

**PIMA HEALTH SYSTEM
STANDARD AND PROCEDURE**

SUBJECT: Prior Authorization Process – Provider Generated Request	MM-III-001
APPLICABLE TO: Ambulatory, LTC-Institutional, HCBS, Family Planning Extension Services	
EFFECTIVE DATE: 9/09 APPROVED BY: Fred Miller, M.D. by signature	
SUPERSEDES: 8/95, 6/96, 10/96, 12/96, 1/97, 4/98, 6/98, 11/98, 1/99, 8/99, 3/00, 4/00, 5/00, 7/00, 9/00, 2/01, 6/02, 5/03, 12/03, 9/04, 5/05, 10/05, 8/06, 5/07, 5/08, 5/09	

I. STATEMENT OF PURPOSE:

To establish the process for prospective review of medically necessary covered services requested by a licensed provider requiring prior authorization for Pima Health System members in accordance with AMPM (Chapter 1000).

II. DEFINITIONS:

Routine authorization: A request for which PHS must provide a decision as expeditiously as the member’s health condition requires but no later than 14 calendar days following the receipt of the authorization request from the requesting provider.

Expedited authorization: A request for which a provider indicates or PHS determines that using the standard (Routine) 14 day timeframe could seriously jeopardize the member’s life or health, or ability to attain, maintain or regain maximum function. PHS must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires but no later than 3 working days following the receipt of the authorization request, with a possible extension of up to 14 days.

Notice of Extension: A written notification extending the time frame, up to 14 calendar days, for which PHS must provide a decision determination. The member or the provider may request an extension or, if PHS prior authorization establishes the need for additional information and the delay is in the member’s best interest. If PHS does not receive adequate information to make a decision the request will be considered denied.

III. STANDARDS:

A. The Prior Authorization Process is available twenty-four (24) hours per day, seven (7) days per week.

- B. The Pima Health System Prior Authorization Process provides a prospective review of the requested service to determine the following:
 - 1. Service is an AHCCCS covered benefit.
 - 2. Service meets PHS criteria for medical necessity.
 - 3. Provider/Provider site is appropriate.
 - 4. Member is currently eligible.

- C. Prior authorization does not guarantee payment. Reimbursement is based on the accuracy of the information received with the original request being substantiated through the claim submission, member eligibility at the time of service, and the claim meeting claims submission requirements.

- D. Prior authorization referral requests (Attachment #1) must be initiated and/or reviewed, and show evidence of signature by the member's PCP and/or specialist contained on one of the following documents: referral request form, written order, or recent clinical documentation to support the request for service(s). Prior Authorization referral requests by house staff of residency training programs must be submitted under the signature of the attending physician.

- E. Prior Authorization referral requests ordered by a physician assistant or an advanced practice nurse will be reviewed to the extent that the service/item would be reviewed if it were ordered by a physician. All orders written must be signed by a PHS credentialed physician assistant or advanced practice nurse and must indicate their credentials. The name of the supervising physician must be included in requests generated by a physician assistant.

- F. Prior Authorization referral requests must be accompanied by supporting clinical documentation that includes a physical examination and a plan of care that indicates the service/item being requested.

- G. Prior Authorization clinical staff attempts to make determinations as quickly as possible. The maximum timelines are as follows, except when pending for further information:
 - 1. Routine authorization - no longer than 14 calendar days
 - 2. Expedited authorization - no longer than 3 working days

- H. In cases where the member needs immediate medical services within the next 24-48 hours the requesting provider's office should call the 24 hour answering service line (520)243-8062 for assistance. The caller will be connected to a PHS on call staff member who can assist them.

- I. Prior Authorization referral requests for which PHS will need additional time to make a decision determination may be requested by the member, the provider or PHS Prior Authorization Department. A letter of Notice of Extension (Attachment #2), up to 14 calendar days, will be issued to the member and provider. If PHS fails to receive information to make a decision within the 14 days of extension, the request will be considered denied.
- J. The Prior Authorization Division will consult with board certified physicians or other licensed specialists from appropriate specialty practices, *when applicable*, regarding standards of practice in the community prior to making decision determinations.
- K. Prior Authorization referral requests that are duplicative of existing authorization requests or are lacking a provider signature will be returned to the requesting provider with appropriate annotation.
- L. PA decision determinations are made using AHCCCS guidelines, Medicare guidelines, PHS guidelines, community standards of care, consultation with community specialists, and other published clinical guidelines such as Hayes Technology Assessment.
- M. Services that require a Prior Authorization referral request, if not specifically excluded by the Provider/Facility contract, include, but are not exclusive to:
- Procedures/Services**
- Botox injections
 - Cardiac and Pulmonary Rehabilitation
 - Chiropractic Care
 - Dentures (medically necessary)
 - Elective medical and surgical admissions, including outpatient surgery
 - All Bariatric surgeries
 - Genetic Testing and Counseling, other than during pregnancy
 - Home Health Services (Nursing, Home Infusion, Home Therapy)
 - Hospice Services (if PHS in primary position)
 - Inpatient Rehabilitation Services
 - MRI, MRA
 - Non-network provider (PCP or specialist)
 - Therapies (Physical, Occupational, Speech and Respiratory)
 - Obstetrical Care
 - Pain Management
 - PET scans
 - Sleep Studies
 - Second Opinions (only covered if medically necessary)
 - Termination of Pregnancy
 - Transplants

Equipment/Supplies

- Durable Medical Equipment (hospital beds, ventilators, wheelchairs, etc.)
 - Oxygen and associated supplies
 - Enteral/Oral Nutritional Supplements/TPN/Medical Foods
 - Prosthetics/Orthotics/Braces
 - Medical Supplies (wound care dressings, urinary catheters, bowel routine)
 - Eyeglasses post cataract surgery
- N. If the item or service requested is categorized as a “new or new use of an existing technology”, or an item or service that has not been previously provided by the Plan, the PA staff will research information and/or request such information from the ordering provider and present to the PHS Chief Medical Officer for evaluation and consideration. Urgency of need and time dependence will be taken into consideration.
- O. The requesting provider will notify the member regarding the approval status of the prior authorization request. The requesting provider will coordinate the services with the member for scheduling purposes. If the services have been denied a Notice of Action will be issued to the member and provider per MM-III-004.
- P. All service authorization decisions that are not reached within the stated timeframes are considered denied. A Notice of Action will be issued to the member and provider per MM-III-004 following the timeframe definitions as stated in section III-G or section III-I.

IV. PROCEDURES:

The provider completes and submits a PHS PA request form to the Prior Authorization Division via date stamped fax.

Client Services Support Specialists Initial Processing Procedures:

- A. The inbound fax machine is checked on an hourly basis for incoming faxes. Incoming requests can also be transmitted electronically.
- B. The transmitted documents are sorted stapled with all incoming fax paperwork.
- C. The PA referral request form is checked and annotations made for:
- Member demographics
 - Member eligibility
 - Member program enrollment into LTC, HCBS, Acute, KidsCare or Family Planning Extension Program
 - Evidence of member’s enrollment into Medicare or other third party insurer
 - Initial review for benefit coverage
 - Evidence of provider signature
 - Determination of “referred to” provider’s contractual status

- Duplication of request or similar request in QNXT system
 - Identification of request status: Routine or Expedited
- D. If the requested service does not require prior authorization, or lacks the provider's signature, or is a duplicate, the PA referral request is NOT entered into the QNXT system. Instead the request is returned to the sender with appropriate annotation made indicating either, the service does not require prior authorization, is a duplicate and/or lacks a required signature, ICD-9 or HCPCS coding or additional necessary forms such as a certificate of medical necessity.
- E. If the service requested REQUIRES prior authorization the member's account is accessed for data entry into the QNXT system. The following information is entered into the QNXT system:
1. Date PHS notified (date stamp from inbound fax machine)
 2. Referring provider's name, usually the PCP but can be the specialist
 3. Service provider name (the name of the individual or company to whom the referral is being made to).
 4. The ICD-9/Diagnosis(s) code and the CPT/HCPCS(s) Code/Service Group.
 5. Status is assigned as medical review.
- F. Following initial data entry the PA referral request is posted with the date entered and the initials of the individual doing the data entry.
- G. Expedited/Routine PA referral requests are entered into the QNXT system within 24-48 hours and placed in the Prior Authorization Nurse in-basket in a timely manner.
- H. Review of the Pend Report is done every business day to track PA Requests issued a Notice of Extension. Those remaining in 'pend status' for 16-27 calendar days awaiting receipt of additional information, are monitored closely to assure that determinations are processed within the required timeframes. The original PA Request form is routed to the PA RN for medical review with the PHS Chief Medical Officer or designee for the decision determination.

Prior Authorization Nurse (RN or LPN) Procedures:

- A. Routine/Expedited requests will be prioritized for review during normal business hours.
- B. The Prior Authorization Nurse in-basket is checked at least every 2 hours during normal business hours. All requests will be distributed back to the Client Services Support Specialists by alphabetical sort following the decision determination.
- C. The PA nurse will review the appropriateness of each prior authorization request status and notifies the requesting provider when status is modified. The PA

nurse will document the modification activities and review date on the referral request, in the non-clinical notes, call tracking and authorization attributes in the QNXT system. The status of the request will be changed when documentation received from the provider indicates:

1. Request status marked Expedited but actual service dates are not indicated.
2. Documentation received does not support “Expedited” status.
3. Physician did not order Expedited.
4. Dates of service are beyond 7 calendar days.
5. Request marked “Routine” but physician documentation indicates urgent need.

D. All PA referral requests are reviewed by a PA nurse for:

1. Benefit coverage
2. Medical necessity
3. Service provider
4. Coordination of benefits

E. Following PA nurse review the PA referral request will become one of the following:

1. Approved:
 - a) PA referral requests that are “Approved” will be annotated with the approval, approval date, signature of nurse approving, and designated dates of service span and data will be entered into the QNXT system.
 - b) PA referral request is returned to the appropriate Client Services Support Specialist (by alphabetical distribution).
2. Pended for PHS Chief Medical Officer Review:
 - a) PA referral requests that are pended for PHS Chief Medical Officer review will be reviewed with the PHS Chief Medical Officer or designee on a regular basis. The CMO is available by phone when not physically on premises, during the normal business week. The PA nurse will present all PA requests that have been in pend status for 16 -27 calendar days to the PHS Chief Medical Officer for a decision determination.
 - b) The PA nurse presentation to the PHS Chief Medical Officer results in approval, continued pend for additional clinical information or denial of the referral request. If approved, the PA referral request is processed as noted in section III-G-1. above.
 - 1) If continued to pend, the PA referral request is annotated with the reason for the “pend status”, the pend date, and signature of the PHS Chief Medical Officer and PA nurse. The PA referral request is returned to the Client Services Support Specialist (by alphabetical distribution) after data entry into the QNXT system by PA nurse.
 - 2) If denied the PA referral request is annotated with the reason for the denial, the denial date, and signature of the PHS Chief Medical Officer and PA nurse. The PA nurse will change the request status to “denied”, including any line items denied. The PA referral request is

given to the designated PA nurse for completion of the Notice of Action to be sent to the member and provider. (MM-III-004)

3. Pended for additional clinical documentation:

- a) PA referral requests that are “pended for additional clinical documentation” will be annotated with the information requested, date of initial pend, and the PA nurses’ signature.
- b) The PA nurse completes data entry into QNXT system and returns the PA referral request to the appropriate Client Services Support Specialists (by alphabetical distribution).
- c) Upon return of the requested additional clinical information the PA nurse will review the new information and either:
 - 1) Approve, see section III-G-1. above
 - 2) Refer to PHS Chief Medical Officer review, see F.2. above

PHS Chief Medical Officer Procedures:

- A. The PHS Chief Medical Officer or designee will meet with the PA nurses on a regular basis during the normal business week and as necessary for Expedited PA referral requests. Also, the PHS Chief Medical Officer or designee is available telephonically 24 hours/7 days a week.
- B. The PHS Chief Medical Officer or designee will review all Pended for PHS Chief Medical Officer Review PA referral requests with the PA nurse. The PHS Chief Medical Officer will make decision determinations on all PA requests that have been pended for 16 - 27 calendar days.
- C. The PHS Chief Medical Officer or designee will make decision determinations using AHCCCS guidelines, Medicare guidelines, PHS guidelines, community standards of care, consultation with community specialists, and other published clinical guidelines such as Hayes Technology Assessment. If the item or service requested is considered a “new or new use of existing technology” or an item or service that has not previously been considered for approval by the PHS Plan, the PHS CMO will review the presented information and will make a determination based on above criteria.
- D. The decision determination for approval, denial, or pend for additional clinical documentation will be annotated on the PA referral request with the date of decision determination and signature of the PHS Chief Medical Officer or designee.

Client Services Support Specialists Post Decision Determination Processing Procedures:

- A. All Expedited requests will be processed immediately after receiving from the PA nurse.

- B. The Client Services Support Specialists will check their assigned return basket every 1 -2 hours for returned PA referral requests for post decision determination processing
- C. Prior Authorization fax sheets (cover sheet and the decision determination sheet) will be generated from the QNXT system.
- D. **The Prior Authorization Fax sheets and referral request form are faxed to the requesting provider and the referred to provider.** If a provider, such as a DME or medical supply provider, needs all clinical documentation accompanying the PA referral request it will be faxed with the Prior Authorization Fax sheets.
- E. The Prior Authorization Fax sheets are stamped with the faxed date, usually the same day or next day following decision determination, and initialed by the individual faxing the decision determination. The sheets are attached to the original PA referral request and filed by month and alphabetical sort.
- F. A written Notice of Action will be issued for Denied referral requests, see MM-III-004.
- G. For pended referrals, the initial pend notification letter is completed to the provider and sent with the fax sheets as stated. If there is no response to an expedited request in 3 working days or routine request in 14 calendar days, then a Notice of Extension will be issued, refer to MM-III-005.
- H. When additional clinical information is received it is date stamped by the inbound fax machine. Appropriate annotation (received additional information), date received, initials of the individual doing data entry is made in the notes section of the QNXT system. The additional clinical information is attached to the original PA referral request and routed to the PA nurses.