SMSO Policy Manual
AUTHORIZATION EXCEPTION

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 compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

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

Line of Business:

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

1.0 Purpose:

1.1 To document the rare circumstances where flexibility in service delivery demonstrates cost savings by maintaining or promoting optimal health.

1.2 To ensure members and providers that SummaCare follows and adheres to all federal and state guidelines pertaining to utilization and prior authorizations.

2.0 Policy:

2.1 The Health Services Management (HSM) Department is responsible for evaluating requests for extra-contractual benefits or deviating from normal authorization procedures for patients receiving care management services. Authorization exceptions may be approved under limited circumstances.

2.2 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 guidanceFor 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.

2.3 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

3.0 Procedure:

3.1 Create authorization.

3.2 Complete medical necessity review. Note in comments that the request is either a network exception or a benefit exception, using the pertinent note type. Describe reason for the request.

3.3 If the care or treatment is determined by the Pharmacist or the Medical Director not to be medically necessary, issue a medical necessity denial. Considering these requests are reviewed for medical necessity by the HSM UM RN, pharmacist or the physician, cite plan language on denial as well. A utilization management nurse may issue a denial that is unrelated to medical necessity such as when benefits are exhausted, or the request is not a covered benefit.

3.4 If the care or treatment is determined by the HSM UM RN, pharmacist or the Medical Director to be medically necessary and appropriate for:

3.4.1 Network Exception Requests:

3.4.1.1 Inform requestor or member of the availability of in-network provider, if known. If not known, attempt to locate an in-network provider; then guide to

the in-network provider. If an in-network provider cannot be located, send request to the Medical Director for a decision on coverage level. Approval by employer groups that require input will be handled at this stage.

3.4.2 Benefit Exception Requests:

3.4.2.1 Review is processed by HSM UM RN, pharmacist or sent to the Medical Director for determination of the benefit exception. As such, all of the following must apply:

3.4.2.1.1 The care or treatment is deemed to be medically necessary;

3.4.2.1.2 There is no alternative option for the member and the care or treatment is provided in order to allow covered care to continue;

3.4.2.1.3 The employer group is agreeable to the network exception (where required by the group); and

3.4.2.1.4 The service requested is not specifically excluded in the Evidence of Coverage.

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

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

3.6.1 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

4.1.1 Medicare Managed Care Manual, Chapter 13 40.4; 40.5.

4.1.2 Code of Federal Regulations (CFR): 422.101; 422.101; 422.112; 422.137; 422.138; and 422.202

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 None

4.3 Are there other policies that work in conjunction with this policy?

4.3.1 Utilization Management Policy

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 **Authorization Procedures:** Authorization procedures are those policy and procedures that are in use for determining medical necessity for medical care or treatment and are found to be in compliance with state, federal and regulatory laws and standards.

5.2 **Network Exception Request:** Request for coverage of care or treatment at an in-network level when either:

5.2.1 There is no out-of-network benefit; or

5.2.2 The Provider is out-of-network.

5.3 **Extra-contractual Benefits:** Approval for coverage of item(s) specifically excluded in the member's plan Evidence of Coverage (EOC) or Certificate of Insurance (COI); or approval for coverage over the quantity limit as stated in the member's plan documents.

5.4 **Emergent Care:** An emergent request is defined as a situation that, in the absence of immediate medical attention, could result in placing the health of the individual in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

5.5 **Urgent Request:** Is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:

5.5.1 Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or

5.5.2 In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

5.6 **Non-Urgent Care:** A non-urgent request is defined as routine care that is not urgent or emergent (e.g., elective surgery, ambulatory care).

6.0 Key Words or Aliases (Optional):

6.1 Authorization exception

6.2 Network exception request

6.3 Benefit exception request

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