QualChoice® HEALTH INSURANCE

Pre-Authorization and Concurrent Review Guidelines

Elective Services

All elective inpatient admissions and designated outpatient services must be pre-authorized to determine medical necessity and appropriate site of care. The provider should submit a pre-authorization request at least **five (5) business days** prior to the proposed service date.

Emergency Care

QualChoice defines "emergency" as *services provided in a hospital emergency facility to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy; or serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.*

If in an emergency a member goes to an out-of-network facility's emergency room for treatment, and is admitted for further care or inpatient treatment, the member, a family member or the facility is required to notify QualChoice once the member is stabilized, but in no event more than **48 hours** after initial treatment. If pre-notification is not received, charges incurred will be paid at the member's out-of-network benefit level. Refer to Out-of-Network Referrals (BI109) medical policy.

All emergency care is subject to clinical review by QualChoice for medical necessity. If medical necessity is not established, payment will be denied. When members utilize emergency rooms for treatment, specific emergency cost sharing applies.

Pre-Authorization Process

To request a pre-authorization, call the toll-free Customer Service number on the back of the member's ID card or submit a *Pre-authorization Request Form.*

P: 501.228.7111 or 800.235.7111

F: 833.681.2498

Provide the following information:

1. Member name
2. Member ID number
3. Member date of birth
4. Diagnosis
5. Proposed service or treatment plan
6. Provider Name
7. Facility Name
8. Expected date(s) of service
9. Clinical indications for the requested service:
   - Relevant history and symptoms
   - Results of diagnostic tests to date
   - Other treatment modalities attempted

The provider is responsible for obtaining in-network pre-authorization. The member is responsible for obtaining out-of-network pre-authorization.

NOTE: Notification by the facility is required even if notification was supplied by the physician and a pre-authorization approval is on file.

As QualChoice is also a third party administrator please refer to the member's ID card for coverage information as benefits and options may vary.

Clinical Review

A nurse will review the clinical information provided using nationally accepted clinical criteria, and may request additional information or medical records if needed to complete the review.

a. If criteria are met, the service will be authorized. The caller is given a pre-authorization number, and authorization letters will be generated to the PCP, the specialist, the member, and/or the facility (as appropriate) within **two (2) business days**. The review nurse will also evaluate case management or discharge planning needs at the time of pre-authorization.

b. If criteria are not met, or if the physician does not provide the information necessary for review, the service will not be authorized. QualChoice will verbally notify the facility and the physician of the denial. A letter is also sent within **two (2) business days** to document the denial and to explain to the member and/or the physician (as appropriate) the process to initiate an appeal.

NOTE: *If at the time of the authorized procedure, additional clinical information is discovered that leads to additional or different testing being performed — a request for authorization may be submitted up to* ***two (2) business days*** *after the procedure. If the additional or different testing meets the criteria for appropriateness, the testing may be covered. If authorization is* ***not*** *requested, or if the additional testing does* ***not*** *meet criteria, the claim will be denied.*

Pre-Authorization Denials

All pre-authorization denials undergo a physician review. If the member and/or the attending physician disagree with the denial, he/she may contact our Care Management Department (501.228.7111 or 800.235.7111) and request Medical Director Reconsideration within **three (3) business days** of the denial.

a. ***Initiated by the attending physician —*** the physician should be ready to provide pertinent information about the patient, including the patient's QualChoice ID number. The attending physician will be given the opportunity to discuss the case with the Medical Director. The attending physician should be prepared to offer clinical information not previously provided and/or to support the clinical course advocated by referencing peer-reviewed medical literature.

b. ***Initiated by the member —*** the member should be ready to provide medical information not previously submitted and insure that the attending physician is available to talk with the Medical Director. It is generally much more efficient for the reconsideration to be initiated by the attending physician on behalf of the member.

Concurrent Review

Concurrent Review is conducted on all inpatient stays. If the clinical information supports medical necessity for continued stay, the nurse will continue to review the care and verify medical necessity at appropriate intervals, but generally no less than every **three (3) days**. The review nurse will also assess the potential for alternate care settings, discharge planning and case management needs and make appropriate referrals.

If the clinical information provided does not support the medical necessity for continued stay, the nurse will contact the attending physician's office for additional information. If the nurse is unable to obtain information **within 24 hours,** the stay will not be authorized due to failure to provide adequate information

If the additional information provided **does not support** medical necessity for continued stay, the case will be referred to the Medical Director or other physician advisor for review. If the additional information **supports** medical necessity for continued stay, it will be authorized and the review process will continue.

NOTE: *The physician must respond to requests from the nurse and/or the physician reviewer for additional information in a timely manner. If the physician is not available to discuss the case during this time period, the continued stay will not be authorized due to lack of information. A decision will generally not be delayed more than one (1) day while the nurse and/or the physician reviewer attempt to contact the attending physician to discuss the case.*

The physician and the facility will be notified by phone within **one (1) business day** of the denial decision. A denial notification letter explaining the decision and the procedures to follow in initiating an appeal will be mailed to the physician and the facility within **two (2) business days**.

Guidelines for a Smooth Pre-Authorization or Concurrent Review Process

- If someone other than the attending physician calls, it should be a nurse or another practitioner with good clinical knowledge.
- The attending physician must be accessible by phone if additional information is needed.
- All relevant patient information must be made available during the call (medical record, history, signs and symptoms, test results, etc.).
- Clinical information provided must follow generally accepted standards of medical practice in diagnostic and treatment recommendations.
- If the requesting physician knows that the request deviates from generally accepted medical practice, he/she should be prepared to provide additional information to support medical necessity.

Appeal Process for Medical Determinations

If the member (or physician on behalf of the member) disagrees with the decision to deny coverage, he/she may request an appeal by putting the request in writing to the address below **within 180 days** of receipt of the denial notification letter.

QualChoice
ATTN: Grievance and Appeals Coordinator
P.O. Box 25610
Little Rock, AR 72221

The member or physician may provide additional information for consideration in the appeal process. QualChoice may request additional information, including but not limited to medical records. A physician advisor who was not involved in the original denial will review the case. The attending physician will receive an appeal determination letter, which will include the appealing physician's review.

For further information, visit QualChoice.com, *Your Right to Appeal.*

Expedited Appeal

An Expedited Appeal is available for a denial of coverage for an ongoing inpatient stay or a pre-authorization denial if the physician believes that immediate attention is required due to the member's medical condition. An Expedited Appeal may be requested verbally or in writing within **three (3) business days** of the original denial decision.

The appealing physician may submit any additional written information for consideration in the Expedited Appeal process.

The Expedited Appeal decision will be communicated as soon as possible but no later than **three (3) business days** after the request is made and any additional information provided is considered.

IMPORTANT NOTE

A determination to deny reimbursement for a service as not medically necessary or not covered under the Plan is related only to responsibility for payment by the Plan. It is the responsibility of the physician and the member, not QualChoice, to make all treatment decisions.

According to our Provider Agreement, the member is not responsible for payment of services provided by network providers that are not properly pre-authorized. Members are also not responsible for payment of services that are determined by QualChoice not to be medically necessary unless the member is notified in advance that the service is not considered medically necessary by QualChoice and agrees in writing to be responsible for payment of that service.