Subject: Referrals & Pre-Authorizations

Objective:

I. To ensure appropriate utilization of Tuality Health Alliance (THA) resources.

II. To simplify the referral and pre-authorization process while providing appropriate service utilization.

III. To create a mechanism by which pertinent member information and recommendations are communicated between THA, primary care providers (PCP), and specialists.

Definitions:

Referral – an administrative document submitted by the healthcare provider as a formal request for a member's particular medical procedure(s), or as a request that a member visit a specialist who is not part of the THA network as a Full/Associate or Preferred THA Specialist. Referrals help ensure THA members' safety and quality of care.

Prior or Pre-Authorization – an administrative document submitted by the healthcare provider as a formal request for a member's specialty or non-formulary prescription medications or durable medical equipment. Prior authorizations help ensure THA members' safety and quality of care.

Formulary – a list of medications that are covered or not covered, as well as those that require prior authorization for determination of medical necessity.

Policy:

I. For a member's referral or pre-authorization to be valid, he/she needs to have been evaluated by his/her THA-network PCP within the previous 12 months.

II. Referral or pre-authorization is not required for visits to a Full/Associate or Preferred THA Specialist, for office or outpatient procedures that are above-the-line with matched ICD and CPT codes, or for covered formulary medications.

III. Referral or prior authorization is required for the following services:

- Blepharoplasty;
- Diagnostic imaging – CTs, MRIs, and Pet Scans;
- Durable Medical Equipment (DME);
- Genetic testing;
- Hemophilia factor services;
- Inpatient procedures, hospital stays, and skilled nursing facility stays;
- Medications that are non-covered, non-formulary, and/or require step therapy;
- Neuropsychology services for any diagnosis other than dementia;

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- Neurosurgery procedures;
- Outpatient procedures for below-the-line and unmatched code diagnoses;
- Outpatient therapies for chronic conditions;
- Pain management visits;
- Tubal ligations and vasectomies (Consent to Sterilization Form [DMAP 742] must be properly completed); and
- Visits to an out-of-plan (non-THA-network) provider;**

***When THA does not have the necessary in-network THA specialist, referral to an out-of-plan specialist is considered*.

IV. The *THA PCP/Specialist Referral Form* must be used for all THA member referrals and procedure pre-authorizations. The form must be filled out completely and accurately to ensure timely processing. The form should include at a minimum:

- The member's name, THA ID number, and birth date;
- The name and contact information for all involved healthcare providers;
- A current ICD-10 code diagnosis that accurately reflects the condition for which the member is being referred;
- The CPT or HCPCS code(s) (if a procedure is requested); and
- Attached copies of legible and relevant chart notes, lab or radiology reports, etc.

V. The *THA Drug Prior Authorization Form* must be used for all THA member medication pre-authorizations. The form must be filled out completely and accurately to ensure timely processing. The form should include at a minimum:

- The member's name, THA ID number, and birth date;
- The name and contact information for all involved healthcare providers;
- A current ICD-10 code diagnosis that accurately reflects the condition for which the member is seeking medication;
- The name, dose, and directions for use of the medication being requested;
- Notification of the member's current medication use and related or step-therapy medications; and
- Attached copies of legible and relevant chart notes, lab or radiology reports, etc.

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VI. The *THA Durable Medical Equipment Prior Authorization Form* must be used for all THA member medical equipment pre-authorizations. The form must be filled out completely and accurately to ensure timely processing. The form should include at a minimum:

- The member's name, THA ID number, and birth date;
- The name and contact information for all involved healthcare providers;
- A current ICD-10 code diagnosis that accurately reflects the condition for which the member is seeking medical equipment;
- The name, units, and directions for use of the medical equipment being requested; and
- Attached copies of legible and relevant chart notes, lab or radiology reports, etc.

VII. THA Medical Management staff uses established referral guidelines, the *THA Formulary*, and the *THA Pre-Authorization List* when making coverage determinations on referral and pre-authorizations for members.

- National Guidelines are utilized for establishing medical appropriateness.
- OHP guidelines are used to confirm that provided diagnoses are funded and that requested procedures pair with the diagnoses.
- Specific health plan criteria may also be used as a reference.

VIII. Upon approval of a referral or pre-authorization, the following steps are followed:

1. The provider who requested the referral or pre-authorization, as well as the provider to whom the referral or pre-authorization was made, are notified via fax of the approval.**

   ***Initial referrals are approved for an evaluation and one follow-up unless specified otherwise. Continuation of the referral depends on prior authorization requirements, medical appropriateness, and benefit restrictions; exceptions may be made with Case Management review.*

IX. Upon denial of a referral or pre-authorization, the following steps are followed:

1. A *Notice of Action* denial letter, with instructions for requesting an appeal and/or administrative hearing, is mailed to the THA member.
2. The *Notice of Action* with appeal instructions, and THA contact information, is faxed to all involved providers.

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X. **Routine Referrals and Prior Authorizations**

THA is allowed 14 calendar days to make a pre-determination regarding referral and pre-authorization requests. Refer to *THA Policy V-7: Timeliness of Referrals* for detailed guidelines.

XI. **Urgent/Expedited Referrals and Prior Authorizations**

Providers may submit requests for "urgent" or "expedited" referrals or pre-authorizations by checking the "Expedite" box on any THA referral or prior authorization form and submitting the form to THA via fax or phone. THA Medical Management staff will make an expedited referral determination within 72 hours of receipt. Refer to *THA Policy V-7: Timeliness of Referrals* for detailed guidelines.

XII. **Referrals and Pre-Authorizations for After-Hours and Weekend Services**

a. If a provider renders relevant services to a member without pre-authorization in the event of an emergency, that provider may request a retroactive pre-authorization review, notifying THA on the next business day.
b. In the event of an emergency, THA will authorize one follow-up visit to the provider who cared for the member in the Emergency Department, or to the provider to whom the member was directed.
c. THA reserves the right to deny coverage of any after-hours service that was done out-of-plan and was not emergent.

XIV. **Second Opinion**

a. The purpose of a second opinion is to obtain more information when referral or pre-authorization indications are not clearly established, or when the indications given for a procedure or treatment do not clearly meet approved criteria.
b. When the THA Medical Director requests a second opinion, the member's PCP will be consulted and the member will be contacted with instructions regarding the process.
c. Additional member history and laboratory and diagnostic imaging information may be needed. Participating providers must give such information at no cost to second opinion reviewers.
d. If the member's PCP refuses to allow a second opinion, THA Medical Management may advocate to the PCP on the member's behalf to facilitate the second opinion, as it is the member's right.
e. A THA member has the right to a second opinion at no cost. A THA Case Manager will assist in coordinating that referral as needed; it is the expectation, however, that the PCP works with the member to initiate the

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second opinion referral. The referral should be clearly marked as a "second opinion".

XIII. **Providence Health Plan Members**

Any Providence Health Plan (PHP) member, qualified member representative, and/or provider acting on the PHP member's behalf, has the right to request a referral or prior authorization. The request must include all necessary referral information; it may be submitted verbally or in writing, using the *THA PCP/Specialist Referral Form* or another similar form.

References: 42 CFR 422.568
42 CFR 438.206 (b3)
42 CFR 438.210(d)
OAR 410-141-0420
Oregon Health Authority Health Plan Services Contract 2016
RAE Participation Agreement
THA Policy VI-10: Timeliness of Referrals
THA Policy VI-7: Denials

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