Services Requiring Authorization Desk Procedure

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS) Utilization Management (UM) Department maintains and updates a list of services for which prior authorization is required.

Procedure Detail:

It is the responsibility of the contracted provider and/or practitioner to obtain authorization. Contracted providers/practitioners may not hold the member/participant financially responsible for services rendered when prior authorization is not requested as required.
Commercial, ACA and Self-Insured members/participants are required to obtain authorization for out of network services per their Certificate of Coverage, Qualified Health Plan, Individual and Family Policy, Summary Plan Description and/or Rider. Members/participants with a Point of Service (POS) plan are still required to obtain prior authorization for out-of-network services if they are on the prior authorization list. Services requiring prior authorization are contained in the member portal and are updated at least annually.

Procedure:

I. The list of Services Requiring Authorization is reviewed at least annually.
II. Updates (additions/deletions) to the Services Requiring Authorization list are based upon the following considerations:
    - consistency with Medicare Advantage Evidence of Coverage (EOC), Certificate of Coverage (COC), Qualified Health Plan (QHP), Individual and Family Policy (IFP), Summary Plan Description (SPD), Rider, Medicare bid and/or employer group authorization requirements
    - newly covered technology
    - over/high utilization or increased utilization trend
    - high cost
    - appropriateness of treatment
    - potentially cosmetic procedure
    - potentially experimental procedure
    - care management candidate trigger
III. The updated Commercial, ACA, Self-Insured and Medicare Prior Authorization Lists are presented to the Code and Edit Committee for review and approval.

IV. Providers (both contracted as well as non-contracted), members/participants or a member's appointment of representative may request a prior authorization to be expedited.
    a. Providers may request the prior authorization to be processed within the expedited timeframe, if they believe the member's health may be in serious jeopardy having to wait the standard turnaround timeframe.
    b. The provider may indicate the request is to be expedited, by checking the expedited box on the authorization request form, verbally telling the UM staff they'd like it expedited, or indicating within their electronic note.
        i. Expedited requests are processed in 72 hours.
        ii. Standard requests are processed within 14 calendar days.

V. Provider requests for prior authorization may be submitted via Network Health's electronic prior authorization portal, https://networkhealth.com/provider-resources/authorization-information. Requests are also accepted via phone to 866-709-0019 and fax to 920-720-1916.

VI. Member/participant/AOR may submit a prior authorization request via fax or phone to NH's utilization management department at p: 866-709-0019 f: 920-720-1916

Regulatory Body:
CMS

Regulatory Reason:
• CFR 422.202(a)(2)

Department:	Origination Date:	Next Review Date:
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8		
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02-14-2017: Annual Review, 3.21.18: annual review, 3.11.19 annual review, 3.6.20 annual review, 3/8/21 annual review, 3/3/22 annual review-minor wording updates, 3/29/23 annual review, updated info to include providers/members may submit a request to be expedited, in addition, providers need to submit via the portal while members may call or fax. 3/22/24 updated to include phone/fax will be accepted by providers as well, additional detail around how to request expedited status was added.		