group health Cooperative of eau claire **KMTSJ, Inc.**	DEPARTMENT:	Utilization Management
	SUBJECT:	Prior Authorization Guidelines
	PRODUCT LINE:	All
	POLICY NUMBER:	HM 90
	ORIGINAL POLICY EFFECTIVE DATE:	09/27/2017
	LAST REVISED DATE:	11/05/2024
	LAST REVIEWED DATE:	11/05/2024

SCOPE:

This policy outlines the processes related to prior authorization requests to ensure Group Health Cooperative of Eau Claire (the Cooperative) correctly and consistently manages prior authorization (PA) requests also known as coverage requests according to NCQA, Federal and State requirements.

POLICY:

Reasons for Prior Authorization

It is the policy of the Cooperative that specific medical, behavioral health, and pharmaceutical services require prior authorization for members. This is to ensure providers, as well as members, understand beforehand what the covered benefits are as well as what will not be covered (denied), along with the associated denial reason(s). In addition, providers and members will be informed with each denial what their respective rights are to appeal or grieve.

A prior authorization (PA) ensures the correct service or referral is being provided based on medical necessity criteria, and plan coverage. The respective member handbook or certificate of coverage that outlines the covered benefits is reviewed as part of the prior authorization process for making coverage determinations. A PA verifies clinical appropriateness by using Cooperative policies & procedures, InterQual, National Clinical Practice Guidelines, or Hayes Technologies that are evidence-based criteria and evaluate the current symptoms, impact on functioning, and the member's support system. The prior authorization process helps identify under and over utilization of services.

PROCEDURE:

Prior authorizations should be submitted at least 3 business days before the requested service to allow time for review of the service(s).

Definition of a PA (Coverage) Request

The following outlines various scenarios that would be reviewed as a PA request and where a coverage determination would be made through the prior authorization process.

- Coverage is requested (including through a call) for an item/service/drug that is subject to a plan's prior authorization requirement
- Coverage is requested for an item/service/drug that is NOT subject to a plan's prior authorization requirement when requested by the member, the member's representative or provider
- A plan makes a decision related to coverage of an item/service/drug without first receiving a party's request for coverage

- A coverage request is received before the provision of the item/service/drug that is the subject of the request to the member
- A coverage request is received during or after the provision of the item/service/drug that is the subject of the request to the member
- When the Cooperative's decision related to coverage of an item/service/drug will be issued during or after the provision of the item/service/drug to the member
- Member wants to continue care with a provider who is no longer contracted with the plan (out of network coverage or is seeking out of network coverage
- Member wants to continue receiving services already received in accordance with the original organization determination (this is a request for a new set of services).

In circumstances where there is a question whether the plan will cover an item or service, the member, member's representative, or the provider on behalf of the member, has the right to request approval from the plan. Such approval requests to the plan (even if to an agent or contractor of the plan, such as a network provider) are requests for an organization determination and the Cooperative will comply with the applicable regulatory requirements. Whenever a member contacts the Cooperative to request a service, the request itself indicates that the enrollee believes the Cooperative should provide or pay for the service.

The Cooperative will educate members and providers when there is a disagreement with a provider's decision to decline to furnish a service or a course of treatment, in whole or in part, that the member has the right to request and receive an organization determination from the Cooperative about whether coverage of the benefit would be provided; such determination about coverage would address if the item or service is medically necessary. Members have the right to seek treatment from other in-network providers.

Who May Request PA (Coverage) Requests

Members or their representatives and other parties as outlined below may make coverage requests.

Type of Request	Who May Request
Standard Request	• Contract or non-contract provider/physician that furnishes, or intends to furnish, services • Staff of said provider's/physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider)

Expedited Request	• A physician or staff of said physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead)
Payment Request	• Contract or non-contract providers

Guidelines for Accepting PA Requests

The Cooperative has processes in place for receipt and documentation of PA requests, as described below.

Filing Method	**Process**
Verbal	• The electronic care management system allows for categorizing and documenting verbal requests. • Documentation of a verbal request is retained in the case file in the electronic care management system.
Written	• The Cooperative accepts all written requests. • The Cooperative has standard PA forms that are available to providers but does not require requests to be on a specific form. • Documentation is retained in the case file in the electronic care management system.

Guidelines for Expedited PA Requests

To ensure members do not have delays in care that may jeopardize their life or health, the Cooperative has processes in place to facilitate expedited requests in an efficient and convenient manner.

Expedited requests can be written or verbal to allow for a convenient method of requesting. Verbal and written expedited requests are received in the Utilization Management Department. To facilitate receipt of these requests, there is a dedicated fax number or dedicated phone number.

The Cooperative's prior authorization forms include a place to mark if the request is urgent. For verbal requests, the UM staff will ask if the request is expedited. Expedited requests are reviewed by a physician to determine if they meet expedited criteria. For those that meet expedited criteria (whereby applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to reqain maximum function) and for DSNP members, whose request is made or supported by a physician, prescribing physician, or other prescriber who indicates applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the Cooperative will process as expedited. The UM Specialist will enter this designation in the case file in the electronic care management system. Once it is designated as urgent in the file, it is automatically prioritized within the queue with an appropriate due date according to expedited standards. All staff working the case can easily identify expedited cases and review them within required timelines. All expedited requests (written and verbal) are documented in the case file in the electronic care management system.

If the Cooperative needs additional information from a non-contract provider, the necessary information will be requested within 24 hours of the initial request for an expedited request.

When a request for an expedited request is denied, the request will be designated as a standard request in the case file and be processed as a standard request. For DSNP members: the member will be given prompt verbal notice of the denial to expedite the request, and a written notice will be sent within 3 calendar days of the verbal notice of the denial to expedite the request.

The Cooperative does not take or threaten any punitive action against a member or a physician who acts on behalf or in support of a request for expedited determination.

If a request involves both a payment request and a request for approval of an item, service, or drug, the member has a right to ask for an expedited initial determination for the approval request.

Services that Do Not Require PA

A prior authorization is not required for:

- The first six visits of physical therapy (PT)
- Speech or occupational therapy evaluations if it is a benefit
- Urgent or Emergent services
- Hospice or palliative care

Services that Require PA

In general, prior authorization or a coverage request is required for (this list is an example and is not all-inclusive):

- Occupational therapy (OT) and speech therapy (ST)
- Physical therapy after the sixth visit
- Cosmetic services
- Admissions: Inpatient medical and behavioral health, Skilled nursing facilities

- HMO may provide inpatient services in an in-network IMD for a person 22-64 years of age for no more than 15 days during the period of monthly capitation payment in lieu of traditional psychiatric intervention services. Out of network IMD requests are reviewed on a case-by-case basis to determine if services are medically necessary and available in network.
- Medical or surgical services that have medical necessity criteria (such as, but not limited to, bariatric surgery, panniculectomy, blepharoplasty)
- Behavioral Health services that have medical necessity criteria (Intensive Outpatient, Day Treatment, Residential Treatment, NeuroPsych and Psych testing)
- Office-based procedures performed in a setting other than an office
- DME items (excluding nebulizers)
- Outpatient Injections or infusions
    - Excluding drugs or radiopharmaceuticals administered in conjunction with diagnostic or radiographic testing if the test itself does not require prior authorization
- Most pain injections
- Out-of-network (OON) services. All OON requests are reviewed to determine if services are medically necessary and if the requested service is available in network. When a service is not available in network, the Cooperative provides adequate and timely coverage of medically necessary services at the out-of-network provider. The Cooperative coordinates with out-of-network providers with respect to payment and ensures that cost to the member is no greater than it would be if the services were furnished within the network.

Prior Authorization Approval Timeframes:

Service	Approval time length or visit number standards
OT, PT, ST	Visits are approved up to 12 visits at a time. Approved frequency will be one visit per week based on standards of care, but an increased frequency can be approved based on the clinical circumstances and at the discretion of the advisor reviewer.
Surgery/ procedures and other requests not specifically listed	90 days from the request date
Initial CPAP, BIPAP, NIV	One month trial
Other DME rental	One month or at the discretion of the advisor reviewer based on the clinical situation
Pharmaceuticals	Drugs administered more than twice per year are approved up to 3 doses per PA request. Chemotherapeutic drugs administered more frequently than once per month are approved up to a 3 cycles per PA request.

Prior Authorization Denials

A prior authorization denial is a response to a prior authorization request under the following circumstances:

- It is not medically necessary because:
  - Does not meet criteria using the Cooperative's policy & procedure or evidence-based clinical criteria sets such as InterQual
  - Did not fail a more conservative level of care
    - Example: Surgery without first attempting physical therapy and/or pharmaceutical intervention
  - Maintenance therapy (PT, OT, ST)
  - Based on medical necessity tenets as outlined in the Wisconsin Administrative Code
- Is considered experimental or investigational
- Lack of clinical information. A medical necessity decision cannot be made without clinical information. When a PA request is received without any clinical information, the UM staff sends a denial letter and informs the provider and member what clinical information is needed to do a medical necessity review and to submit the documentation.
- Contract exclusion
- Lack of prior authorization for a rendered service that requires prior authorization
- Out of network requests are denied when services are available in network
- Duplicative. Services that are considered duplicative will be denied as not medically necessary. Duplicative services may include services that are being repeated when the clinical situation is unchanged or a similar service that would provide the same intended outcome as the previously approved service without providing significant additional information to improve decision making.

A physician or pharmacist reviews all prior authorization requests that involve medical necessity and make all medical necessity determinations. The CMO is licensed to practice medicine in WI. The CMO is an MD and is board certified in Internal Medicine. The CMO has 24 years of managed care experience which has included utilization management, disease management, pharmaceutical management, case management, and wellness experience. One Assistant Medical Director is board certified in Obstetrics and Gynecology. A second Assistant Medical Director is board certified in Family Practice. The Cooperative's clinical pharmacist has a doctoral degree in pharmacy and has experience in utilization management.

Use of Board-Certified Consultants

The Cooperative uses board-certified consultants to assist in making medical necessity determinations when there are questions about treatment options or about the clinical circumstances. The Cooperative uses board certified consultants from our provider network which are listed in our online provider directory or from our contracted IROs.

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APPROVED: Michele Bauer MD. DATE: 11/05/2024

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
09/27/2017	Michele Bauer, MD, CMO	New policy.
10/20/2017	Michele Bauer, MD, CMO	Updated to add denial letter specifications.
08/01/2018	Sarah North, Dir of UM	Removed Methadone, no longer requires PA
04/02/2020	Michele Bauer, MD	Updated criteria
11/15/2020	Michele Bauer, MD, CMO	Clarified medical necessity determinations
02/20/2021	Michele Bauer, MD, CMO	Update processes to reflect changes for NCQA and clarified that chemotherapy requires PA
02/03/2022	Michele Bauer, MD, CMO	Updated prior authorization guidelines. Added advisor review roles
05/24/2022	Michele Bauer, MD, CMO	Added IMD language
06/13/2022	Michele Bauer, MD, CMO	Added process when clinical information is not received with a PA request
07/10/2022	Michele Bauer, MD, CMO	Added approval timeline standards, duplicative denials
09/26/2022	Michele Bauer, MD, CMO	Added process for OON requests
09/15/2023	Michele Bauer, MD, CMO	Added frequency limits for therapy requests
09/10/2024	Michele Bauer, MD, CMO	Reviewed. No changes.
11/05/2024	Michele Bauer, MD, CMO	Updated processes to include new Medicare Advantage requirements