SmartHealth

Prior Authorization FAQ

What is prior authorization?

Prior authorization is a requirement that your physician obtains approval from your health plan, SmartHealth, to ensure that a health care service, treatment plan, a medical specialty prescription drug that is administered by a physician or durable medical equipment is medically necessary. There is also prior authorization for certain medications under the Ascension Prescription Drug plan. This review helps to minimize costs and better manage your care.

Prior authorization can also be called prior approval, precertification, or prior notification.

When do I need prior authorization?

The SmartHealth medical plan requires prior authorization for the following services:

- All inpatient admissions to any acute/subacute care facility* require authorization and concurrent review. This requirement applies to all physicians and facilities, regardless of the provider's network contract. (e.g. Ascension Network, National Network or Out-of-Network)
- Admission to other inpatient facilities such as skilled nursing facilities, inpatient hospices, long term acute care hospitals and rehab facilities
- Certain outpatient surgeries, treatments, services and durable medical equipment
- High Tech Radiology (MRI & MRA) excluding Brain MRA, Brain MRI, Orbital and PET scans
- All anesthesia and facility charges that are provided for dental care not covered by the health plan
- Other services as noted. A full list of all procedures that require prior authorization is posted on www.mysmarthealth.org in the Member Info Center.

*Examples of acute care and subacute facilities include hospitals, ambulatory care facilities, home health agencies, hospice, inpatient rehabilitation centers, among others.

Who is responsible for requesting prior authorization?

For both, elective and emergent services, your provider/facility is responsible for requesting prior authorization, but it is ultimately the member's responsibility to ensure prior authorization has been obtained.

Prior authorization is provided pending benefits & eligibility on the date of service, experimental/investigational status, and is not a guarantee of benefits/payment.

When does my provider need to submit prior authorization?

For future, elective inpatient admissions, please submit the completed Seton Health Plan Prior Authorization Form along with the supporting clinical documentation as soon as possible, or at least **14 business days prior to the admission date.** The form can be located on www.mysmarthealth.org in the Provider Info Center and Member Info Center.

For ALL inpatient admissions (elective & emergent), please submit the facility demographic fact sheet and medical records within **two business days of admission** or a penalty will be applied.

- Seton Family of Hospitals (facilities that utilize Allscripts/ECIN) are to submit a task to Seton Health Plan for emergent inpatient admissions

This documentation includes the following:

- Seton Health Plan Prior Authorization Form filled out in its entirety
- Associate's name and ID number
- Associate's date-of-birth
- Claimant's name and date-of-birth (if clamant is not associate)
- Diagnosis including ICD-10-CM
- Requesting or referring healthcare professional
- Servicing health care professional, vendor or facility
- Pertinent medical history and justification for service
- Date of injury (if applicable)
- Anticipated length of stay for inpatient stays
- Place of service
- Description and code for procedure, service (CPT-4 or HCPCS).

These prior authorization requirements apply when:

- SmartHealth is considered primary or secondary coverage unless otherwise noted in this document
- The admission or service is elective or direct/urgent
- The service is inpatient or outpatient

These requirements DO NOT apply to members who have Medicare or Medicaid as primary coverage.

How long does it take to process a prior authorization request?

Processing times for prior authorization requests are based on the receipt of all required and relevant supporting documentation. Submitting requests without all relevant supporting documentation will result in longer processing times.

- **Urgent* Pre-service**: Within **3 business days** of receipt of the request
- **Non-urgent Pre-service (Standard or Elective Services):** Within **15 calendar days** of the receipt of the request
- **Urgent Concurrent Review:** Within **1 business day** of receipt of request
- **Post Service**: Within **30 calendar days** of receipt of request if eligible under the plan. Genetic testing requests will not be reviewed or authorized after the test has been done. HTR requests will not be reviewed retroactively unless the request was an emergency and meets the plan definition of emergency.

*Emergent as defined by SmartHealth Plan: An unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care, but which is not life threatening, and does not require use of treatment at a hospital emergency room.

How can my provider and I track the status of a request?

Each prior authorization has a tracking number for ease of reference. All prior authorizations are approved pending benefits and eligibility on the date of service and are not a guarantee of payment.

Providers and members can call customer service to check on the request's status or look up the status in the claims portal.

How long is my prior authorization effective?

Elective prior authorization are valid **90 days** from the approved date of authorization. Prior authorization for transplants are valid for **12 months** upon approval.

Do I need prior authorization for prescription drugs?

Some prescriptions may require prior authorization. To find out which approved prescription drugs are covered and which prescription drugs require prior authorization, please view Ascension's Prescription

Drug List here. You can also access this list on www.mysmarthealth.org by clicking the Cigna Pharmacy link in the "Member Info Center" and viewing the pdf located on the "Formulary Prescriptions" section on www.cigna.com/ascension.

To view what specialty medications are covered, please view the Specialty Drug List here. You can also access this list on www.cigna.com/ascension by viewing the pdf under the "Specialty Medications" section.

How do I know if my medical specialty physician injectable or infusion requires prior authorization?

If you use a physician infusion/injection medication, please view the Cigna Specialty Pharmacy Drug List located on www.mysmarthealth.org to see if your medication requires prior authorization. Once in your ministry's Member Info Center, view the "Specialized Medications as Medical Benefits" section and select the "Cigna Specialty Pharmacy Drug List."

To confirm that your provider is in the Cigna Open Access Plus (OAP) Network and/or for additional questions, please visit www.cigna.com/ascension and select the "Medical Infusions and Injections" section.

Cigna manages Prescription and Specialty Medication prior authorization.

What if I have an emergency? Do I need prior authorization?

Prior authorization is not required for emergency room or observation services. However, prior authorization is required within **two business days** from the inpatient facility if a member is admitted as a result of emergency services or an observation stay.

What if I have an inpatient admission to a facility? When do I need prior authorization?

The inpatient prior authorization program requires that all inpatient admissions are authorized within **two business days** of admission. Below are services included as part of the inpatient prior authorization program:

- Acute care
- High risk and maternity (only if inpatient stay exceeds federal requirements)
- Inpatient rehabilitation
- Inpatient mental health and substance abuse
- Inpatient mental health and substance abuse residential treatment
- Long term acute care

- Skilled nursing and sub-acute facilities
- Inpatient hospice

For **elective**, inpatient admissions, prior authorization is requested at least **14 business days** prior to the admission date.

Any inpatient admission from an Ascension, National Network or Out-of-Network facility not prior authorized within two business days of the admission date will be considered ineligible under the plan unless medically necessary. If medically necessary, all eligible charges will be paid under the plan, however a penalty of $500 to the facility will be assessed for noncompliance with the prior authorization requirement. Concurrent review will also be performed on all inpatient admissions to ensure appropriate length of stay and discharge planning.

Do I need to request prior authorization for maternity/obstetric admissions?

Maternity and obstetric admissions that result in a length of stay of no more than **48 hours after vaginal deliveries** or no more than **96 hours after Cesarean deliveries** do not require prior authorization. These admissions are referred to as "pre-qualified maternity stays."

However, prior authorization is required within **two business days** for obstetric admissions that extend beyond 48 hours following vaginal deliveries or 96 hours following Cesarean deliveries. If either mother or baby remains hospitalized beyond the pre-qualified maternity stay, authorization must be obtained.

I need genetic testing or genetic counseling services. What steps do I need to take to receive prior authorization?

For genetic testing, prior authorization must be obtained prior to the date of the scheduled service. Retroactive review (after the service has been rendered) is no longer permitted in 2019.

For genetic testing prior authorization requests, please submit the Genetic Counseling Recommendation Form found on www.mysmarthealth.org under the Prior Authorization section in the Member Info Center. The form, along with a 3-geneation pedigree, copy of the ordering HCP's Lab Requisition form and photocopy of your evaluation are required for consideration of this request.

What services do not require prior authorization?

Prior authorization is required ONLY for the services listed on the 2019 Services Requiring Prior Authorization List. This list can be found on www.mysmarthealth.org in the Member Info Center. If a request is submitted for services that do not require prior authorization, no acknowledgment or

response will be sent back to the provider. If your provider does not receive a response, please check to make sure the service requires prior authorization before submitting a second request.