SMSO Policy Manual
2026 PRIOR AUTHORIZATION POLICY

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 Insurance Company**
☒ **Service Management Service Organization (SMSO)**	

Line of Business (check all that apply):

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

Medical Prior Authorization List
(For Services and Equipment)

Effective – January 1, 2026
THIS LIST APPLIES TO ALL MEDICARE/COMMERCIAL FULLY-INSURED/SMALL GROUP/SELF-FUNDED

Certain services require prior authorization in order to be covered under your health plan. Prior authorization review is the process of determining the medical necessity of a proposed procedure, surgery or treatment (including prescribed drug intervention) relative to approved criteria. Prior authorization is required to ensure that the service is medically necessary and that you will receive the benefits to which you are entitled. Emergency services do not require prior authorization.

Requests for prior authorization must be received before the services are provided. Failure of a network provider to contact the health plan for required authorization of items covered under your plan will relieve the health plan and you from any financial responsibility for the service, if those services are rendered before notifying the plan.

NOTE: Your in-network providers are responsible for obtaining authorization 48 hours prior to the provision of services. It is your responsibility to make sure prior authorizations are completed for all services that require a prior authorization outside our service area or performed by a non-preferred provider. The number to call for prior authorization is listed on the back of your SummaCare Identification Card.

For PPO members only: If prior authorization is not received, your claim will be reviewed for medical necessity and whether the service is a covered benefit. If the service is not medically necessary or not a covered service, the claim will be denied. You always have the right to appeal this denial if you feel the service was medically necessary.

How to request prior authorization for services:

Type of Service	24/7 Online Requests*	Fax Routine Requests	Tel Urgent Requests
Radiology, Medical/Radiation Oncology, Genetic Testing	..:: Summacare ::.. (Guiding Care Portal) or www.evicore.com	Fax: 800-540-2406	855-774-1315 or 330-996-8710 option 1
Inpatient	..:: Summacare ::.. Guiding Care Portal) SummaCare	Fax: 330-996-8992	330-996-8710 or 888-996-8710 option 2 (TTY 800-750-0750)
All other requests	..:: Summacare ::.. Guiding Care Portal) SummaCare	Fax: 330-996-8992	330-996-8710 or 888-996-8710 option 2 (TTY 800-750-0750)

**Online or electronic/fax submission of requests for prior authorization should be used for non-urgent requests.*

IMPORTANT INFORMATION

1. All services, even if authorized, are subject to your benefit plan contract coverage and exclusions, eligibility, network design and submission of concurrent review. Approvals are not guarantee of coverage, as your benefit plan contract may retroactively terminate at a future date.

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.

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.

4. Durable Medical Equipment (DME) may be purchased or rented according to Medicare guidelines for Medicare Advantage Members. All plans should refer to your Evidence of Coverage (EOC) for additional information. If you have any questions regarding this, contact our DME provider, HomeLink, at 844-358-2549.

5. Services listed in this document may not be covered because they are listed as exclusions in your plan contract. Your benefit plan contract exclusions and current status of eligibility may be verified online at **www.summacare.com**.

6. Providers may call 330-996-8400 or 800-996-8401 or visit **www.summacare.com** with questions about eligibility and coverage of services.

7. If the provider submits the request for prior authorization electronically through The SummaCare Authorization Portal, we shall respond to all prior authorization requests within 48 hours for urgent care services, or 10 calendar days for any prior authorization request that is not for an urgent care service, of the time the request is received. Upon receipt of the prior authorization, SummaCare will provide an electronic receipt to the provider acknowledging that the prior authorization request was received.

    a. The response shall indicate whether the request is approved or denied. If the prior authorization is denied, Utilization Management shall provide the specific reason for the denial.

    b. If the prior authorization request is incomplete, Clinical Management shall indicate the specific additional information that is required to process the request.

8. Changes to prior authorization requirements will be disclosed at least 30 days prior to the effective date of the new requirement. This notice may be sent via electronic mail or standard mail and shall be noted "Notice of Changes to Prior Authorization Requirements." The notice is not required to contain a complete listing of

   all changes made to the prior authorization requirements but should include specific information on where the provider may locate the information on our website or the SummaCare Authorization Portal.

9. All Preferred Providers shall promptly notify SummaCare of any changes to their electronic mail or standard mail address.

10. A listing of prior authorization requirements are made available to providers via the website or the SummaCare Authorization Portal l, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

11. SummaCare will make available on our website information about the policies, contracts, or agreements we offer that clearly identify specific services, drugs or devices to which a prior authorization requirement exists.

12. For an adverse prior authorization determination, the appeal process relating to that shall include all of the following:

    a. For urgent care services, also known as Expedited requests, the appeal shall be considered within the following timeframes
        - Medicare Expedited Requests shall be decisioned within 72 hours from receipt
        - Commercial Expedited Requests shall be decisioned within 48 or 72 hours, dependent upon member's plan language, from receipt

    b. For Standard Pre-Service (Non-Urgent) Requests, the appeal shall be considered within the following timeframes
        - Medicare Standard (Non-Urgent) Pre-Service Requests shall be decisioned within 30 days from receipt
        - Commercial Standard (Non-Urgent) Pre-Service Requests shall be decisioned within 10 or 15 days, dependent upon member's plan language, from receipt

    c. The appeal shall be between the provider requesting the service in question and a clinical peer.

    d. For Commercial requests, if the appeal does not resolve the disagreement, either the covered person or an authorized representative as defined in section 3922.01 of the Revised Code may request an external review under Chapter 3922.01 of the Revised Code to the extent Chapter 3922.01 of the Revised Code is applicable.

    e. For Medicare requests, if the appeal is denied, also known as upheld, the appeal and all supporting documentation will be submitted electronically to CMS vendor, Maximus, for review of the facts. Maximus will then render a decision that either upholds or overturns the Plan's determination

Except in cases of fraudulent or materially incorrect information, we will not retroactively deny a prior authorization for a health care service, drug or device when all of the following are met:

a) The provider submits a prior authorization request to us for a health care service, drug or device;

b) We approve the prior authorization request after determining that all of the following are true:

1. You or your dependent is eligible under the health benefit plan.
2. The health care service, drug or device is covered under your benefit plan.
3. The health care service, drug or device meets our standards for medical necessity and prior authorization.

c) The provider renders the health care service, drug or device pursuant to the approved prior authorization request and all of the terms and conditions of the provider's contract with us;

d) On the date the provider renders the prior approved health care service, drug or device, all of the following are true:

1. The member is eligible under the health benefit plan.
2. The member's condition or circumstances related to the member's care has not changed.
3. The provider submits an accurate claim that matches the information submitted by the provider in the approved prior authorization request.

To find the most current list of services, surgeries, durable medical equipment or drugs covered under your medical benefit requiring prior authorization, please visit **www.summacare.com** or call the Member Services number located on your Member Identification card.

If you are unsure as to what requires prior authorization, or if you have questions about eligibility and coverage, please call Member Services at 330-996-8700 or 800-996-8701 (TTY 800-750-0750).

SERVICES

SummaCare provides coverage for medically-necessary healthcare services and equipment. SummaCare requires prior authorization before the provision of select services. The following services require prior authorization:

- Air Ambulance-Fixed Wing
- Applied Behavioral Analysis (ABA)
- Aquablation Robotic Therapy
- Cardio MEMS System
- Cochlear device and/or implantation
- Cosmetic or potentially cosmetic surgery or procedures
- Dental care that is non-routine and needed for the purpose of treating illness or injury
- Durable medical equipment
- EEG Video Inpatient Seizure Monitoring
- Experimental medical and surgical procedures and new technology
- Genomic testing
- Genetic testing
- Gene therapy
- Hyperbaric Oxygen therapy

- Left Ventricular Assist devices
- Medical Oncology
- Melanoma testing

- Outpatient surgeries – contact Provider Services @ 330-996-8400 or (800) 996-8401
- Prosthetics/prosthetic devices
- Radiation therapy
- Radiofrequency ablation
- Radiology testing o Computed Tomography (CT)
- Gastrointestinal imaging through capsule endoscopy
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Infertility diagnostic and treatment services
- Inpatient Admission o Acute Care Hospital o Behavioral Health Hospital o Long-term Acute Care Hospital o Rehabilitation Facility o Residential treatment Center o Skilled Nursing Facility (SNF), sub-acute or transitional care facility
- Newborn Notification
- Nuclear Medicine scans o Positron Emission Tomography (PET)
- Single-Photon Emission Computed Tomography (SPECT)
- Transplant Services

  Pre-transplant evaluation - Human organ, bone marrow and stem cell transplants