Policy

DEPARTMENT: Utilization Management	**POLICY#: UM - 021**
TITLE: Precertification Authorization Type	**VERSION: 1.0**
APPROVED BY: UM Committee	**DATE:** 7/29/2022
DEPENDENCIES:	

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Purpose

This policy outlines Longevity Health Plan's Precertification (Prior Authorization) review by the Utilization Management Department based on the type of request.

Definitions, Abbreviations, and Acronyms

Acronym	Meaning
Authorization Request	The request for approval of a health care product or service such as a specific medical treatment, surgical procedure or diagnostic test
Duplicate Request	a. A request that is submitted by the same provider, for the same member, with the same International Classification of Diseases (ICD) diagnosis coding and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) coding within the appropriate appeal timeframe for the line of business OR b. A request that includes additional clinical documentation but is resubmitted by the same provider, for the same member, with the same ICD coding and CPT/HCPCS coding within the appropriate appeal timeframe for the line of business on a previously denied request, OR c. Any authorization request that includes wording within the request such as "reconsideration" or "review" or any other additional wording that would indicate the submitting provider office is requesting an additional review of an authorization request that has been previously reviewed with a recorded outcome determination.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction or any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.
Expedited (Urgent) Request:	A request for a health care product or service where application of the time frame for making routine or non-life-threatening care determinations: a. Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state; or b. In the opinion of a practitioner with the knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is subject of the request.
Prior Authorization	A pre-service request for evidence-based clinically appropriate health plan review and determination of health care services under the applicable benefit plan. Each line of business has a list of services that require authorization prior to the service being completed which is updated annually and posted to the health plan website. Contracted providers agree to be familiar with services that require prior authorization. Services that require prior authorization may include, but are not

Acronym	Meaning
	limited to, surgical services, diagnostic testing, items of DME, etc. Prior authorization is not required for urgent care or emergency services as defined herein.
Urgent Care Services	Health services that are clinically appropriate and immediately required to prevent serious deterioration of a member's health that are a result of unforeseen illness or injury.
Valid New Request:	An authorization request where all the required data elements are present.
Invalid Request:	An authorization request that is missing required data elements
Received Date	The date the request is received by the health plan. This date is counted as Day 0.

Policy

If a precertification (prior authorization) is required for a service, the request is completed and sent to the Utilization Management Department for entry and review. The request should also contain supporting documentation to support medical necessity for the requested service. The Utilization Management Department will review the request based on the information submitted by the requesting provider.

Expedited Requests

If the provider indicates on the request submission that the request is "urgent" or "expedited," the Utilization Management Department will do the following:

1. Review the request to determine if any of the following conditions are met:
   a. Failure to treat the request as expedited could seriously jeopardize the life, health, or safety of the member or the member's ability to regain maximum function, based on a layperson's judgment, or
   b. Failure to treat the request as expedited could seriously jeopardize the life, health, or safety of others based on a prudent layperson's judgment.
   c. In the case of a pregnant woman, could seriously jeopardize the life, health, or safety of the fetus, or
   d. In the opinion of a practitioner with knowledge of a member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Note: If it is unclear if any of the above conditions have been met within the request, the Utilization Management Department will contact the requesting provider verbally to request the additional information needed in order to make a determination to maintain the request as expedited or downgrade the request to standard with 24 calendar hours of receipt of the request.

2. Once reviewed based on the above conditions, the Utilization Management Department will do one of the following:

a. Maintain the authorization as expedited and enter the request with that authorization type following all state and federal regulations, CMS timelines, and NCQA standards, or
b. Downgrade the authorization type to standard due to conditions not being met and notify the provider and member within 72 calendar hours of the request verbally and in writing within 3 calendar days of the verbal notification.

Note: If submitted as expedited but determined to not be expedited, then standard precertification (prior authorization) timelines apply.

Change Log

Document Version	Major or Minor Revision?	Date	Name	Comments
NEW		7/29/2022	Courtney Gonzales	NEW

Appendices

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