GUIDELINES TO OBTAINING A PRE-AUTHORIZATION

Pre-Authorization

1. Requests for pre-authorization for elective services should be made at least five business days prior to an elective service.

   NOTE: QualChoice encourages physicians to submit requests for pre-authorization of elective services three (3) days in advance in order to assure ample time for completion of the pre-authorization process in case additional information is needed.

2. Requests for procedure/service needed on an emergency basis must be made within 48 hours or two business days after performed/rendered.

3. 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.

4. 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 business days. The review nurse will also evaluate case management or discharge planning needs at the time of pre-authorization.

5. 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 notify both the facility and physician verbally of the denial and a letter documenting the denial and explaining the process to initiate an Appeal will be generated to the enrollee and/or the physician (as appropriate) within two business days.

6. All pre-authorization denials will receive the attention and judgment of a physician reviewer at QualChoice.

7. If the enrollee or the attending physician disagrees with the pre-authorization denial, he/she may request Medical Director Reconsideration within three business days of the denial.

8. Medical Director Reconsideration – *initiated by the member.* The member may telephone the QualChoice Care Management Department to request reconsideration. The communication should offer medical information not previously provided, and the member should insure that the attending physician will be available to talk on the telephone with the Medical Director. It is generally much easier for the reconsideration to be initiated by the attending physician on behalf of the member.

9. Medical Director Reconsideration – *initiated by the attending physician.* The physician may telephone the QualChoice Care Management Department. The physician should have the pertinent information about the patient at hand, including the member's ID number. If the Medical Director who made the initial decision is available, the attending physician will be offered 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 reference to the peer-reviewed medical literature.

PRE-AUTHORIZATION REQUEST PROCESS

Phone: 501.228.7111, ext. 7014
Fax: 501.228.9413

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 such as:
   - Relevant history and symptoms
   - Results of diagnostic tests to date
   - Other treatment modalities attempted

Guidelines to Assure a Smooth Pre-Authorization or Concurrent Review Process

- Have all the relevant patient information available during the call (e.g. medical record, history, signs and symptoms, test results, etc.).
- If someone other than the physician calls, make sure it is a nurse or another practitioner with good clinical knowledge.
- Make sure the physician can be easily accessed for additional information, if needed.
- Follow generally accepted standards of medical practice in diagnostic and treatment recommendations.
- If the Network provider knows that the request deviates from generally accepted medical practice, he/she should be prepared to speak directly to the QualChoice Medical Director to provide additional information to support the medical necessity.

Concurrent Review

Nurse Review

1. Concurrent Review will be conducted on all inpatient stays.

2. If the information provided to the QualChoice Care Management Department supports the medical necessity for continued stay, the nurse will continue to review the care and verify medical necessity at intervals appropriate to the case, but generally no less than every three days. The review nurse will also assess the potential for alternate care settings, discharge planning and case management needs at each review and make appropriate referrals to hospital discharge planning or QualChoice case management staff.

3. If the information provided to QualChoice does not support the medical necessity for continued stay, the nurse will contact the attending physician's office for additional information. The nurse will attempt to obtain information from the facility or physician's office. If the nurse is unable to obtain information within twenty-four (24) hours, the stay will not be authorized due to failure to provide adequate information

4. If the additional information provided supports the medical necessity for continued stay, it will be authorized and the review process will continue.

5. If the additional information does not support the medical necessity for continued stay, the case will be referred to the Medical Director or other physician advisor for review.

Physician Review

1. The physician and the facility will be notified by telephone within one business day of a denial. A letter documenting the denial will be generated to the physician and the facility within two business days of the decision. The letter will include an explanation of the decision and the procedures to initiate an appeal.

   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 does not make him/herself available to discuss the case with the nurse, or, if necessary, the physician reviewer, 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 a total of one day while the nurse and/or the physician reviewer attempt to contact the attending physician to discuss the case.*

Emergency Care

1. All emergency care is subject to review by QualChoice for medical necessity.

2. QualChoice defines "emergency" as those services that are 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 lay person, 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:

a. placing the patient's health in serious jeopardy; or
b. serious impairment to bodily functions; or
c. serious dysfunction of any bodily organ or part.

3. If medical necessity is not established, payment will be denied.

Appeal Process for Medical Determinations

If the physician or the enrollee disagrees with the decision to deny reimbursement for services subsequent to Physician Review, he/she may request an Appeal. An Appeal will be conducted by a physician reviewer or consultant who was not involved in the original denial decision.

To request an Appeal, the physician or enrollee should call or write QualChoice within 60 days of the denial. An Expedited Appeal may be requested by phone or in writing within three business days of verbal or written notification of the non-authorization.

1. If the physician or enrollee disagrees with the initial Physician Review decision, he/she may request an Appeal by putting the request in writing to QualChoice (see below) , within 60 days of receipt of the denial notification letter. The physician or enrollee may provide any additional information he/she wishes to be considered in the Appeal. QualChoice may request additional information, including but not limited to medical records.

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

2. A physician advisor who was not involved in the original denial will review the case, and will be reasonably available by telephone to discuss the case with the attending physician if desired.

3. QualChoice will notify the physician and the facility (if applicable) of the decision.

Expedited Appeal

1. An expedited appeal is available for a denial of coverage for an ongoing inpatient stay or a pre-authorization denial which is rendered immediately prior to scheduled inpatient or outpatient services if the physician believes that immediate attention is required due to the enrollee's medical condition. An Expedited Appeal may be requested verbally or in writing within three business days of the denial.

2. The expedited appeal will be conducted with the appealing physician over the phone by the Medical Director or other physician reviewer. The appealing physician may also submit any additional written information he/she wishes to be considered in the Expedited Appeal.

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

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 enrollee, not QualChoice, to make all treatment decisions. According to the QualChoice Network Provider agreements, the enrollee is not responsible for payment of services provided by Network Providers that are not properly pre-authorized. Enrollees are also not responsible for payment of services that are determined by QualChoice not to be medically necessary unless the enrollee is notified in advance that the service is not considered medically necessary by QualChoice and agrees in writing to be responsible for payment for that service.