SUD Treatment
Community of Practice

January 4, 2019

Prior Authorization Panel Discussion
Insurers: Optum, Cigna, Cenpatico Behavioral Health, Beacon Health Options

Questions and Answers

Q1. What are the themes among the prior authorizations that get denied?

A1. Prior authorizations are denied for multiple reasons to include::

- ***Timeliness*** *– Call in a timely manner, 24-48 hours after assessment*
- ***Staff*** *– Prior authorizations need to be completed by a licensed clinician and that person should be knowledgeable about the care determination and the clinical background in order to answer questions and provide clarity during a review.*
- ***Specificity*** *– Be prepared and provide all specific details when calling (start date/end date, level of care, number of units)*
- ***Completeness*** *– All parts of the form needs to be completed. DO NOT leave blanks.*
- ***Timeframe*** *– Know each insurer's period for callbacks, review, and be available to answer questions within those timeframes.*
- ***Authenticity*** *– Be able to properly authenticate the member and provider/facility and include proper authentication for HIPAA. *Please note, if member's insurance card is missing/lost, they can call Member Services line to get eligibility information.*
- ***Adherence to ASAM*** *– The requested level of care needs to match the needs of the member or fit the ASAM dimensions of the level of care they are requesting.*

*Note: For patients with **Beacon Health Options** – providers must call and request prior authorization on the day of the admission to the treatment program. Calling several days after a member starts a program could result in an administration denial for the initial days.*

*Note: For patients with **Cigna** – providers can submit authorization requests before or after the member has started treatment. If the request is being made before admission, be sure to have an assessment that was done in the past few days.*

Q2. What are the best practices for completing a successful prior authorization?

A2. A provider should utilize the following tips to complete a successful prior authorization:

- *Be sure you are calling the right number for prior authorizations. Do not use the direct line of an employee you have worked with in the past.*
- *Have the necessary basic information ready, this includes patient (patient full name, date of birth, ID number) and provider details (provider organization name and NPI).*
- *Be prepared with specific clinical information and ASAM backup for medical necessity.*
    - *Remember that the insurance company cannot confirm/deny or provide information on SUD history without prior approval from the member.*

- *Know the patient's historical information the best you can – what has and hasn't worked in the past?*
- *Have an established continuity of care plan, including the patient's aftercare plan.*
- *The provider must also be able to attest that the information provided is accurate and reflected in the member's medical record.*
- *Be sure to complete the correct and most current forms. Complete all parts of the form and do not leave any section/field blank. Check the provider websites for the most current forms:*
    - ***Harvard Pilgrim / Optum** offers two websites:*
        - *For providers: www.providerexpress.com*
        - *For members: www.liveandworkwell.com *For the HPHC account, you can click "I don't know my access code" then select Harvard Pilgrim Health Care from the drop down menu, hit Enter, and this will bring you into the website*
        - *Harvard Pilgrim/Optum also offers a 24/7 Substance Use Disorder Helpline 1-855-780-5955.*
        - *If the provider/facility is out of network, then the member must be aware of and agree to use their out of network benefits.*
    - ***Cigna:** www.cignaforhcp.com. The site has information about the pre-certification process, but providers will need to create a log in name and password if they have never accessed the site before. Providers do not have to be in the network to create a log in, and facilities or clinics can create a single log in for all of their clinicians to use. If the provider/facility is out-of-network, the member must be aware of and agree to use their out-of-network benefits.*
    - ***Centene:***
        - *May be reached via phone at 1-866-769-3085*
        - *https://www.nhhealthyfamilies.com/providers.html*
        - *https://www.nhhealthyfamilies.com/providers/resources/forms-resources.html*
        - *https://www.nhhealthyfamilies.com/providers/resources/eligibility-verification.html*
        - *https://www.nhhealthyfamilies.com/providers/resources/clinical-payment-policies.html*
    - ***Beacon:***
        - *Prior Authorization access line: 1-855-834-5655*
        - *Well Sense: www.wellsense.org - View medical benefits and also click on the BH benefits to get to the Beacon website*
        - *Beacon: www.beaconhealthoptions.com/providers/dashboard/ Providers Dashboard for Well Sense.*

Q3. What are strategies to negotiate discrepancies between treatment programs and the payor?

A3. Involve your clinical team when speaking with the reviewer. The reviewer will typically be an MD, as a utilization manager cannot deny requests on their own. It will vary by insurer – but some will negotiate. For example, if the provider does not want to elevate the claim to a clinical review, they could potentially offer to accept a lower level of care and resubmit later. Be sure to follow ASAM criteria, and have your clinical back up in order to clearly state why you are seeking the care requested. Encourage your medical director to handle a peer review or appeal situation when necessary.

*Note: **Centene** cannot negotiate care, or make recommendations on units of care.*

Q4. How is medical necessity determined? What criteria are used to make this determination?

A4. Most companies utilize ASAM criteria to determine medical necessity. In the case that a company does not utilize ASAM, their criteria can be found on their websites, and the criteria should still align with ASAM.

*Note: **Cigna** does not utilize ASAM criteria for medical necessity decisions. Refer to the Cigna Medical Necessity criteria:*
https://apps.cignabehavioral.com/cignabehavioral/media/consumer/educationAndResourceCenter/medicalNecessityCriteria.pdf

Q5. Why are repeated authorizations needed for intensive outpatient programs? What is the requirement?

A5. Routine outpatient does not require prior authorizations; however, intensive outpatient or a higher level of care does require authorization. These reviews are utilized to provide additional clinical detail and information about where a patient is in relation to the six ASAM dimensions. This includes that symptoms are still present that necessitate intensive outpatient care, that the treatment plan is being reviewed and modified to address the ongoing symptoms and barriers to recovery, and that the member is actively participating in, and benefiting from, the treatment being provided.

*Note: **Beacon Health Options** authorizes 16 sessions of IOP when prior authorization is requested and the member meets medical necessity criteria. Beacon requests that if a member uses all 16 sessions, that the provider calls to obtain an authorization for additional units.*

*Note: Currently, authorizations are not required for providers in-network for IOP services through **NH Healthy Families**. Providers are responsible for submitting a notice of admission to NH Healthy Families via fax. For non-participating providers, prior authorization is required.*

*Note: Some facilities are in Practice Management with **Harvard Pilgrim / Optum** based upon good outcomes. When an Intensive Outpatient Program is in Practice Management, they are not subject to clinical reviews and are only required to call at admission and discharge. Practice Management is only available to in-network facilities and programs.*

Q6. What would be the best ways to communicate with insurance companies in an effort to avoid hold times, missed calls, etc.?

A6. Ensure that you are calling the correct number and the right department. Call the Prior Authorization line, and not the personal phone of someone you may have worked with in the past. Be aware that you may be speaking to someone in a different time zone. In the event that you will be unavailable when the insurance company is looking to call back, designate another staff person to take that call who may be available. However, also indicate your availability to the insurance company and request a call back during the time most feasible for you to be able to pick up (be specific about time zone!). At times, it may be helpful to ask to speak directly with a behavioral health utilization manager.

*Note: **Cigna** is available for initial authorization requests 24/7 and on all holidays. The number should be called that appears on the back of the member's insurance card.*

*Note: If a provider is in-network with **Harvard Pilgrim / Optum** – they may use the provider express portal for electronic processing. www.providerexpress.com*

Q7. Why are on-going authorizations necessary after a pre-authorization?

A7. Concurrent reviews are necessary to ensure members are getting the right care at the right time. They are utilized to identify if a higher or lower level of care may be needed, or if other services and supports may be needed (e.g., care management).

Q8. What services require pre-authorization?

A8. Typically, intensive outpatient services or a higher level of care requires pre-authorization. Routine outpatient does not.

*Note: **NH Healthy Families** (not including Ambetter) does not require prior authorization for any level of care.*

Q9. Can a prior authorization be requested for residential services before a patient is admitted?

A9. A clinical assessment is needed and it needs to be completed within 72 hours of admission.

Q10. What happens if the recommendation is a level of care the patient does not want?

A10. A provider should communicate the recommendation with the insurer and the reasons why the patient does not want that level of care.