12.4 Authorization of Services

General Requirements

Other than for emergency care, providers must obtain prior authorization from Medical Management for all Healthfirst plans for acute inpatient admissions; selected outpatient procedures and services, including certain ancillary services; and all out-of-network care. Prior authorization may be requested by the member's PCP or by the specialist who has received a referral from the PCP who is caring for this member.

The following information must be supplied when requesting prior authorization of services:

- Member's name and Healthfirst ID number
- Attending/requesting provider's name and telephone number
- PCP's name (if not the attending/requesting provider)
- Diagnosis and ICD9 Code. ICD10 Codes will be needed after October 1, 2015.
- Procedure(s) and CPT-4 Code(s) and procedure date(s)
- Services requested and proposed treatment plan
- Medical documentation to demonstrate medical necessity
- For inpatient admissions: hospital/facility name, expected date of service, and expected length of stay

Please be sure that ALL of the above information is included when you fax a prior authorization request. If you are calling in the request, please have the information available when you call Medical Management.

Healthfirst Level III PCPs who do not have admitting privileges at a Healthfirst hospital must contact Healthfirst's Medical Management department to arrange for elective admissions. In these situations, the PCP, not the admitting liaison, is responsible for obtaining prior authorization.

Standard Time Frames for Prior Authorization Determinations

Medical Management will make a preauthorization determination within three (3) business days of receipt of all necessary information to make the determination. Providers may take up to fourteen (14) calendar days to provide this necessary information for Medicare and Medicaid member request for prior authorization. For Healthfirst Leaf Plan members, providers have forty-five(45) calendar days from the request for information to provide the necessary information. If, after review of the requested information, the request does not meet medical necessity criteria or meet benefit coverage limits, the request is forwarded to the Clinical Peer Reviewer for an adverse determination. If the requested information needed to make a determination has not been received by the plan, the request will be forwarded to the Clinical Peer Reviewer for an adverse determination. The provider will have the opportunity to request an informal reconsideration of the adverse determination for Medicaid and Leaf and formal appeal of the adverse determination for Medicare.

Determination decisions are issued to the requesting provider, the member, or the member's representative and the PCP as appropriate. Authorization for services is valid for ninety (90) days from the date of issue for most medical/surgical services.

After requesting an authorization, providers are given a notification number that can be used to obtain authorization status. Authorization status may be checked at www.healthfirst.org/providerservices. Please allow one (1) business day after the authorization is issued for it to be posted on the website.

For Medicaid and Leaf plans, in the event that Healthfirst has determined that the services in question are not medically necessary and has not attempted to discuss the matter with the provider who requested the services, that provider may request that Healthfirst reconsider its determination. Except for retrospective reviews discussed below, such reconsideration shall occur within one (1) business day of receipt of the

request and shall take place between that provider and Healthfirst's Clinical Peer Reviewer.

Expedited Determinations

A Healthfirst member or provider may request an expedited determination regarding service authorization under the following circumstances:

The request is for healthcare services or additional services for a member undergoing a continued course of treatment.

The standard process would cause a delay that poses a serious or imminent threat to the member's health.

The provider believes an immediate determination is warranted.

All requests for expedited determinations must be made by contacting Medical Management at **1-888-394-4327** and faxing documentation containing support for the expedited determination to **1-646-313-4603**.

If Healthfirst determines that a member's request does not meet the criteria for an expedited determination, the request will be processed automatically under the standard time frames indicated above, and the member will be notified verbally and in writing of this decision. If a provider requests or supports the member's request for an expedited determination, Healthfirst must expedite the process. The provider/member requesting the expedited organization determination request will be notified as to Healthfirst's decision orally within seventy-two (72) hours of receipt of the request for Healthfirst Leaf and Medicare plan members and within three (3) business days for all other Healthfirst plans. A written notice will follow within one (1) calendar day of the decision.

Authorization of Inpatient Admissions: Elective Admissions

All elective inpatient admissions require prior authorization. This applies to hospital admissions for medical/surgical services, as well as to facility admissions for inpatient behavioral healthcare and substance abuse services, as well as to Skilled Nursing Facility and Acute Rehab admissions. The prior authorization process allows for pre-admission review of the proposed hospitalization.

Elective admissions must be scheduled in advance of the hospitalization. The admitting provider must contact Medical Management at **1-888-394-4327** for prior authorization no later than seven (7) days prior to admission. The admitting provider must obtain an authorization number from Medical Management for an approved admission. This number must be included on all claims submitted in relation to the admission. If questions arise during the prior authorization review as to the appropriateness of the admission, the case will be referred to the Healthfirst Clinical Peer Reviewer for determination. If the requested admission is not approved, the provider may work with Medical Management to initiate an appeal. The appeal process is discussed in Section 15 of the Healthfirst Provider Manual.

Emergency Admissions

All emergency admissions, including admissions in which the member proceeds directly from the provider's office to the hospital for immediate admission, require notification to Healthfirst. Emergency services never require authorization. Hospital staff must contact Medical Management within 48 hours of the admission or on the next business day following a weekend admission. **However, prior authorization from Healthfirst is never required for emergency admissions**. The staff must provide Medical Management with details regarding the admission, including the same data elements required for prior authorization of inpatient care as listed in this section. Notification from the member's PCP or admitting provider is also acceptable. Providers may call Medical Management at **1-888-394-4327** or fax information to **1-646-313-4603.**