SECTION 6 PRIOR AUTHOIRZATION GUIDELINES

Prior Authorization (PA) is a process which identifies specific procedures or services which require a medical necessity and/or medical appropriateness review prior to services being rendered for either inpatient and/or outpatient services.

6.1 Authorization for Services

GHC-SCW maintains a prior authorization list at ghcscw.com. This list has specific CPT procedure codes and HCPCs DME/specialty drug codes which require prior authorization. To view the PA list, please see click here.

GHC-SCW uses the Milliman Care Guidelines® to ensure consistency in utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The Milliman Care Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request. To support prior authorization, concurrent review, and retrospective review decisions, GHC-SCW uses nationally recognized evidence-based criteria with input from health care providers in active clinical practice. These criteria are applied on the basis of medical necessity and appropriateness of the requested service, the individual member's circumstances, and applicable contract language concerning the benefits and exclusions. The criteria will not be the sole basis for the decision.

Criteria sets are reviewed annually for appropriateness to GHC-SCW's needs and changed as applicable in order to reflect current medical standards. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. Providers may obtain a copy of the utilization criteria upon request.

Prior authorization, concurrent review, and retrospective review requests are presented to the Physician Reviewer or Chief Medical Officer for review when the request does not clearly meet criteria applied as defined above. Before making a determination of medical necessity, the reviewing physician may contact the requester to discuss the case.

The prescribing or treating provider may request a peer review to discuss a medical necessity denial with a chief medical officer reviewer.

Health care services and items must be medically necessary and provided in an appropriate, effective, timely, and cost efficient manner. Providers will need to submit by fax or complete the appropriate authorization online via EpicLink.

The following information is required for prior authorization:

- Current, applicable codes (e.g., Current Procedural Terminology (CPT)/HCPCs codes)
- Member name
- Date of birth

- Gender
- Member ID #
- Primary care or treating provider Tax ID#
- Facility name
- Facility address
- Facility phone and fax number
- Signature, if applicable of the referring provider
- Problem/diagnosis, must include the ICD-9 code
- Reason for the referral
- Clinical information such as progress notes, consultation reports, or a letter of medical necessity, reports of laboratory and imaging studies, and treatment dates, as applicable for the request.
- If DME, indicate rental or purchase

Following the NCQA guidelines, the Care Management Department has up to 15 days to make a determination; however, if all the clinical information is submitted with the initial PA requests, a determination is made within 5-7 business days. If additional information is required, the Utilization Management (UM) staff will contact the provider to inform them what clinical information is needed. UM staff will contact the provider twice in one week to submit the additional information. If the information is not received after 5 business days upon receipt of the prior authorization, the PA will be sent to Physician or Chief Medical Officer to review as is.

When the Care Management Department approves the referral request, a letter is mailed to the member and the specialist only if provider does not have access to EpicLink. EpicLink will identify PA approval and/or denials for providers to view. When the member receives the letter of approval, the member may schedule the appointment to see the specialist. It is helpful for the member to take the letter of approval to the appointment as it is not always seen by the specialist office in the member's electronic medical record. If the member makes an appointment without approval from the GHC-SCW Care Management Department, they may be responsible for full payment of the services provided.

If the member's referral request is denied, both the provider and the member will receive a denial letter in the mail explaining member/provider appeal rights. If the appointment has already been scheduled for the same day or next day after the denial decision is made, GHC-SCW Care Management Department will contact the member and the provider of the denial decision. Please see Appendix A.11 for the policy and procedure regarding GHC-SCW's Member Grievance and Appeals System.

GHC-SCW approves services or supplies based on the information that is available at the time of the approval/denial decision. Approval does **not** guarantee a member's eligibility or benefits under his/her health plan. It is the responsibility of the member to know their deductible, Co-payment, or Co-insurance amounts that apply to Specialty Services.

6.2 Second Opinions

Second opinions are a covered benefit when provided by another GHC-SCW plan provider. Members should contact their Primary Care Provider for a prior authorization for a second opinion if the request is for an out of plan provider.