SMSO Policy Manual

AUTHORIZATION APPROVALS AND DENIALS

Executive Sponsor: Chief Medical Officer

Issuing Department: Clinical Management

Gate Keeper: Director, HSM Clinical Management

COMPLIANCE STATEMENT:

Enforcement: All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule: This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing: The Issuing/Collaborating Department (s) is responsible for monitoring and compliance with this policy.
Documentation: Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare Apex
- ☐ Summa Management Service Organization (SMSO)
- ☒
- ☒ Summa Insurance Company

Line of Business:

3.2.1.1 For Medicare Advantage Members will follow the CMS Inpatient Only List

- ☒ Commercial Groups Medicare
- ☐ Supplemental On-Exchange
- ☒ Off-Exchange Self-Funded (IPO)
- ☒ Medicare
- ☒
- ☒

1.0 Purpose:

1.1 To ensure members and providers that the Plan follows and adheres to all federal and state guidelines pertaining utilization and prior authorizations.

2.0 Policy:

2.1 To ensure the plan follows standard approval and denial time frames based off the specific request on the prior authorization submitted.

2.2 A Medical Necessity review will be completed on prior authorization requests. Benefit Determinations are excluded from a medical necessity review

2.3 For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance.

2.4 For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate.

An Authorization is not a guarantee of payment

3.0 Procedure:

3.1 Prior Authorization requests with No scheduled date.

3.1.1 Approval date span will be put in for 90 days starting with the day the health plan receives the request.

3.1.1.1 For Medicare Advantage Members, will follow the CMS Inpatient Only List (IPO)

3.1.2 Denial date span will be based on the health plan received date and end after the allotted appeal timeframe for each line of business. After the denial date span has ended any request for the same service will be treated as a new request

3.1.3.1 Marketplace/Commercial lines of business is 180 days

3.1.3.2 Medicare lines of business are 65 day in compliance with CMS Standard: Medicare Managed Care Manual, Chapter 13 Organization Determinations; Chapter 13 50.2.1 Guidelines for Accepting level 1 Appeal Requests (IPO)

3.2 Prior authorization requests with a specific scheduled date

3.2.1 Approval date will be the specific date of the service listed on the prior authorization

3.2.2 Approval date will span a total of 90 days starting with the specific scheduled date

3.2.3 Denial date will be the specific date of the service listed on the prior authorization.

3.2.4 After the appeal timeframe, any request for the same service will be treated as a new request.

3.2.4.1 Marketplace/Commercial lines of business is 180 days

3.2.5 3.2.3.2 Medicare lines of business are 65 day in compliance with CMS Standard: Medicare Managed Care Manual, Chapter 13 Organization Determinations; Chapter 13 50.2.1 Guidelines for Accepting level 1 Appeal Requests

3.3 Pharmacy

3.3.1 Approval date spans will follow National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and Pharmacy and Therapeutics (P & T) criteria

3.3.2 Denial date span will be based on the health plan received date and end after the allotted appeal timeframe for each line of business. After the denial date span has ended any request for the same service will be treated as a new request.

1.1.1.1 Marketplace/Commercial lines of business are 180 days

1.1.1.2 Medicare lines of business are 65 days in compliance with CMS Standard: Medicare Managed Care Manual, Chapter 13 Organization Determinations; Chapter 13 50.2.1 Guidelines for Accepting level 1 Appeal Requests

3.4 Inpatient Authorizations which include; Acute Care Hospital, Behavioral Health/Substance Abuse, Skilled Nursing, Rehabilitation, Long Term Acute Care, Residential Treatment Center, Newborn Notifications

3.4.1 Approval start date will be the initial date of treatment

3.4.1.1 Further approval of Inpatient days will be based on continued stay medical necessity reviews.

3.4.1.2 Authorizations for MA members will be compliant with CMS rules and regulations including Code of Federal Regulations (DFR) 422.101 and 422.138. (IPO)

3.4.1.3 Approved authorizations for pre-service requests for Skilled Nursing, Acute Rehabilitation, Long Term Acute Care and Residential treatment Center will be valid up to 48 hours. If member has not transitioned to the approved level of care, updated clinical will need to be provided to further determine if member continues to be appropriate for admission.

3.4.1.4 For Medicare Advantage Members will follow the CMS Inpatient Only List (IPO)

3.4.2 Denial date span will begin with the date the medical director issues through discharge

3.5 Durable Medical Equipment (DME)
- 3.5.1 Please refer to the Evidence of Coverage (EOC) for specific DME rental and purchase timeframes.
- 3.5.2 Appropriate NCD and LCDs are applicable for Medicare Advantage (MA) members

3.6 Director, HSM Clinical Management, has the authority and responsibility for the activities in this policy or procedure.

3.7 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, and internal standard)
- 4.1.1 CMS Standard: Medicare Managed Care Manual, Chapter 13 Organization Determinations; Chapter 13 50.2.1 Guidelines for Accepting level 1 Appeal Requests
- 4.1.2 NCQA UM 8: Policies for Appeals

4.2 Are there any references to other documents, regulations, or intranet locations?
- 4.2.1 Center for Medicare and Medicaid Inpatient Only List; Code of Federal Regulations (CFR) 422.138; 422.101; 422.112

4.3 Are there other policies that work in conjunction with this policy?
- 4.3.1 None

4.4 Replaces (if applicable):
- 4.4.1 None Applicable

5.0 Definitions:

5.1 A Benefit Determination: is an approval or denial of a requested service that is specifically excluded from a member's benefit plan, which the plan is not required to cover under any circumstances. Benefit determinations include decisions about services that are limited by number, duration or frequency in the member's benefit plan, denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan, and decisions about care that do not depend on any circumstances, such as the member's medical need or a practitioner's order

ORIGINAL EFFECTIVE DATE:
REVIEWED: 11/24/23, 12/14/2023
REVISED: 12/1/2023, 7/30/2024