may not have met the required criteria.

Any request that is denied can be appealed by a member or their authorized representative. All lines of business have individual appeal processes including internal and external review. An impartial provider, who was not involved in the initial denial, makes the redetermination of medical necessity.

Note: The LHP Chief Clinical Officer, Medical Director(s), contracted physician reviewers, the Medical Management utilization management staff and Appeals staff must use the specific criteria contained within to ensure consistency and applicability in utilization management decisions. When applying the specific criteria to authorization requests, the additional aspects listed in this policy are also incorporated into the utilization management decision making process.

Prior Authorization List (Below)

Longevity Health Plan
2022
Authorization/Referral Chart

Service Type	Requirement	Notes
Hospitalization: Inpatient Emergent (Medical and Psychiatric)	Prior Authorization/Notification	LTACs require a referral in addition to PA
Hospitalization: Inpatient Elective (Medical and Psychiatric)	Prior Authorization	
Hospitalization: Partial	Prior Authorization	
Outpatient Hospital Services Including Observation Status	Prior Authorization	Prior Authorization is required, however, any emergent CT Scan performed or ordered by a Longevity Health Plan Nurse Practitioner or participating/ contracted provider does not require a prior authorization.
Ambulatory Surgery Center	Prior Authorization	
SNF Part A Stay	No Authorization Required	For non-network SNF require PA for Part A no more than 14 days per auth
SNF Part B Therapy (ST, OT, PT)	No Authorization is Required	For non-network SNF require PA for Part A no more than 14 days per auth
Cardiac and Pulmonary Rehab Services	Prior Authorization	
ALL out of Network Services	Prior Authorization Except New Jersey PPO	For New Jersey Out of Network services, pre-service pre-certification is recommended
Certain Prescription Drugs	Prior Authorization	Refer to Part D Plan PA, Step Therapy List
Chiropractic Services	Prior Authorization	
Diabetic Supplies/Services	No Authorization Required	For Medicare approved diabetic supplies
Dialysis	Prior Authorization	
Durable Medical Equipment	Prior Authorization	Medicare allowable DME for members transitioning out of nursing home OR member specific Medicare allowable DME for NH resident only
Hearing Aids	Prior Authorization	Plan limits apply
Home Health Services	Prior Authorization	
Home Infusion	Prior Authorization	
Laboratory Services	No Authorization Required form most services Prior Authorization Required for all Genetic Testing	
Medicare Part B Drugs	Prior Authorization for some medications	Prior authorization is required for some medications. For chemo-therapy the initial drug approval only is required.
Mental Health Specialty Services	Prior Authorization for some services	Prior authorization is only required for psychological testing services and counseling.

Change Log

Document Version	Major or Minor Revision?	Date	Name	Comments
1.0	New	1/20/2021	Heidi Wold	Approved
1.2	Minor	10/27/2021	Heidi Wold	New Template
1.3	Minor	2/18/2022	Kiomaris Caldana	Updated policy# for inventory List
1.4	Minor	9/7/2022	Kiomaris Caldana	Re-formatting
1.5	Minor	9/21/2022	Courtney Gonzales	Minor wording change the service type paragraph