SMSO Policy Manual

EVALUATION OF THE PRIOR AUTHORIZATION PROCESS AND THE IMPLEMENTATION AND COMMUNICATION OF CHANGES

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

Line of Business:

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

1.0 Purpose:

1.1 To define the process by which changes to the prior authorization list are effected and communicated.

1.2 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 The Plan will evaluate the effectiveness of its prior authorization processes on an annual basis. Updates are reviewed quarterly. Any changes made to the Prior Authorization List as a result of the evaluation will be made available to the members, providers and staff, employers and brokers through the SummaCare Authorization Portal at www.summacare.com

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 guidance.

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 Evaluation of the Prior Authorization Process

3.1.1 The Clinical Business Informatics staff will produce utilization data for targeted services subject to prior authorization.

3.1.2 The data will be compared with industry standard benchmarks and compared with previous utilization to determine the impact of the process on utilization.

3.1.3 The HSM Leadership will evaluate the data and make a determination about necessary changes. Policy changes for Medicare Advantage members will be taken to the Utilization Medical Policy Committee (UMPC) for review and ensure alignment with applicable Medicare rules and regulations.

3.1.4 If changes are made, HSM Management will complete a service request detailing code specific changes and submit to the Configuration Department for claim system configuration.

3.2 Changes to the Prior Authorization List

3.2.1 The Director of Clinical Management will obtain input of prior authorization change from appropriate departments such as: Health Service Management, Provider Support

Services, Legal/Compliance, Marketing, Member Services, Pharmacy, Configuration, and Fully Insured sales and Self-Insured Sales representation.

3.2.2 Authorization changes for Medicare Advantage members will be taken to the Utilization Medical Policy Committee (UMPC) for review to ensure requirements comply with Medicare Advantage rules and regulations.

3.2.2.1 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.

3.2.2.2 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.

3.2.3 With input from designated departments, the Director of Clinical Management will have the following documents created:

3.2.3.1 Prior authorization list, codes and services with revisions are made available at www.summacare.com. Prior authorization codes will be updated by the Configuration Department on a quarterly basis

3.2.3.2 Member Communications

3.2.3.2.1 Letter to member (as needed) detailing changes

3.2.3.2.2 Member newsletter article

3.2.3.2.3 Member webpage at www. Summacare.com

3.2.3.3 Provider Communications

3.2.3.3.1 Letter to provider detailing changes within 30 days of change

3.2.3.3.2 Provider newsletter article

3.2.3.3.3 Presentation at Provider Update Seminar (as timing permits)

3.2.3.3.4 Provider webpage at www.summacare.com

3.2.3.4 Compliance Communications

3.2.3.4.1 Documentation of requested changes

3.2.3.4.2 Sample regulatory documents (Prior Authorization List) in track change format

3.2.3.5 Brokers and Employers

3.2.3.5.1 Letter detailing changes to employers within 30 days of change

3.2.3.5.2 Email communication to brokers

3.2.4 The Legal/Compliance Area will ensure that member notification of changes communications comply with state and federal regulations.

3.2.5 Account management will notify self-funded groups of recommended changes and obtain approval. No changes will be made for self-funded groups who do not approve of the recommended changes.

3.2.6 The Provider Support Services Area will develop mailing lists for the provider mailing including physicians and contracted physician hospital organizations, and hospitals.

3.2.7 The Marketing Department will:

3.2.7.1 Proofread and edit all communications to ensure appropriate grammar, spelling, readability, formatting and branding/look of the document.

3.2.7.2 Coordinate replacement of the prior authorization list on the company web sites.

3.2.7.3 Coordinate the printing and mailing of the member and provider notice.

3.2.8 The Clinical Business Informatics area will develop a member mailing list.

3.2.9 The Director of Clinical Management will send final draft documents to UMPC (identified above).

3.2.10 All changes to the Prior Authorization List will be communicated to affected members and to providers in writing 30 days in advance of the effective date, unless otherwise specified by law or contract.

3.2.11 The Director of Clinical Management will work with Corporate Training to coordinate internal staff training for Customer Service, Sales, Provider Support Services and Health Services Management.

3.2.12 The Corporate Training area will assign a mandatory training curriculum regarding the revision(s) for all service units including Benefit Determination Unit, Provider Support Services and Member Services.

3.3 Quality review: Verification of accuracy of prior authorization list available to members on the company web site at www.summacare.com.

3.3.1 The Marketing Area will maintain web site controls that allow only authorized persons to publish/republish the Prior Authorization list. An audit log is available to track changes made.

3.3.2 At least annually, HSM Leadership will conduct a review of the Prior Authorization list posted and available on www.summacare.com to verify that the information is congruent and accurate. A record of this review will be maintained in the HSM Clinical Management area. This information will be shared with the UMPC to ensure compliance with Medicare Advantage regulations.

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

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

3.5.1 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, and internal standard)
- 4.1.1 NCQA UM 1.D
- 4.1.2 CMS Standard: Medicare Managed Manual: Chapter 16 Private Fee for Service 50.4; Code of Federal Regulations (CFR) 422.138; 422.101; 422.138; 422.202 (b) (1)

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 None

4.4 Replaces (if applicable):
- 4.4.1 None

5.0 Definitions:

5.1 None

6.0 Key Words or Aliases (Optional):

6.1 Evaluation of prior authorization process

6.2 Changes to the prior authorization list

ORIGINAL EFFECTIVE DATE: 5/7/2007

REVIEWED: 11/20/2009; 5/9/2016; 9/26/2016; 11/29/2016; 11/30/2017, 10/11/2023, 5/1/25

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