12. Medical Management

12.1 Program Overview

The Healthfirst Medical Management Program has been designed to maximize the quality care delivered to Healthfirst members. The program focuses on assisting providers in collaboration with members/caregivers in planning for, organizing, and managing the healthcare services provided to Healthfirst members to promote member health and well-being. Information and data collected through medical management procedures are used by the Medical Management department to properly allocate resources and to foster efficient and effective care delivery. The Medical Management program emphasizes collaboration with network providers, contracted vendor organizations, and other Healthfirst staff to ensure that high-quality healthcare is provided at the most appropriate level by the most qualified panel of providers.

The Medical Management department is responsible for the following areas:

- Authorization and Notification Processes
- Continuity of Care
- Concurrent and Retrospective Review
- Care/Disease Management

Each of these program components, with the exception of Care/Disease Management, is discussed in detail in the following subsections of Section 12. The Healthfirst Care/Disease Management Program is described in Section 13 of the Healthfirst Provider Manual.

12.2 PCP-Directed Care

For Medicaid, Medicare, and CHP members, providers do not need to submit referrals to Healthfirst for approval when referring to participating providers in the Healthfirst network.

For members enrolled under the Healthfirst Leaf Plans, the PCP or OB/GYN provider must submit electronic referrals for all specialist visits. There are some exceptions to the referral requirements for Leaf Plan members. See subsection 12.3 for a list of referral requirements and exceptions.

However, there are no non-emergent, out-of-network benefits for any plan, and the provider must obtain approval from Healthfirst's Medical Management department if the provider wishes to refer a member to a nonparticipating provider. See subsection 12.5 on how to refer members out of network.

General Guidelines

The following guidelines may assist in ensuring referrals are appropriately managed:

Members should be referred to specialists who can best communicate with the member in accordance with the principles of cultural competence. This is to ensure optimal communication between providers and members of various racial, ethnic, and religious backgrounds, as well as disabled individuals. For example, members should be referred to specialists who speak the member’s language when the member does not speak or understand English. The Provider Directories provide data on languages spoken by the provider, as well as other relevant information. Or you may contact Medical Management for assistance.

Specialists may assume primary care responsibility for members with life-threatening, degenerative, or disabling conditions requiring prolonged specialty care services. In certain cases, it is more effective for a specialist or specialty care center to manage the full spectrum of care for a particular member. Under these circumstances, the member’s PCP should contact Medical Management to arrange for the member’s primary and specialty care services to be coordinated and managed by a designated specialty care provider with expertise in the member’s condition.

If possible, the PCP, OB/GYN, or the office staff should assist the member in making appointments with specialists and should provide directions to the specialist's office. This is important for ensuring member compliance with specialty referrals and for obtaining prompt access to specialty services for members requiring urgent care. Medicaid members and certain Medicare members are entitled to transportation assistance. Please see Section 10 for additional details.

Ancillary Services

The PCP or specialty care provider may refer a member for ancillary services, such as laboratory or routine x-ray services, by filling out a prescription to order these services.

Prior authorization from Healthfirst-delegated entities including, but not limited to, radiology, dental, vision care is required. Refer to Section 10 and Appendix XI for additional information on this process. Please refer to Appendix XI-B for Leaf Plan provider authorization requirements.

Behavioral Health and Chemical Dependency Services

Members may self-refer to a participating Behavioral Health Specialist for assessment or treatment of a mental health or substance use disorder. Healthfirst members may obtain assistance regarding behavioral health services by contacting the Behavioral Health Unit at **1-888-394-4327.**

Authorization for routine in-network outpatient behavioral health services is not required. Please note that admissions and the following outpatient services: ECT, neuropsychological testing, partial hospital program, intensive outpatient treatment, and day treatment, are subject to utilization and medical-necessity review to ensure that the most appropriate treatment and level of care is being provided. Authorization from the Healthfirst Behavioral Health Unit or the delegated behavioral care management organization is required.

Obstetrical Services

Healthfirst does not require female members to obtain referrals before accessing routine gynecological care. In accordance with NYS prenatal care regulations (10 NYCRR Part 85.40), Healthfirst provides comprehensive prenatal care services to its members, including but not limited to prenatal risk assessment, health education, mental health and related social services, labor and delivery, and post-partum care.

During pregnancy, the obstetrician assumes the responsibility for coordinating and managing the member's care. The OB/GYN may treat and/or make specialty referrals for any medical conditions arising during pregnancy without referring the member back to her PCP; however, if illness or injury occurs that is unrelated to the pregnancy, the OB/GYN should refer the member to her PCP for further evaluation and treatment. In addition, when caring for a high-risk pregnant member, the provider should register the member in the Obstetric Care Management Program by calling the Obstetric Care Manager at **1-888-394-4327.**

12.3 Referrals for Leaf Plans

When a Healthfirst Leaf Plan Member needs elective care that a PCP or OB/GYN (women can choose either an OB/GYN or PCP) cannot generally provide within the scope of his/her practice, a referral is required for the member to be evaluated by a contracted specialist provider in our commercial network.

Referrals from the health plan are not required for the following services:

- Emergency services
- Contracted urgent care centers
- Obstetric and gynecologic services (OB/GYN) including preventive care, acute gynecologic care, and pregnancy care
- Mental health and substance abuse practitioners
- Delegated vendor authorization and referral rules apply for the following services:

- Chiropractic (ASHN)
- Dental (DentaQuest)
- Vision, including Optometrists and Opticians (Davis)

Please refer to Section 10 — Ancillary and Other Special Services for additional information on our ancillary service providers.

The member's assigned PCP is responsible for generating any referrals for the member. If the PCP is not available, the PCP's designated covering physician should generate a referral for the member.

If the member has a specialist provider acting as the member's PCP, then that specialist physician can generate a referral for the member. Please see the Healthfirst Provider Manual for how a specialist physician can request designation as a PCP.

All evaluation and management services by the specialist provider, except for those services rendered in an inpatient setting, require a referral. Other treatment and diagnostic procedures and services may require a prior authorization. The service will be reviewed for medical necessity. Once the review is completed, the provider and the member will be notified of a decision. Please refer to Appendix XI for the preauthorization guidelines for Leaf Plans.

Any eligible service under the Commercial benefits are subject to the member's eligibility on the date(s) of the service and any conditions, terms, and/or limitations under their Summary of Benefits. Any referrals will be subjected to copay, coinsurance, deductible, etc.

Before receiving a referral, it is recommended that the member see their PCP. We encourage our PCPs and other providers to make sure they have all the necessary information they need about the current clinical status of a member, as well as any needed past medical history, to make sure the referral is appropriate and medically necessary for the member. This may require examination of the member and other diagnostic procedures prior to making a referral. At the provider's discretion, they can generate a referral without seeing the member while using appropriate medical judgment on the situation.

Referrals should be generated prior to the service being rendered. In case of an urgent situation or business administrative emergency that does not allow for prior processing of a referral action, a referral can be generated for up to three (3) business days after the service was rendered. Healthfirst reserves the right to question the referring provider about the reason for any retroactive referrals. Referred providers are subject to their scope of reimbursement under their current contract with Healthfirst. Provider and member self-referrals are not allowed.

Referrals cannot be issued by the PCP or OBGYN for out-of-network or out-of-area providers. Requests for elective services from out-of-network/out-of-area providers will require review and authorization from Healthfirst Medical Management.

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.**

12.5 Out-of-Network Services

At times, a Healthfirst member may require healthcare services from a nonparticipating provider. These situations may arise for reasons of medical necessity or because a particular service or specialty is not available within the Healthfirst network. When this occurs, our Medical Management department should be contacted at 1-888-394-4327, Monday through Friday, between 8:00am and 5:30pm. Our staff will obtain the clinical information needed to address the member's specific health condition. A determination will be made regarding whether or not out-of-network care can be supplied by an in-network provider and whether the requested service(s) are medically necessary. Healthfirst will inform you of its decision within three (3) business days of receiving all the information needed to make a decision. Out-of-network care for all plans must be approved by Medical Management, which evaluates the case in conjunction with the attending practitioner and the member's PCP. When a Healthfirst member is referred for out-of-network inpatient hospitalization, the hospital must:

- Verify the member's eligibility at the time of admission;
- Contact Medical Management to verify that the member's scheduled admission has been preauthorized and to obtain the authorization number for submission with the claim.

Out-of-network coverage is not available in any Healthfirst plan except for emergency services or by referral by Healthfirst. Healthfirst members who opt to receive out-of-network services without authorization will be held liable for the cost of those services.

In the case of a Medicare member who was referred to an out-of-network provider by an in-network provider, this is considered plan-directed care, and the member will be held harmless except for any copayment responsibility.

Please refer to Appendix XI-A for a complete list of prior authorization guidelines for Healthfirst Medicaid, CHP, and Healthfirst Medicare Plans. Please refer to Appendix XI-B for a complete list of prior authorization guidelines for Healthfirst Leaf Plans.

12.6 Continuity of Care

Healthfirst has established mechanisms to ensure that continuity of care be maintained for members under a variety of circumstances. Each of these situations is discussed in detail below. All questions regarding continuity of care issues should be addressed to Medical Management at **1-888-394-4327**. For information on specialists as PCPs and on specialty care centers, please refer to Section 8.

Standing Referrals

Healthfirst allows standing referrals for specialty care in cases in which the member's diagnosis or condition requires ongoing care from a specialist, specialty center, or specialty institution. In these situations, the PCP or requesting provider must coordinate a standing referral with the member, the specialist, and Healthfirst. To arrange this referral, the requesting provider must call Medical Management to discuss the treatment plan and the need for the extended referral. When appropriate, Medical Management, in consultation with the requesting provider/PCP and the specialist, will issue an authorization designating the approved number of visits, the services to be rendered, and the time period covered by the standing referral.

For Healthfirst Leaf Plan members, the PCP must submit the referral request for specialist care to Emdeon via the Healthfirst Provider Portal.

Transition from Nonparticipating to Participating Providers

Healthfirst has policies to address transition periods when a new member is currently undergoing a course of treatment with a nonparticipating provider as well as when a member's provider leaves the Healthfirst network. These policies are required both in Healthfirst's provider agreements as well as in Section 4403 of the New York State Public Health Law.

These transition policies apply only in situations when the member is being seen regularly for management of a complex, life-threatening, or degenerative and disabling disease, or is in the second or third trimester of pregnancy and under the care of an OB/GYN.

In all cases, continuation of care with a nonparticipating provider depends upon the provider's acceptance of Healthfirst's reimbursement rates as payment in full. The provider must also agree to do the following:

- Adhere to Healthfirst's quality assurance requirements
- Abide by all Healthfirst policies and procedures
- Provide Healthfirst with medical information related to the member's care
- Obtain referrals from the PCP for Healthfirst Leaf Plan members
- Obtain prior authorization from Medical Management for applicable services
- Agree not to "balance-bill" the member for services provided (for Healthfirst Medicaid, CHP, FHP, Medicare (all plans) members only). Healthfirst Leaf Plan -members may be liable for the cost-sharing amounts and may be responsible for the cost of non-covered care).

Continuity of Care Guidelines

LOB	New Enrollee	Provider Leaves Network
Medicaid to	If a new Enrollee has an existing relationship with a	The transitional period shall continue up to

include HARP	health care provider who is not a member of the Contractor's provider network, the Contractor shall permit the Enrollee to continue an ongoing course of treatment by the Non-Participating Provider during a transitional period of up to sixty (60) days from the Effective Date of Enrollment if the Enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition. If the Enrollee has entered the second trimester of pregnancy at the Effective Date of Enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of post-partum care directly related to the delivery up to sixty (60) days after the delivery. Ninety (90) days or until the Patient Centered Service Plan (PCSP) is in place, whichever is later, for Long Term Social Services at the same level, scope, and amount as you were receiving Ninety (90) days for the current care plan or until an alternate care plan is authorized, whichever is later, for new enrollees receiving Adult Day Health Care (ADHC) or AIDS ADHC services . Can keep their service with existing provider for up to one year unless the enrollee elects to change.	ninety (90) days from the date the provider's contractual obligation to provide services to the Contractor's Enrollees terminates; or, if the Enrollee has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery through sixty (60) days post partum. Ninety (90) days or until the Patient Centered Service Plan (PCSP) is in place, whichever is later, for Long Term Social Services at the same level, scope, and amount as you were receiving Ninety (90) days for the current care plan or until an alternate care plan is authorized, whichever is later, for new enrollees receiving Adult Day Health Care (ADHC) or AIDS ADHC services . Can keep their service with existing provider for up to one year unless the enrollee elects to change.
Medicare	For medically necessary treatment associated with a chronic or serious condition, or other Medicare covered services, will provide a limited number of visits with enrollee's current provider or caregiver at the same level scope and amount that they were receiving. Will work with enrollee and their Primary Care Physician (PCP) to find a provider in network that can meet the enrollee's medical needs. For the rest of the pregnancy if the member has entered the second trimester on the date of enrollment becomes effective. This includes delivery and the provision of postpartum care directly related to the delivery for up to sixty (60) days after the delivery.	If you are undergoing a specified course of treatment with a provider who leaves our network, we will authorize a transitional period of up to 90 days from the date the provider leaves Healthfirst to ensure continuity of your care and prevent any disruptions in your treatment plan. In addition, if you are in your second trimester of pregnancy (more than three (3) months pregnant) when your provider leaves our network, we will authorize a transitional period of up to 60-days postpartum (after the baby is born) to ensure continuity of care.
Complete Care	If the service is regarding a Medicaid only benefit the Medicaid rules apply otherwise Medicare rules apply	If the service is regarding a Medicaid only benefit the Medicaid rules apply otherwise Medicare rules apply
EP	If the enrollee is in an ongoing course of treatment with a Non-Participating Provider when their coverage under this Certificate becomes effective, they may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of their coverage under this Certificate. This course of treatment must be for a life-threatening disease or	If the enrollee is in an ongoing course of treatment when their Provider leaves the network, then the enrollee may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date their Provider's contractual obligation to provide services to them terminates.

	condition or a degenerative and disabling condition or disease. If the Enrollee has entered the second trimester of pregnancy at the Effective Date of Enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of post-partum care directly related to the delivery up to sixty (60) days after the delivery.	
QHP/HNY	If the enrollee is in an ongoing course of treatment with a Non-Participating Provider when their coverage under this Certificate becomes effective, they may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of their coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. The enrollee may also continue care with a Non-Participating Provider if they are in the second or third trimester of a pregnancy when their coverage under this Certificate becomes effective. The enrollee may continue care through delivery and any post-partum services directly related to the delivery.	If the enrollee is in an ongoing course of treatment when their Provider leaves the network, they may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date the Provider's contractual obligation to provide services to the enrollee terminates. If the enrollee is pregnant and in their second or third trimester, they may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.
FIDA	The FIDA Plan allows Participants receiving any Covered Item or Service at the time of Effective Date of Enrollment other than Nursing Facility services or Behavioral Health Services to maintain current Providers, including with Providers who are currently out of the FIDA Plan's Provider Network (i.e., Non-Participating Providers), and service levels, including prescription drugs, until the later of: For at least ninety (90) calendar days after the Effective Date of Enrollment; or Until the PCSP is finalized and implemented. The FIDA Plan allows Participants who reside in a Nursing Facility to maintain current Nursing Facility Providers for the duration of the Demonstration. The FIDA Plan shall allow Participants who are receiving Behavioral Health Services to maintain current Behavioral Health Service Providers (i.e., Participating and Non-Participating) for the current Episode of Care. The IDT may review a current Episode of Care to determine whether it needs to be continued with the Behavioral Health Service Provider that was providing services before the Participant's Enrollment in the FIDA Plan. This requirement will be in place for not to exceed two (2) years from the date of a Participant's Effective Date of Enrollment and applies only to Episodes of Care that were ongoing during the transition period from Medicaid Fee-For-Service (FFS) to Enrollment in a FIDA Plan.	Providers are required to continue a course of treatment until arrangements are made to transition the member's care to another provider. Specifically, providers are required to continue providing services to Healthfirst members for a period of ninety (90) days from the date that they leave our plan. The FIDA Plan allows Participants who reside in a Nursing Facility to maintain current Nursing Facility Providers for the duration of the Demonstration.

Medical Records

When a member selects a new PCP, upon his/her request the former PCP should transfer the member's records to the new provider in a timely manner, thereby ensuring continuity of care.

12.7 Concurrent Review

Healthfirst has implemented a concurrent review program to monitor the allocation of resources during an episode of care. The program uses evaluation criteria from InterQual and Medicare guidelines to review services provided to members. These criteria are available to providers upon request.

Inpatient Concurrent Review

The inpatient concurrent review program comprises three (3) basic components. They are as follows:

Admission Review: Admission review is based on clinical information provided to verify the appropriateness and medical necessity of the hospitalization. Emergency admissions that occur during weekends or holidays, when Healthfirst is closed, will be reviewed when the office reopens, and a medical-necessity determination will be made, provided that the hospital has complied with the Healthfirst notification policy. Please refer to Section 12 for more information on this policy.

Continued Stay Review: Continued stay review is conducted to re-establish that inpatient hospitalization continues to be appropriate and medically necessary. Providers requesting continuation of service authorization will receive a verbal determination, followed by written confirmation, within one (1) day of Healthfirst receiving the necessary information. The notice will include the authorized service(s), the number of authorized visits or sessions, and the next expected review date.

Discharge Planning: Discharge planning begins prior to admission for elective admissions. For an emergency admission, the process begins with the first review of the case. The goal of discharge planning is to move members efficiently and effectively through the different levels of care required to manage and treat their medical condition.

Outpatient Concurrent Review

Medical/Surgical/Behavioral Health Services: Outpatient concurrent review focuses on the effective allocation of resources during an episode of care to ensure that care be provided at the most appropriate level, is coordinated among all disciplines, that continued benefits exist for the service, and that problematic cases and quality issues have been identified. Providers must furnish clinical information to Medical Management to support continued authorization of services before the expiration of the authorized treatment period. Providers requesting continuation of service authorization will receive a verbal determination, followed by written confirmation, within one (1) day of Healthfirst receiving the necessary information. The notice will include the authorized service(s), the number of authorized visits or sessions, and the next expected review date.

12.8 Retrospective Review

Retrospective reviews are performed after healthcare services have been provided. Healthfirst conducts retrospective reviews to evaluate the medical necessity for services that were not preauthorized or reviewed concurrently. Healthfirst will make retrospective determinations within thirty (30) days of Healthfirst receiving the necessary information.

We may only reverse a preauthorized treatment, service, or procedure on retrospective review when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review;
- the relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us;
- we were not aware of the existence of such information at the time of the preauthorization review; and
- had we been aware of such information, the treatment, service, or procedure being requested would not have been authorized;
- the determination is made using the same specific standards, criteria, or procedures as used during the preauthorization review.