Prior Authorization/Organization Determination

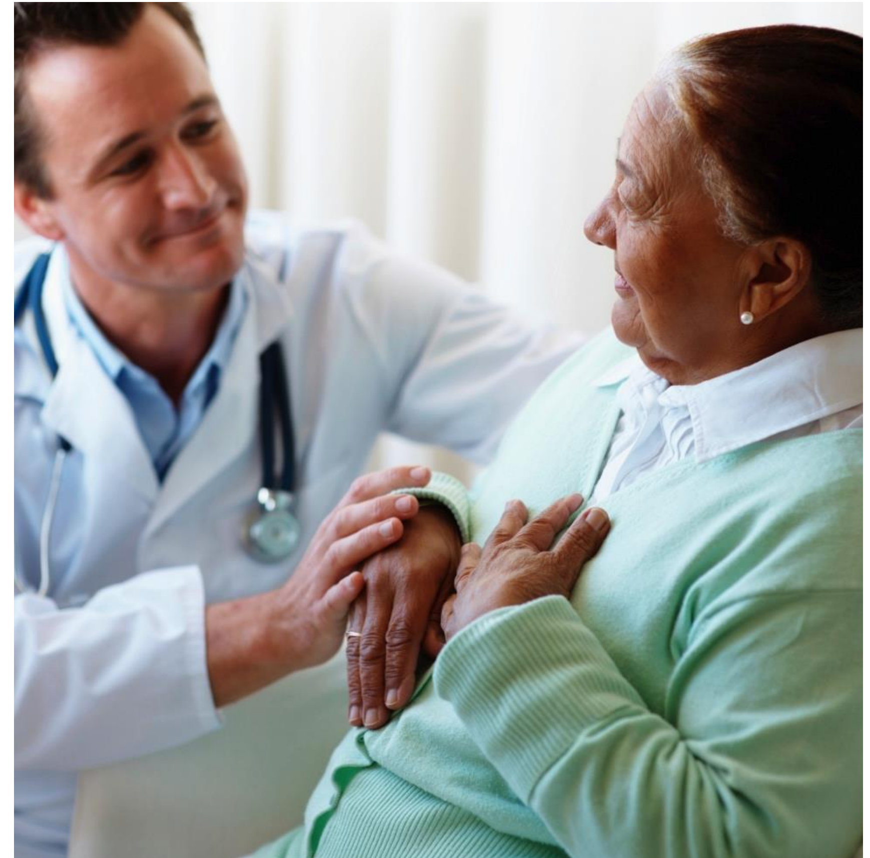
A Quick Guide on the Importance and Process of Requesting a Prior Authorization/Organization Determination

First Choice VIP CARE®
by Select Health of South Carolina

Prior Authorizations — Benefits of Using Prior Authorizations

Prior authorization:

- Ensures the patient receives the right care for the right condition.
- Helps identify members who may not be engaged in the Care Management process.
- Provides a better picture for the Interdisciplinary Care Team, enabling them to develop/update comprehensive care plans.



Prior Authorization Lookup Tool

Use our Prior Authorization Lookup Tool to find out if a service needs prior authorization. It's as easy as 1, 2, 3:

1. Locate the Lookup Tool on our website under Provider > Resources > Prior Authorization.
2. Type a Current Procedural Terminology (CPT) code or a Healthcare Common Procedure Coding System (HCPCS) code in the space provided:

   Enter CPT/HCPCS code

   Enter CPT/HCPCS code Submit
3. Hit submit.

This tool provides general information for outpatient services performed by a participating provider. The following services always require prior authorization:

- Elective inpatient services.
- Urgent inpatient services.
- Services from a nonparticipating provider.

The results of this tool are not a guarantee of coverage or authorization. All results are subject to change in accordance with plan policies and procedures and the Provider Manual.

Prior Authorizations — Where to Submit Organization Determination Requests

Medical services (excluding certain radiology):

- Call the prior authorization line at 1-877-375-4460.
- Complete the one of the following forms found on our website and fax to 1-833-512-1700:
  - Prior Authorization Request Form
  - Skilled Nursing Facilities Prior Authorization Form
  - Clinical Review for Outlier Days to Original DRG Approval Request Form – To request outlier days beyond originally approved DRG
- You may also submit a prior authorization request via NaviNet.

Behavioral health services:

- Call 1-866-426-7690
- Complete one of the following forms and fax to 1-844-211-0972:
  - Behavioral Health Outpatient Treatment Request Form
  - Behavioral Health Clinical Fax Form
  - Neuropsychological and Psychological Testing Request Form

Prior Authorizations — Where to Submit Organization Determination Requests Cont.

Radiological Services:

For the following non-emergent outpatient radiological procedures contact National Imaging Associates, Inc. (NIA) at 1-800-424-4788 or visit www.radmd.com:

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging
- MUGA Scan

Pharmacy Services

For prescription drugs not found on our formulary, an exception can be requested by completing the following:

- Request for Medicare Prescription Drug Coverage Determination Form
- Request for Medicare Prescription Drug Coverage Determination Form – Online

Prior Authorizations - NaviNet Portal

First Choice VIP Care Plus -- Medicare-Medicaid Plan and First Choice VIP Care -- D-SNP

Workflows for this Plan

- Eligibility and Benefits Inquiry
- Claim Status Inquiry
- Claim Submission
- Report Inquiry
- Provider Directory
- Pre-Authorization Management
- Forms & Dashboards

Planned maintenance to the Care Gaps and Condition Optimization Program (COP) platforms may occur on **Thursday evenings betwe** patience.

Important information for providers regarding COVID-19.

Pre-authorization management portal

Prior Authorizations — Time Frames

- First Choice VIP Care has up to fourteen (14) calendar days to complete a standard request for prior authorization and notify the provider of the organization's determination.
- First Choice VIP Care has seventy-two (72) hours to complete an expedited request.
- Once an authorization is processed, the First Choice VIP Care provider will receive a phone call and a fax alerting him or her to the organization's determination.
- Peer-to-peer process:
  - ✓ Preservice requests – Must be requested during initial outreach by the Clinical Care Reviewer notifying the provider that the request is not meeting for medical necessity and will be pended to the Medical Director for determination. The peer to peer must occur before the whole or partial denial determination is rendered.
  - ✓ Inpatient requests –
    - ➢ Anytime during the inpatient stay.
    - ➢ Within 5 business days of the verbal/faxed denial notification or up to 5 business days after the member's discharge date, whichever is later.
  - ✓ Retrospective requests – Up to 5 business after a determination has been rendered.

Prior Authorizations — Organization Determination Process

- If the request is partially or fully denied, the member receives an Integrated Denial Notice from First Choice VIP Care, alerting the member of his or her appeal rights. Providers will also receive this notice for informational purposes.
- Refer to sections five (5) and six (6) of the First Choice VIP Care Provider Manual or the Provider section on the First Choice VIP Care website for more information.
- Please note: Providers may NOT use the Advanced Beneficiary Notice of Non-coverage (ABN) Form CMS-R-131 with Medicare Advantage plans.

Prior Authorizations – How to Prevent Appeals

Many times, the appeal process can be prevented by doing the following:

1. Providing all supporting documentation at the time of request or upon our request for additional information before the allowed authorization timeframe (14 days or 72 hours) elapses.
2. Accept the request for a peer-to-peer review at the time it is offered. Please note, it will be scheduled for a later date.
3. Provide updates to existing authorizations if the member's status changes, which may affect the original authorization.
4. For pharmacy authorizations respond to Requests for Information (RFI) within 24 or 72 hours of the date of receipt of the request depending on whether the request is urgent or standard, respectively.

Partial List of Services That Require Prior Authorization and/or Organization Determination*

- All out-of-network services (excluding emergency services).
- All inpatient hospital admissions, including medical, surgical, skilled nursing, and rehabilitation.
- Elective transfers for inpatient and/or outpatient services between acute care facilities.
- Inpatient services.
- Surgery.
- Surgical services that may be considered cosmetic.
- Transplants, including transplant evaluations.
- Certain outpatient diagnostic tests.
- Radiology outpatient services (**authorized by NIA**)
- Ambulance:
  - Elective/nonemergent air ambulance transportation.
  - Certain types of scheduled, nonemergency ambulance trips.
- Home health.
- Durable medical equipment (DME):
  - All DME rentals and rent-to-purchase items.
  - Purchase of all items in excess of $500 in total allowable charges.
  - Prosthetics and orthotics in excess of $500 in total allowable charges.
  - The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components), regardless of cost per item.
- Cardiac and pulmonary rehabilitation.
- Speech therapy, occupational therapy, and physical therapy provided in home or outpatient setting, after the first visit, per therapy discipline/type.
- Medications: All infusion/injectable medications listed on the Medicare Professional Fee Schedule — infusion/injectable medications not listed on the Medicare Professional Fee Schedule are not covered.
- Pain management — external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation, and injections/nerve blocks,
- Nutritional supplements.
- Hyperbaric oxygen.
- Religious Non-Medical Health Care Institutions (RNHCI).
- All "miscellaneous", "unlisted", or "not otherwise specified" codes.
- All services that may be considered experimental and/or investigational.

For services not typically covered under Medicare, providers must still request an organization determination.

*** Exceptions apply. For a full list of services that require prior authorizations, please refer to the Provider Manual or call Care Management.**

Services That Do Not Require Prior Authorization

- Emergency services.
- Women’s health specialist services (to provide women’s routine and preventive health care services).
- Low-level plain films – i.e. x-rays, etc.
- EKGs.
- Post stabilization services (in-network and out-of-network).
- Imaging procedures related to emergency room services, observation care and inpatient care.
- Laboratory services.
- Ultrasounds.

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