Prior Authorization-Organization Determination
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:

• NaviNet: [www.firstchoicevipcareplus.com](http://www.firstchoicevipcareplus.com) or [www.navinet.net](http://www.navinet.net).


• Fax: 1-855-809-9202.
Prior Authorizations — NaviNet Portal to Prior Authorization Management

Welcome to NaviNet

This easy-to-use portal will provide you with the latest plan updates and other pertinent information that will enable you to provide the best care possible to our members. You can search our provider directories, view prior authorization criteria, download forms, and more.

As a First Choice VIP Care Plus Medicare-Medicaid Plan provider, you are a part of a dedicated network that is ready to meet our members’ healthcare needs. As partners in care, we’ll work with you to ensure that our members receive access to the quality healthcare they need and deserve. Our robust network is designed to provide our members with integrated care.

First Choice VIP Care Plus requires members to have referrals from their Primary Care Physicians (PCP) to see specialists. Specialist visits, ambulatory center services, and diabetes self-management training are a few examples of services that require a referral. Some services not requiring a referral are outpatient diagnostic procedures.
You will be linked to the First Choice VIP Care Plus authorization system called Jiva to enter the authorization request:
Prior Authorizations — Jiva Member Search Results Page

Select the action button to enter a new request
Prior Authorizations — Jiva Inpatient Request Page

All information in Red is required for a valid Prior Auth request.
• 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.

• Providers have up to two (2) business days upon receipt of the organization determination to request a peer-to-peer review by contacting the Prior Authorization Line at 1-855-294-7046.

• 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.
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.

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.

Please note - Providers may NOT use the Advanced Beneficiary Notice of Non-coverage (ABN) Form CMS-R-131 with Medicare Advantage plans.
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.
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]

- Date: 
  Member number: 

Name: 

Service Subject to Notice: 
  Type of Service: [Medicare-only, Medicaid-only, both Medicare and Medicaid]

Date of Service: 

Provider Name: 

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]:

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.
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.