# Prior Authorization- Organization Determination

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

# Prior Authorizations — Benefits of Using Prior Authorizations

**Prior authorization:**

- Ensures the patient receives the right care for the right condition.
- Helps identify members who may not be engaged in the Care Management process.
- Provides a better picture for the Multidisciplinary Team, enabling them to develop comprehensive care plans.

# Prior Authorizations — Where to Submit Organization Determination Requests

**To submit a request for an organization determination use:**

- Prior Authorization Line: 1-888-244-5410.
- Fax: 1-888-257-7960.
- NaviNet: www.firstchoicevipcareplus.com or www.navinet.net.

# Prior Authorizations - Time Frames

- First Choice VIP Care Plus has up to fourteen (14) calendar days to complete a standard request for prior authorization and notify the provider of the organization determination.
- First Choice VIP Care Plus has seventy-two (72) hours to complete an expedited request.
- Once an authorization is processed, the First Choice VIP Care Plus provider will receive a phone call and a fax alerting him or her to the organization determination.
- Providers may only request a peer-to-peer review during initial outreach by the Clinical Care Reviewer notifying the provider that the request is not meeting for medical necessity and will be pended to the Medical Director for determination. The peer to peer must occur before the decision is rendered.

# Prior Authorizations - Organization Determination Process

- If the request is partially or fully denied, the member receives an Integrated Denial Notice from First Choice VIP Care Plus , alerting the member of his or her appeal rights. Providers will also receive this notice for informational purposes.
- Refer to chapters five (5) and six (6) of the First Choice VIP Care Plus Provider Manual or the Provider section on the First Choice VIP Care Plus website for more information.
- Please note - Providers may NOT use the Advanced Beneficiary Notice of Non-coverage (ABN) Form CMS-R-131 with Medicare Advantage plans.

# Notice of Denial

**Important:** This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

## Notice of Denial of Medical [Coverage/Payment]

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**Date:**

**Member number:**

**Name:**

**Service Subject to Notice:**

**Type of Service:** [*Medicare-only, Medicaid-only, both Medicare and Medicaid*]

**Date of Service:**

**Provider Name:**

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## Your request was denied

We've [denied, stopped, reduced, suspended] the [*payment of*] medical services/items listed below requested by you or your provider:

# Notice of Denial Continued

## Why did we deny your request?

We [denied, stopped, reduced, suspended] the [*payment of*] medical services/items listed above because [*Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision*]:

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## You have the right to appeal our decision

You have the right to ask First Choice VIP Care Plus to review our decision by asking us for a Level 1 Appeal.

Ask First Choice VIP Care Plus for a Level 1 Appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

*If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your appeal, you may have to pay for these services.*

# Partial List of Services that Require Prior Authorization and/or Organization Determination*

- Elective/non-emergent air ambulance transportation.
- All out-of-network service (excluding emergency services).
- Inpatient services.
- Certain outpatient diagnostic tests.
- Home health services.
- Therapy and related services.
- Transplants, including transplant evaluations.
- Certain durable medical equipment (DME).
- Religious nonmedical health care institutions.
- Hyperbaric oxygen.
- Surgery.
- Surgical services.
- Gastric bypass or vertical band gastroplasty.
- Hysterectomy.
- Pain management.
- Radiology outpatient services:
    - CT scan.
    - PET scan.
    - MRI.
- **For services not typically covered under Medicare, providers must still request an organization determination.**
- *** Exceptions apply. For a full list of services that require prior authorizations, please refer to the Provider Manual or call Care Management.**

# Appeals

Members, their authorized representative, including providers, may file appeals with First Choice VIP Care Plus:

- Initial appeals must be filed with First Choice VIP Care Plus.
- Next level appeals for Medicare A and B only benefits will be reviewed by the Medicare Independent Review Entity (IRE) and are filed automatically.
- Next level appeals for Medicaid only benefits will be reviewed through a State Fair Hearing and must be initiated by the member.
- Next level appeals for benefits that overlap will first go to the IRE then to a State Fair Hearing or an Administrative Law Judge if not in favor of the member.

# Appeal Time Frames

**Appeals must be initiated within:**

- 10 days of the date of the denial notice or before the service is stopped / reduced, whichever is later in order for services to continue while the case is being reviewed.
- 60 calendar days from the date of the denial notice.
- 30 calendar days from a resolution notice to request a next level appeal.

**Appeals must be resolved within:**

- 15 Calendar days for standard appeals with First Choice VIP Care Plus.
- Independent Review Entity (IRE) appeals follow existing Medicare appeal time frames.
- 90 Calendar days for State Fair Hearings.
- 72 Hours for all expedited appeals.

# Grievances

Members also have the right to file grievances with First Choice VIP Care Plus regarding any area of dissatisfaction they have with the plan or provider. Such as:

- Provider office staff rudeness.
- Customer Service hold time was too long.
- Their prescription brand is not covered under the formulary.
- Quality of care concerns.

First Choice VIP Care Plus has 30 calendar days to research and respond to these grievances which can either be found unsubstantiated or substantiated. If found to be substantiated typically education to the provider's office or internal staff occurs.

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