CORPORATE POLICY & PROCEDURE

	Policy Name: Prior Authorization
Department: Clinical Engagement	Policy Number: CE12
Version: 7	Creation Date: 6/8/2017
Revised Date: 1/20/19, 7/23/19, 9/30/19,7/17/20, 1/22/21, 7/19/21	Review Date:
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek	☐ Umpqua Health Management ☐ Umpqua Health Network
Signature:  Approved By: F. Douglas Carr, MD, Chief Medical Officer	Date: 7/22/2021

POLICY STATEMENT

Umpqua Health Alliance (UHA) shall provide medically appropriate, cost effective health services including substance use disorder treatment, skilled nursing facility services and flexible services within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the Coordinated Care Organization (CCO) Contract and Oregon Administrative Rules (OAR) 410-141-3820 and 410-141-3835.

PURPOSE

Prior authorization (PA) provides a mechanism, using nationally recognized guidelines, to review a service for medical necessity and benefit coverage. This approach is based on the Oregon Administrative Rules (OARs), our CCO Contract with the Oregon Health Authority (OHA) and its requirements; as well, as evidence based guidelines and clinical judgement. An additional purpose of the PA process is to provide notification to UHA of members with conditions that might warrant focused care coordination.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Alcohol: The treatment of individuals that have a substance use disorder with the substance "alcohol" per OHA.

Behavioral Health: For this policy, refers to mental health and substance use disorders.

Behavioral Health Services: Medically appropriate services rendered, or made available, to a recipient for treatment of a behavioral health diagnosis.

Cost Effective: The lowest cost health service or item that, in the judgment of UHA staff or its contracted agencies, meets the medical needs of the client.

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Covered Services: Medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the legislature funds, based on the Prioritized List of Health Services.

Drugs: The treatment of individuals that have a substance use disorder with "drugs" substances such as heroin, OxyContin, benzodiazepines, marijuana, methamphetamine, etc. per Oregon Health Authority.

Drug Services: Substance use disorder (SUD) treatment services.

Emergency Services: Health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the member's condition is not likely to materially deteriorate from or during a member's discharge from a facility or transfer to another facility.

Family Planning Services: Services that assist with the family planning include but are not limited to: appointments to obtain birth control and emergency contraceptives, pregnancy testing and counseling, testing and treatment of sexually transmitted diseases, abortion, tubal ligation, and vasectomy.

Prior Authorization (PA): Payment authorization for specified medical services or items given by authority staff or its contracted agencies prior to provision of the service. A physician referral is not a PA.

Prioritized List of Health Services: The listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering the Oregon Health Plan (OHP).

Urgent Care Services: Health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.

PROCEDURES

General Requirements

1. Emergent care does not require prior authorization (PA) according to OAR 410-141-3840. UHA will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

2. UHA does not require PA for or restrict freedom of choice to providers of family planning services as referenced in UHA's Member Handbook.
    a. Additionally, members are permitted to self-refer to any provider for the provision of family planning services, including those not within UHA's Provider Network.
3. UHA will ensure the provision of sexual abuse exams without a PA.
4. Services performed or supplied by out-of-network (OON) providers do require prior authorization.
5. Second opinions for OON providers also require a PA as described in CE10 – Second Opinion.
6. Services requiring a PA are available on the UHA's website. If a provider does not have the required form, they can contact Member Services and one will be faxed or mailed.
7. When UHA is the secondary insurance (payer) a PA is not required if the primary insurance authorization guidelines are met, except when a pharmacy claim exceeds fifty dollars. All pharmacy claims exceeding fifty dollars will be reviewed by a pharmacist.
8. All PA decisions for medical, pharmacy, dental, and behavioral health services are conducted by qualified healthcare professionals that have the necessary training and expertise to make authorization decisions for more information refer to UHA policy CE05 – Medical and Pharmacy Review.
9. UHA shall maintain, and ensure that its clinical providers maintain documentation that meets the standards specified in OAR 410-172-0620 (documentation standards), OAR 309-019-0135 (assessment) and OAR 309-019- 0140 (service plan and notes). These record-keeping requirements shall apply regardless of clinic provider's licensure or certification status. Compliance with these clinical documentation standards is an express condition of payment under the Provider Network Agreement and this Oregon Health Plan (OHP) Plan Addendum.
10. UHA does not incentivize providers, employees, or other utilization reviewers to inappropriately deny, limit, or discontinue medically appropriate services to any member.
11. UHA may not authorize services under the following circumstances:
    a. The request received by UHA was not complete;
    b. The provider did not hold the appropriate license, certificate, or credential at the time services were requested;
    c. The recipient was not eligible for Medicaid at the time services were requested;
    d. The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to UHA;
    e. The services requested are not in compliance with OAR 410-120-1260 through 410-120-1860.

12. Any requests for authorization after 30 days from the date of service requires documentation from the provider that indicates why authorization could not be obtained within 30 days of the date of service.
13. Prior authorization of services shall be subject to periodic utilization review and retrospective review to ensure services meet the definition of medical appropriateness.
14. Prior to performing any transplant surgery, UHA shall provide OHA's Provider Clinic Support Unit with administrative notice to HSD.Transplants@dhsoha.state.or.us of all transplant prior authorizations. UHA shall use the same limits and criteria for transplants as those established in the Transplant Services Rules, in OAR Chapter 410, Division 124.

Pharmacy

1. UHA will respond to PA requests for outpatient prescription drugs, including physician administered drugs (PAD), within 24 hours. A response shall include:
    a. A written, telephonic, or electronic acknowledgement of receipt of the PA request to give an expected timeframe for a decision. An initial response indicating only acceptance of a request will not delay a decision to approve or deny the drug within 72 hours from the date and time stamp on the initial PA request for a drug.
    b. Written, telephonic or electronic notice of a coverage decision to approve or deny the drug to the member, and prescribing practitioner, and when known to the MCE, the pharmacy.
    c. A written notice of adverse benefit determination (NOABD) of the drug to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy if the drug is denied or partially approved.
    d. A written, telephonic, or electronic request for request for additional documentation to the prescribing provider when the PA request lacks sufficient information or documentation.
        i. If additional documentation is needed, UHA will identify and notify the prescribing provider of the required documentation to make a coverage decision. Following the receipt of the completed PA forms and required documentation UHA will issue a decision within 72 hours from the date and time stamp on the initial request or as expeditiously as the member's health requires.
            1. If the drug is approved as requested, UHA will notify the member in writing and prescribing practitioner, and when known to UHA, the pharmacy, telephonically, or electronically; or
            2. If the drug is denied or partially approved, UHA will issue a written NOABD to the member, and telephonic or electronic notice

to the prescribing practitioner, and when known to UHA, the pharmacy (CE21 - Adverse Benefit Determinations).

3. If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for PA, UHA will issue a written NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to UHA, the pharmacy (CE21 - Adverse Benefit Determinations).

ii. If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours or longer shall be made available until UHA makes a coverage decision.

iii. UHA's pharmacy benefit manager (PBM) has the authority to allow fills after hours and on the weekend for a 72-hour supply if the medical need for the drug is immediate (OAR 410-141-3835 and policy CE05 - Medical and Pharmacy Review).

Medical, Pharmacy and Behavioral Health

1. In accordance with OAR 410-141-3835(9)(f)(C), received prior authorization requests will be recorded as such:
    a. Date stamping prior authorization when received;
    b. Determining within two business days from receipt whether prior authorization request is valid or non-valid;
    c. Prior authorization requests will be pended for no more than 10 days from initial request of additional supporting documentation;
    d. Once the additional information is received, a determination will be made no more than three (3) days after receipt; and
    e. Any prior authorization received after hours or on the weekend that requires prior authorization will be reviewed in accordance with the authorization timelines listed in sections (3) and (4) of this section of the policy, emergent conditions do not require prior authorization.
2. Standard authorization decisions shall provide notice as expeditiously as the member's health or behavioral health condition requires and within 14 calendar days following receipt of the request for service.
    a. UHA will make three (3) reasonable attempts using two methods to obtain the necessary information during the 14-day period.
    b. Timeframes may be extended up to an additional 14 calendar days by provider or member request, or if UHA justifies a need for additional information and how the extension is in the member's interest.

i. If UHA needs to extend the timeframe, UHA shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension. UHA will notify the member in writing of the reason for the extension and shall make reasonable effort to give the member oral notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

c. Any service authorization decision not reached within the timeframes specified under OAR 410-141-3835 shall constitute a denial and becomes an adverse benefit determination. A notice of action/adverse benefit determination shall be issued on the date the timeframe expires.

3. Expedited PA requests in which the provider indicated, or the plan determines that the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function will be completed and notice will be provided as expeditiously as the member's health condition requires and no later than 72-hours in accordance with 42 CFR § 438.210(d)(2)(i). The Utilization Review Coordinator (URC) will consult as needed with the Chief Medical Officer (CMO) as referenced in UHA policy CE05 – Medical and Pharmacy Review.
    a. Timeframes may be extended by up to 14 calendar days if the member requests and extension, or if UHA justifies to the OHA a need for additional information and how the extension in in the member's interest.
        i. If UHA needs to extend the timeframe, UHA shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension. UHA will notify the member in writing of the reason for the extension and shall make reasonable effort to give the member oral notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.
4. Any decisions to deny or limit the requested services will be determined by the Chief Medical Officer in accordance with OAR 410-141-3225(9)(f)(b).
    a. Determination to deny or reduce the amount, duration, or scope of a required service will not be arbitrarily made solely because of diagnosis, type of illness, or condition of the member (see also policy CE05 – Medical and Pharmacy Review and CE21 – Adverse Benefit Determination).
5. Prior authorization or reauthorization requests for care that is required while in a skilled nursing facility will be completed within two (2) working days as specified in OAR 410-141-3835(9)(f)(D)(iv).

6. For members with special health care needs as determined through an assessment requiring a course of treatment or regular care monitoring, UHA allows members to directly access a specialist as appropriate for the member's condition and identified needs (CE18 – Integrated Care Coordination).

Behavioral Health

1. UHA ensures PA for behavioral health service comply with mental health parity regulations in 42 CFR part 438, subpart K and the requirement set forth within the CCO Contract Exhibit E, Section 22.
2. UHA will not apply more stringent utilization or prior authorization standards to behavioral health services than standards that are applied to medical/surgical benefits as required by Exhibit E, Section 22 and Exhibit M, Section 5 of the Contract, please refer to UHA policy CE24 – Mental Health Parity for further information.
3. In accordance with Exhibit B, Part 2, Section 3(b)(5) of the CCO Contract, UHA will permit members to obtain medication-assisted treatment for SUD, including opioid and opiate use disorders, for up to 30 days without first obtaining PA for payment.
    a. In the event a member is unable to receive timely access to care as required under the CCO Contract, the affect member shall have the right to receive the same treatment from a non-participating provider outside of or within UHA's service area. The rights of the member under Exhibit B, Part 2, Section 2(b)(5) will apply to each episode of care.
4. Members have access to behavioral health screenings and referrals from multiple healthcare entry points, such as a Patient Centered Primary Care Home (PCPCH), the Community Mental Health Provider (CMHP), or the emergency department.
5. Members are not required to obtain a referral from their primary care provider for behavioral health assessment and evaluation services in accordance with Exhibit B, Part 2, Section 4 of the contract.
6. Members are not required to obtain the approval of a primary care physician to gain access to behavioral assessment and evaluation services. Members may refer themselves to any available behavioral health services with in UHA's provider network. Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without authorization.
7. UHA does not require PAs for network providers for outpatient behavioral health services or behavioral health peer delivered services as required in Exhibit M, Section 5(b) of the contract.
8. UHA will insure that members have access to non-participating (out-of-network) providers, including out-of-state, for any behavioral health services that are not available

from a participating (in-network) provider or cannot be obtained within timely access to care standards provided in OAR 410-141-3515.

a. UHA will coordinate behavioral health services with the member and the non-participating provider to ensure timely access to care.
b. UHA will coordinate with non-participating providers to ensure payment of services through the use of prior authorization requests or single-case agreements (SCA), please see UHA policy CE17 – Single-Case Agreements.

9. PAs and reauthorizations for services pertaining to drugs, alcohol, or drug services will be completed within two (2) working days as listed in OAR 410-141-3835(9)(f)(D)(i-iii).
10. PAs are required for non-emergent behavioral health hospitalizations and residential services and will be completed within three (3) days of the time the PA was received in accordance with Exhibit M, Section 5(e) of the contract.
11. UHA shall make payment for medically appropriate behavioral health services when the services are:
    a. Based on the standards of evidence-based practice, and the services provided are appropriate and consistent with the diagnosis identified in the behavioral health assessment;
    b. Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;
    c. Not provided solely for the convenience of the recipient, the recipient's family, or the provider of the services or supplies;
    d. Not provided solely for recreational purposes;
    e. Not provided solely for research and data collection; and
    f. Not provided solely for the purpose of fulfilling a legal requirement placed on the recipient.

<u>UM and Service Authorization Handbook</u>

1. UHA shall create a written Utilization Management Handbook that sets forth UHA's utilization management policies, procedures, and criteria for Covered Services.
    a. The UM Handbook must comply with the utilization control requirements set forth in 42 CFR Part 456, including, without limitation, the minimum health record requirements set forth in 42 CFR §456.111 and 42 CFR §456.211 for Hospitals and mental Hospitals as indicated in policy CE22 – Payment and Authorization of Hospital Admissions.
2. UHA shall provide OHA with its UM Handbook for review and approval upon request, which shall be made to UHA's Contract Administrator via Administrative Notice. UHA shall provide OHA with its UM Handbook in the manner and to the location identified by OHA in its request. OHA will review UHA's UM Handbook for compliance with this

Section 2, Ex. B, Part 2 and any other applicable provisions of the CCO Contract. OHA will notify UHA within thirty (30) days from submission of the approval status of its UM Handbook; OHA will notify UHA within the same period if additional time is needed for review. In the event OHA disapproves of the UM Handbook, UHA shall, in order to remedy the deficiencies in the UM Handbook, follow the process set forth in Ex. D, Sec. 5 of the CCO Contract.

3. UHA shall draft a Service Authorization Handbook that sets forth UHA's written policies and procedures that comply with 42 CFR §438.210 and OAR 410-141-3835 to ensure consistent application of review criteria for authorization decisions.
    a. Contractor shall ensure processes allow for consultation with a requesting Provider for medical services when necessary and that processes are in place for both initial and continuing service authorization requests. Such policies and procedures must include, without limitation:
        i. Those procedures that must be followed in order to obtain initial and continuing service authorizations; and
        ii. The requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's physical, behavioral, or oral health condition or disease, as applicable.
    b. UHA shall require its participating providers and subcontractors to adhere to the policies and procedures set forth in the service Authorization Handbook.

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