CHAPTER 6:
Medical Authorizations & Notifications

Review/Revised: 01/21, 02/21, 7/21

6.0 OVERVIEW

Health Choice Pathway Chief Medical Officer, Medical Director(s), or their designees make determinations of medical necessity based on nationally recognized, evidence-based criteria and 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. [NCQA HPA 2021, UM 4A-1, UM 4C, UM 4D]

Health Choice is committed to making the prior authorization process as efficient as possible, to ensure member access to care is timely. However a requesting provider should make a best effort to submit requests in a manner which can facilitate an effective review process and avoid unnecessary delays.

Please keep the following key points in mind when requesting a medically necessary prior authorization.

For a listing of services which require Prior Authorization please refer to the Health Choice Pathway Prior Authorization (PA) Grid effective to the applicable date of service at:

https://www.healthchoicepathway.com/

The PROVIDER INFORMATION section (located in the PROVIDER drop down menu) contains the Prior Authorization grid. This section is where the PA grid is located which contains the listing of the services requiring prior authorization as well as both Medical and Pharmacy Prior Authorization forms.

6.1 THE FOLLOWING DIRECTIVES APPLY TO ALL HEALTH CHOICE PATHWAY 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 required to meet the medically indicated need for the member
- Health Choice Pathway does not require prior Authorization for Emergency Services
- Health Choice Pathway does not cover or pay for experimental and/or investigational services

6.2 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 Pathway Prior Authorization Request Form. The most current Health Choice PA forms can be found on our website: https://www.healthchoicepathway.com/ under PROVIDERS drop down section under commonly used forms and are included in the Provider Manual as an exhibit to this chapter (Exhibit 6.2 Medical Prior Authorization Form). Providers can submit prior authorization requests via the provider portal.
2. Offices should include accurate ICD-10 codes which support the request, and must provide specific CPT codes, HCPCS codes, and J-codes as well as quantity per code.
3. Offices should only request prior authorization for services listed on the Health Choice Pathway 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. [NCQA HPA 2021, UM 6A, UM 6B]
5. All **expedited** PA request forms **MUST** be signed by the ordering provider. Submission of "Expedited" request are taken very seriously and monitored to ensure members emergent/urgent medical needs are met timely.
6. Prior Authorization requests for Health Choice Pathway can be submitted (24 hours a day/7 days a week) via the provider portal or the Health Choice Pathway prior authorization fax number.

Health Choice has designated fax numbers for medical requests and pharmacy requests.

The office should confirm the fax receipt and this record should be kept for your documentation.

Health Choice Pathway **Medical** PA Fax Line
(877) 424-5680

Health Choice Pathway **Pharmacy** PA Fax Line
(877) 424-5690

7. **eviCore Health Solutions** - All "advanced imaging" radiology services (MRI, MRA, CT and PET), level 2 obstetrical ultrasounds, nuclear cardiac stress testing, echocardiography, and heart catheterizations require prior authorization. The full listing of service codes are identified in the PA Grid.
   Prior authorization for these services must be obtained through the eviCore on-line web portal:
   (http://www.evicore.com),
   Phone (888) 693-3211 or
   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 and requests for multiple (recurring) units of a routine obstetrical ultrasound test (recurring/additional units outside of your Total OB package authorization, refer to Chapter 16 Women and Children's Services of the Health Choice Arizona Provider Manual for additional guidance), MUST be conducted by phone: (888) 693-3211.

6.3 TIME FRAME FOR APPROVALS (AS DEFINED BY 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. [NCQA HPA 2021, UM 5A-4, UM 5B-4]

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. [NCQA HPA 2021, UM 5A-3, UM 5B-3]

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. [NCQA HPA 2021, UM 5A-3, UM 5A-4, UM 5B-3, UM 5B-4]

Outpatient Services

Select ambulatory and outpatient procedures require authorization. Providers should refer to the Health Choice Pathway Prior Authorization Grid to determine which services require prior authorization.

6.4 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. [NCQA HPA 2021, UM 1A-5]

6.5 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 Pathway 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 Pathway will contact the Primary Care Provider (or consulting provider) 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 Pathway does not prohibit providers from advocating on behalf of members within the utilization management process.
- Providers are responsible for informing the member the procedure has been authorized.
- Health Choice Pathway Medical Directors and clinical staff are available to discuss the review determination with the attending physicians or other ordering providers. [NCQA HPA 2021, UM 7A, UM 7D]

- Criteria is available upon request by calling 800-322-8670 [NCQA HPA 2021, UM 2B-2]
- Prior Authorization staff is available for PA questions and issues 8:00 am – 4:30 pm Monday through Friday [NCQA HPA 2021, UM 3A-1]
- Clinical review staff are available on an on-call basis before and after routine business hours, holidays and weekends [NCQA HPA 2021, UM 3A-2]

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.

6.6 REFERRALS TO SPECIALISTS

Please check the Prior Authorization Grid 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 the provider/facility you are referring to is in-network except where out-of-network (OON) authorization had been obtained.

The Health Choice Pathway website has an updated listing of contracted providers at https://www.healthchoicepathway.com/.

6.7 HOSPITAL SERVICES

Acute Inpatient Admissions

All elective and emergent admissions require prior authorization and/or notification. Please fax notification:

Inpatient Notification faxes are sent to 480-760-4732

Utilization Review staff will review the medical necessity criteria to make admission and level of care determinations. Continued stay review will be communicated to the hospital case management staff. Health Choice Pathway staff will assist in coordinating services identified for discharge planning as well as required follow up post discharge.

6.8 CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines (CPGs) are designed to support practitioners in developing treatment regimens that conform to current standards and national guidelines and ensure consistency in chronic disease management.

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 Pathway enrollees. Health Choice Pathway 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. [NCQA HPA 2021, UM 2A-1]

Health Choice Pathway clinical practice guidelines are available on the website at https://www.healthchoicepathway.com/, under *Providers* and then *Provider Information* Link. [NCQA HPA 2021, UM 2B-1]

6.9 SERVICE REQUEST DENIALS

CMS rules and regulations mandate 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.

The Denial of Medical Coverage (NDMC) letter to the member and denial notice to the provider will contain the following:

1. The reason for denial
2. The criteria used to make the decision
3. Description of appeal rights
4. Explanation of appeal process
5. Description of expedited appeal process
   [NCQA HPA 2021, UM 7B-1,2,3, UM 7C-1,2,3]

Information regarding the denial of service will be returned to the provider (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). [NCQA HPA 2021, UM 5A-3, UM 5A-4, UM 5B-3, UM 5B-4, UM 7B-1, UM 7E-1, UM 7C-1, UM 7F-1]

Please note: There are no rewards or incentives offered to health plan staff for issuing denials of coverage or requested services.

6.10 PRIMARY CARE OBSTETRICIAN RESPONSIBILITY (PCO)

The PCO must notify Health Choice Pathway of each pregnant woman at the beginning of her prenatal care (initial visit) by faxing a completed Maternal Risk Assessment form to obtain a Total OB Authorization.

This Risk Assessment form is a critical component of coordinated care between Health Choice Pathway 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 Pathway 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.

6.11 OB ULTRASOUND

Your total OB package, includes two (2) routine ultrasounds, the total OB authorization number can be used to bill for the two (2) routine OB ultrasounds. 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 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

6.12 EDUCATION FOR PREGNANT WOMAN

Health Choice Pathway has an OB Care Management program composed of highly skilled culturally sensitive nurses and care coordinators who provide telephonic interventions for high risk pregnant members during the prenatal and postpartum period.

The OB Care management team provides:

- Education on prenatal care, wellness during pregnancy, and the member's high risk condition(s).
- Referral to community resources (WIC, food, housing, clothing, counseling, MAT, BH).
- Information on Health Choice transportation services.
- Information on family planning.
- A postpartum assessment to identify possible postpartum depression.
- Coordination of care between the interdisciplinary health care team.

Providers can refer high risk pregnant women to the OB Care Management team by completing the Care Management referral form (see Exhibit 5.1 Case Management Referral Form).

Please fax the completed referral form to:
Fax: **(480)760-4762**

Family planning

Family planning is a component of the educational process for male and female members who voluntarily choose to delay or prevent pregnancy. Family planning services include covered medical, surgical, pharmacological, and laboratory benefits.

1. Covered family planning services for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices (IUDs) and subdermal implantable contraceptives):
    a. Contraceptive counseling, medication, and/or supplies, including, but not limited to: oral and injectable contraceptives, LARC, diaphragms, condoms, foams and suppositories,
    b. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning,
    c. Treatment of complications resulting from contraceptive use, including emergency treatment,
    d. Natural family planning education or referral to qualified health professionals,
    e. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (Mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception), and
    f. Sterilization:
        i. Clarification Related to Hysteroscopic Tubal Sterilization:
            1) Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy,
            2) At the end of the three months, it is expected that a Hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test the member is considered sterile.

2. Coverage for the following family planning services are as follows:
   a. Pregnancy screening is a covered service,
   b. Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions,
   c. Screening and treatment for Sexually Transmitted Infections (STI) are covered services for both male and female members,
   d. Sterilization services are covered for both male and female members when the requirements specified in this Policy for sterilization services are met (including hysteroscopic tubal sterilizations), and
   e. Pregnancy termination is covered only as specified in AMPM Policy 410 [including Mifepristone (Mifeprex or RU-486)].

Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available

Prenatal Care

a. Prenatal Care services shall be provided by the OB provider in compliance with the most current American College of Obstetricians and Gynecologists, (ACOG) standards for obstetrical and gynecological services. Practitioners, and licensed midwives adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults/referrals for increased-risk or high-risk pregnancies using ACOG or MICA criteria,
b. The OB provider educates members about healthy behaviors during pregnancy, including the importance of proper nutrition, dangers of lead exposure to mother and child, tobacco cessation, avoidance of alcohol and other harmful substances, including illegal drugs, screening for sexually transmitted infections, the physiology of pregnancy, the process of labor and delivery, breast-feeding, other infant care information, prescription opioid use, history of postpartum depression and postpartum follow-up,
c. Members are referred for support services to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community- based resources to support healthy pregnancy outcomes. In the event where a member loses eligibility, the member shall be notified where they may obtain low- cost or no-cost maternity services,
d. Maternity Care providers maintain a complete medical record, documenting all aspects of Maternity Care,
e. High-risk pregnant members have been referred to and are receiving appropriate care from a qualified physician.
f. For Maternity Care Provider Appointments, initial prenatal care appointments for enrolled pregnant members shall be provided as follows:
   i. First trimester - within 14 calendar days of request,
   ii. Second trimester within seven calendar days of request,

iii. Third trimester within three business days of request, and
iv. High risk pregnancies as expeditiously as the member's health condition requires and no later than three business days of identification of high risk by the contractor or maternity care provider or immediately if an emergency exists.

2. Postpartum Care

Postpartum services are provided by the OB provider within 57 days of delivery.

Screening for postpartum depression shall be completed during the postpartum visit with appropriate counseling and referrals made, if a positive screening is obtained.

6.13 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 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 postpartum 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 Pathway to identify these critical obstetrical appointments.

6.14 OPHTHALMOLOGY/OPTOMETRY

The following services are covered through Health Choice Pathway (See Health Choice Pathway 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.
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.

6.15 DURABLE MEDICAL EQUIPMENT and INFUSION / ENTERAL THERAPY

Preferred Homecare is the statewide contracted service provider of Durable Medical Equipment (DME) for Health Choice Pathway. Requests for Durable Medical Equipment (DME) are to be sent directly to Preferred Home Care 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 or (800) 636-2123
- Main Fax Number: (480) 446-7695

Coram Infusion / Enteral Therapy is the statewide contracted service provider for Health Choice Pathway Infusion/Enteral Therapy services. Request for Infusion/Enterals are to be sent to directly to Coram Infusion 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 Coram Infusion

- Main Office Phone Number: (480) 240-3200
- Main Fax Number: (480) 505-0455

6.16 ORTHOTICS/PROSTHETICS

Health Choice Pathway has several contracted orthotics and prosthetic providers in the geographical areas we serve. The full listing of service codes that require authorization are identified in the PA Grid. Requests must be sent to Health Choice by the requesting provider on a prior authorization form with the supporting clinical documentation.

6.17 PHARMACY AUTHORIZATIONS

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

If the patient requires medication which is listed as "prior approval required" the provider must request prior authorization using the current **Health Choice Pathway 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 Pathway Formulary is available on the web site at: https://www.healthchoicepathway.com/

Note: if you do not have internet access, contact your Provider Performance Representative to arrange for a paper copy to be delivered.

Effective 1/1/19, Health Choice providers have the ability to **submit Pharmacy Prior Authorizations online** through your secure provider portal or by visiting directly PromptPA portal: https://healthchoice.promptpa.com/ *System Requirements: Web browser (i.e. Internet Explorer 9 or higher).

In order to submit an online request, please be prepared with the patient's name, ID number, and zip code.

Clinical information submitted via the PromptPA Portal will be transmitted securely into the Health Choice's Pharmacy Coverage Determination system for review by a Health Choice Pharmacist or Medical Director.

6.18 SPECIALTY MEDICATION PROGRAM

Health Choice Pathway 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 Chapter 10 for instructions on how to order these special medications, or contact the Health Choice Pathway Pharmacy department for additional assistance.

6.19 BEHAVIORAL HEALTH PROGRAM

Health Choice Pathway requires prior authorization for select behavioral health services and non-contracted providers. For a listing of services that require prior authorization, please refer to the Health Choice Pathway Prior Authorization Grid.

Offices must legibly complete all necessary fields of the most current Health Choice Pathway Prior Authorization Request Form. The most current Health Choice PA forms can be found on our website: https://www.healthchoicepathway.com/ under PROVIDERS drop down section under commonly used forms and are included in the Provider Manual as an exhibit to this chapter (Exhibit 6.2 Medical Prior Authorization Form).

A Health Choice behavioral health professional is required to apply the designated authorization and continued to stay criteria to approve the provision of the covered service. [NCQA HPA 2021, UM 4A-2]. Submitted clinical information and documentation relevant to the authorization request are reviewed by a behavioral health professional to determine medical necessity.

If enough clinical information relevant to the medical necessity criteria is not provided with the request, Health Choice will reach out and attempt to gather the clinical information needed to make a decision. [NCQA HPA 2021, UM 6-B]. A decision to deny must be made by the Health Choice Medical Director or physician designee. [NCQA HPA 2021, UM 4-D] When appropriate, Health Choice will provide a consultation with the requesting provider to gather additional information to make a determination. [NCQA HPA 2021, UM4-1, 4D]

Before a final decision to deny is made, the person's attending behavioral health medical practitioner can ask for reconsideration and present additional information. [NCQA HPA 2021, UM 7-A]

Request for prior authorization should include all supporting documents.

Behavioral Health Medical Necessity Criteria

Health Choice Pathway utilizes (InterQual) clinical guidelines to determine medical necessity for both outpatient behavioral health services and psychiatric inpatient levels of care. [NCQA HPA 2021, UM 2A-1]

Inpatient Admission and Continued Stay Review Process

For all initial concurrent and continued stay requests, submit the completed **Certificate of Need (CON),** Health Choice **Prior Authorization and Continued Stay Request Form for Psychiatric Hospitals and Sub-Acute Facilities, w**ithin one business day of admission. For request forms, visit our website request form page.

All request are submitted by faxing to **(480) 760-4732.**

Continued stay reviews will be conducted by Health Choice Pathway Utilization Review staff and communicated to the hospital utilization review staff. The number of days authorized is based on current symptoms and behaviors. Utilization Review staff will conduct and communicate an assessment of discharge needs and recommendations; assist with coordinating of services as needed. Members identified as high risk and over with over utilization will be referred to care management (see section 6.24). Health Choice Pathway Transition of Care call members while they are still inpatient staff provide post three day discharge call and provide conduct telephonic outreach post discharge for up to thirty (30) days to ensure the member's discharge needs are addressed to decrease readmission.

- Admission reviews are completed by Medical Management within one business day of notification (This does not apply to precertification). (**42 C.F.R. 456.125**.) [NCQA HPA 2021 UM 4]
- Initial and continued stay authorization are based on adopted medical necessity criteria. The number of days authorized and frequency of reviews are based on member's diagnosis, condition and projected discharge.
- Continued stay reviews are completed by Medical Management Specialist prior to the end of the current authorization. Hospital UR staff are notified of next review date. The facility is responsible for submitting updated clinical information on the last authorized day.
- For concurrent reviews the request will be made twice in a 48 hour period. If the information is not received within that timeframe the continued stay will be administratively denied for lack of medical information.

- Reviews not meeting medical necessity guidelines are referred to Medical Director or the physician designee for review. [NCQA HPA 2021 UM4-D]
- Clinical information for medical necessity review may include, but is not limited to: [NCQA HPA 2021 UM6-B]
    - Hospital records including, but not limited to history of presenting problem, diagnostic test, psychiatric prescriber evaluations, psychosocial history, medication records, treatment plan, and progress notes.
    - Quality of care
    - Length of stay
    - Whether services meet the member's needs
    - Discharge needs
    - Utilization pattern analysis

Behavioral Health Medications

Health Choice Pathway has formulary medications available to treat identified Behavioral Health Disorders.

If the patient requires a behavioral health medication listed as "Prior Authorization Required", "Step Therapy" and/or "Quantity Limits" the provider must request prior authorization using the **Health Choice Pathway Pharmacy Medication Prior Authorization Form/Exception Request Form** and submit appropriate documentation to support the request. See Exhibit 17.1

6.20 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.

6.21 SPECIALIST PROTOCOL

The specialist is responsible to ensure 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.

6.22 RETROSPECTIVE AUTHORIZATION

It is the policy of Health Choice Pathway that retrospective authorization requests (a request for authorization after services which require authorization have been rendered) will NOT be provided. . The provider is encouraged to follow the appeal and grievance process per CMS guidelines Providers must adhere to Health Choice Pathway policies and procedures in attaining PA prior to any non-emergent service.

6.23 CARE MANAGEMENT

Health Choice Pathway staff will assist with coordinating the care of members with chronic or disabling conditions. Health Choice Pathway providers shall assist and cooperate with Health Choice Pathway care management programs.

Health Choice Pathway care management programs include the following key components:

- Identifies individuals with complex, chronic or serious medical conditions
- Establishes and implements a care plan appropriate to the members' specific needs and medical condition(s)
- Assesses 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 Pathway Care 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 Pathway Care 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. The form is available online at https://www.healthchoicepathway.com/.

Providers may also contact the Care Management Department via phone to refer a member by calling (800) 230-6044 Monday-Friday 8am – 5pm.