Chapter 6

Service Authorizations & Notification Standards

NOTE: *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

Billing Information – Please review the South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

Overview

This chapter provides information on South Country Health Alliance requirements for prior authorization, notification and medical necessity criteria for services. All services must be medically necessary, and coverage criteria may differ between South Country plans. Providers are expected to check member eligibility and enrollment prior to submitting an authorization request.

This Chapter Includes:

- Services requiring prior authorization or notification;
- Authorization requests and decision making;
- Inpatient hospital notification requirements;
- Skilled nursing facility admission and notification requirements;
- Concurrent and retrospective reviews;
- Prior authorization, notification and authorization documentation submission;
- Medical necessity criteria;
- Continuity of care; and
- Access to specialty care.

Definition of Terms

Notification is a process of provider notifying South Country about a service or treatment being provided within a specific period.

Prior authorization is a process of review for the medical necessity of a service or treatment prior to the service and/or treatment being rendered. The prior authorization request is reviewed by medical professionals to determine if the service or treatment requested is medically necessary and appropriate, and that less expensive alternatives have been considered. Emergency services do not require prior authorization.

Standard review timeframe for an authorization decision is within 5 business days from the date the request was received. For Medicare Part B Drugs, the standard timeframe for decision is 72 hours from the date/time the request was received.

Expedited review timeframe for urgent/emergent Medicaid requests is 48 hours including a business day. Expedited timeframe for Medicare requests is 72 hours. Only request an expedited review if waiting for the standard review timeframe would potentially jeopardize the

members health, life or ability to regain function. For urgent Medicare Part B Drug requests, the expedited review timeframe is 24 hours from the date/time of request was received.

Services Requiring Prior Authorization or Notification

South Country focuses on removing barriers for members to see contracted providers for obtaining necessary care. South Country's model is that every member is assigned to a primary care clinic. Members can access other contracted providers without an authorization from their primary care clinic. Some services and treatments do require prior authorization or notification. These services include, but are not limited to:

- Services or treatments that have benefit limit requirements;
- Services or treatments that are listed as non-covered services, but the provider considers the service medically necessary;
- The health service is of questionable medical necessity;
- The health service requires monitoring to control the expenditure of health plan funds;
- A less costly, appropriate alternative health service is available;
- The health service is investigative or experimental;
- The health service is newly developed or modified;
- The health service is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial;
- The health service is comparable to a service provided in a skilled nursing facility (SNF) or hospital but is provided in a member's home;
- The health service may be considered cosmetic; and
- Authorization is mandated by the state of Minnesota.

Refer to the prior authorization or notification grid or the South Country PA look up tool for detailed requirements. If the service or treatment is not listed, call South Country Provider Contact Center at 1-888-633-4055 to determine if an authorization is needed.

South Country uses CMS or DHS coverage criteria, evidence-based standards of care (i.e. InterQual Solution), and South Country's internal medical policies as medical necessity criteria when reviewing medical necessity for benefit coverage for authorization decisions. South Country does not reward providers or other individuals for denying services to members, nor does South Country reward decisions that result in under-utilization of services. Decisions made by South Country do not constitute the practice of medicine. South Country encourages open access to covered services at appropriate levels of care. Service authorization or pre-determination determines medical necessity only and does not guarantee payment. Providers must follow South Country Health Alliance billing policy guidelines. This includes billing and receiving payment from any primary coverage to the fullest extent possible before they bill South Country. Payment is also subject to approved coding and billing standards. The South Country member must be enrolled in the health plan at the time the service is rendered.

Emergency Medical Services and Post-Stabilization Care: No Authorization Required

Covered Services:

Emergency room services

Post stabilization care

Not Covered Services:

Out of country care

Emergency, urgent, or other health care services or items supplied from providers located outside of the United States (U.S.) are not covered. We will not make payment for health care to a provider or any entity outside of the U.S.

Medical Services and Medicare Medical Pharmacy (Part B Drugs) – Prior Authorization and Questions

Providers will submit a prior authorization request and/or notification via the provider portal https://provider.mnscha.org/scha.provider.aspx located on South Country website: https://www.mnscha.org/.

To fax authorizations, the Service Authorization form is located on the South Country website: https://www.mnscha.org/providers/authorizations/. Fax directly to South Country Utilization Management at 1-888-633-4052.

For questions contact: South Country Provider Contact Center at 1-888-633-4055

Providers are encouraged to create a provider account on the South Country provider portal at https://www.mnscha.org/providers/provider-portal/ for ease in submission and status of prior authorizations for medical services.

Prior authorization confirms medical necessity only and does not guarantee payment. Payment is determined at the time the claim is received and is subject to health plan exclusions, benefit limitations and billing and coding guidelines. Providers must follow South Country Health Alliance billing policy guidelines, including billing and receiving payment from any primary coverage to the fullest extent before billing South Country. Members must be enrolled in South Country when the service is rendered. Providers must not request payment for covered services from members beyond cost sharing authorized by Minnesota Statute.

Requests that require prior authorization for non-urgent conditions must be received at South Country at least 14 calendar days prior to the first date of service. South Country will respond to your request in writing within 5 business days (72 hours for Medicare Part B Drugs). If a request is marked urgent/expedited, the reason for the urgency must be included. Urgent requests will be processed within 72 hours for Medicare requests and 48 hours including a business day for Medicaid requests (24 hours for Medicare Part B Drugs) of South Country receiving the request.

Providers should obtain service authorization (Medical Service Authorization Request Form) prior to providing a service. The service authorization requirements apply when South Country Health Alliance is primary, secondary, or tertiary payer for the member. There is an exception when Medicare fee-for-service (FFS) is primary: if Medicare pays for any service, South Country Health Alliance does not require authorization. If Medicare denies or does not cover any service, all South Country Health Alliance authorization rules apply.

Dental Services - Prior Authorization and Questions (see chapter 20):

Delta Dental of Minnesota:

- Phone 1-866-398-9419 or 1-651-348-3222
    - Dental related questions.
    - Authorization requests and reviews.
    - Claim questions for dental services.

Pharmacy Services - Prior Authorization and Questions (see chapter 21):

PerformRx, LLC

Customer Care Center

Medicaid Retail Pharmacy

- Authorization fax 1-855-446-7894
- Provider Help Desk 1-866-935-8874

Medicaid Medical Pharmacy:

  - Provider Help Desk: 1-866-935-8874
  - Authorization fax 1-866-533-5496

Medicare Part B Drugs:

  - Authorizatio*n fax:* 1-888-633-4052
  - Provider Contact Center: 1-888-633-4055

Medicare Part D Retail Pharmacy (for Medicare Part B Drugs, see above)

- Authorization fax 1-855-446-7895 for standard requests.
- Authorization fax 1-855-446-7896 for urgent requests.
- Provider Help Desk 1-866-935-6681
  - Authorization requests and reviews.
  - Coverage determinations and redeterminations.
  - Formulary exceptions, prior authorizations, step therapy and quantity limits.

Contracted Inpatient Hospital Providers

- For hospitals within Minnesota, South Dakota, North Dakota, Wisconsin, and Iowa, you must send NOTIFICATION FORM #4492 to notify of admission and discharge.
- Hospital admissions and discharges – notify health plan within 24 hours via fax 1-888-633-4052.
- Provider can access notification and authorization information via South Country provider portal or website.

Mental Health and SUD Admissions – See Chapter 22

- Notification of hospital admission is required within 24 hours of admission. Provider can access notification and authorization information via South Country provider portal or website.

Nursing Facility Admission and Notification Requirements (See chapter 30 of Provider Manual)

Notification of admission is requested within 24 hours of admission.

Please fax the Nursing Facility (NF) Communication Form to South Country at 1-888-633-4052.The form can be found on the South Country web site www.mnscha.org.

Non-Contracted Providers

- For hospital admission outside of Minnesota, South Dakota, North Dakota, Wisconsin, and Iowa, except for emergency services, non-contracted providers must obtain prior authorization before admission. (Use Form #4494 found on the South Country website www.mnscha.org)
- Concurrent review may be requested.
- For service procedures outside the state of Minnesota, non-contracted providers must obtain prior authorization. Documentation must include information establishing medical necessity and the unavailability of that service in Minnesota.

Concurrent and Retrospective Reviews

South Country may perform concurrent or retrospective reviews dependent on utilization triggers. A medical director is consulted if review of clinical documentation does not clearly demonstrate medical necessity of the admission or services provided. South Country's intent is to be actively involved in hospital discharge planning and member's case management needs. Review information may include:

- Clinical information upon request for any inpatient stays;
- Clinical information for all medical and surgical inpatient stays greater than 2 days faxed to 1-888-633-4052; and
- Access to hospital utilization review staff and additional information and clarification of information as requested.

Medical Necessity Criteria

Medical necessity criteria are based on Minnesota Department of Human Services (DHS) and Centers for Medicare & Medicaid Services (CMS) criteria; in the absence of CMS or DHS criteria, South Country utilizes InterQual criteria or internal medical coverage policies for review of medical necessity. Please refer to the DHS Provider Manual or CMS Benefit Manual. You may also call South Country Provider Contact Center at 1-888-633-4055 to verify criteria for a procedure. Refer to the prior authorization information on the Provider Portal for detail of procedures that require prior authorization.

Medical Necessity is a health service that is consistent with the member's diagnosis or condition and is:

- Recognized as the prevailing medical community standard or current practice by the provider's peer group; and
- Rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or
- Is a preventive health service as defined in Minnesota Rules part 9505.0355

Access to Specialty Care

In accordance with Minnesota Statutes 62Q.58, South Country will approve standing authorizations for a health care provider who is a specialist and South Country does not have an appropriate participating specialist who is reasonably available and accessible to treat the member's condition or disease.

The member must meet one of the following conditions:

- a chronic health condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a degenerative disease or disability; or
- any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

Authorization Requests and Medicare or Third-Party Liability (TPL) Coverage

Except for home care and EIDBI authorization requests, South Country will not consider a request for authorization of a service or item for a member with Medicare or TPL unless the provider has made a good faith effort to receive authorization or payment from the primary payer(s).

For services or items, document and submit to the review agent the good faith effort with any of the following:

- An explanation of benefits (EOB) showing determination of payment by the primary payer(s)
- A determination of authorization or denial of authorization by the primary payer(s)
- Written communication from the primary payer(s) showing that the service is not covered for the member
- Documentation by the provider of a phone call to the primary payer(s) and the statements made by the primary payer about coverage of the service or item for the member.
- Documentation by the provider that, because of recent claim experiences with Medicare, coverage is not available for the service or item