Prior Authorization Process – Updated 8/12/2021

a) Authorization List – Community First requires that certain services are authorized prior to the services being rendered - refer to the Community First Authorization List to determine which services require authorization.

Prior authorization is not a guarantee of benefits or payment at the time of service. Benefits may vary by plan, so always verify eligibility and benefits. Services that require preauthorization must be submitted to Community First prior to rendering the services. Failure to obtain preauthorization may result in non-payment of claims.

Note: The terms "prior authorization" and "preauthorization" and "preservice" are used interchangeably.

b) Documentation Requirements - The requesting physician/provider initiates a preauthorization request. The preferred method of submission is via the internet through the Community First website: www.cfhp.com. Contact Network Management for detailed instructions of this process.

Prior authorization requests can also be submitted by calling Community First, faxing the Texas Medicaid Health care Partnership Authorization Request Form or the Texas Authorization and Referral Form (https://www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf) to the Community First Population Health Management (PHM) Department and providing the information below. The forms are not required but are preferred.

All forms must be reasonably complete with clinical information provided. Preauthorization requests should be made to in-network providers and facilities.

Effective 4/1/2021:
Essential Information Must be Provided, to include:

- ✓ Member name
- ✓ Member number or Medicaid number
- ✓ Member date of birth
- ✓ Requesting and rendering provider names
- ✓ Requesting and rendering providers National Provider Identifier (NPI)
- ✓ Service requested – Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT)
- ✓ Service requested start and end date(s)
- ✓ Quantity of service units requested based on the CPT, HCPCS, or CDT requested
    - If the request does not include **ALL of these elements**, the Community First intake staff will submit a fax to the provider advising the requesting provider to submit the missing information **within one business day.**

Additionally, information necessary to ensure that the request is processed correctly and timely includes those items listed below, and are not limited to the following:

- Gender (for gender specific procedures only)
- Diagnosis Code: International Classification of Diseases (ICD-10) codes
- Name, phone and fax number of the referring/ordering practitioner or provider

- Name, phone and fax number of the rendering practitioner or provider (place of service orfacility)
- Reason for referral
- All miscellaneous codes requested must include a detailed description of the item
- Requesting provider/physician signature
- Total Cost for each DME/Orthotic/Prosthetic Purchased Item (over $500)
- Medical Supplies - # of supplies being requested that are outside the Medicaid allowable limit
- Clinical information including but not limited to: supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

Urgent Admission Notification Process

a) Unplanned Admissions Requirements - Community First requires urgent admission notification within 24 hoursof admission. Facilities are to submit supporting clinical information within 48 hours of the admission. Observation stays do not require authorization.

b) Documentation Requirements - Supporting documentation includes but is not limited to the physician's history and physical, progress notes, and orders. In some instances, vital signs, medication administration records, laboratory/imaging results, and other information may be required.

   If additional information is later required for concurrent review, facilities are to submit requested information within 24 hours of request.

Inpatient Authorization Process

a) Concurrent Review - Community First performs concurrent review for the majority of admissions. The Community First Population Health Management (PHM) department assists in assuring that Members receive medically necessary services at the appropriate level, in the appropriate setting, in a timely mannerand to determine whether services are experimental or investigational in nature.

   - The function of Concurrent Review includes:
     - ✓ Verify continued medical necessity
     - ✓ Reassess appropriate length of stay
     - ✓ Reassess appropriate level and setting of care
     - ✓ Verify that care is coordinated among all disciplines
     - ✓ Identify and refer problematic cases to case management
     - ✓ Initiate timely discharge planning activities
     - ✓ Trigger referrals to case, disease, quality management, and social services
     - ✓ Report suspected or known patient safety issues as appropriate.

   - Discharge Planning is initiated to facilitate the transition of the Member to the next phase of care through coordination with a multi-disciplinary team. The Community First staff work with the Hospital staff to implement the discharge plan and assure that, as the Medical Home, the Primary Care Provider (PCP) has the appropriate clinical information to coordinate the recommended care.

   The function of Discharge Planning includes:

   - ✓ Identifying discharge planning needs in anticipation of/or early in the hospital admission

- ✓ Coordinating discharge plans with multi-disciplinary team
- ✓ Informing and assisting the Primary Care Provider (PCP) in obtaining appropriate clinical information
- ✓ Assistance in arranging implementation of post discharge service.

b) Documentation Requirements - If additional information is required related to a concurrent review, facilities are to submit requested information within 24 hours of request. Facilities agree to work collaboratively with Community First's team as appropriate to communicate the Members' discharge plans. Facilities are to provide discharge plans, as well as a copy of the discharge summary, to Community First within48 hours of discharge.

c) Frequency of Concurrent Reviews - Initial clinical reviewers conduct concurrent reviews for the extension of an initial determination with a frequency that is based solely on the severity and complexity of the Member's condition, or on necessary treatment and discharge planning activity. Community First staff advise the facility when additional supporting clinical information is required.

It is requested that any change in admission status be reported to Community First within 24 hours of the statuschange.

Retrospective Authorizations

For retrospective review, Community First bases review determinations solely on the medical information availableto the attending physician or ordering provider at the time the medical care was provided, including both inpatient and outpatient medical necessity reviews when an authorization is required.

Time Frames for Initial Determinations

Community First strives to issue a determination within the following time frames (in compliance with state regulatory requirements) for each of the three general categories of utilization management review:preauthorization, concurrent, and retrospective:

a) Preauthorization Review Time Frames

- **Urgent Pre-Service Care**
  Within 72 hours of receipt of request (all lines of business)
  - If the request does not meet the definition of "urgent care", the request may be handled as a non-urgent request and decided within the timeframe appropriate for the type of decision notification.

- **Non-Urgent Pre-Service Care**
  Medicaid (STAR/STAR Kids) - Within three (3) business days from the receipt of a request.
  - STAR/STAR Kids Members under the age of 21: For a request for a UM determination that is lacking information, refer to the *STAR <21 Lack of Information* process.

  CHIP - Within two (2) calendar days from the receipt of a request that results in approvaland three (3) business days for a denial
  Commercial - Within three (3) calendar days from the receipt of a request

- **Life-threatening Conditions or Post-Stabilization Care**

Authorization is not required for Emergency Care. "Emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Member's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

- place the Member's health in serious jeopardy;
- result in serious impairment to bodily functions;
- result in serious dysfunction of a bodily organ or part;
- result in serious disfigurement; or
- for a pregnant woman, result in serious jeopardy to the health of the fetus.

Community First makes a medical necessity determination for life-threatening conditions or post-stabilization of care within one (1) hour from the receipt of the request.

b) Concurrent Review Time Frames

- **Urgent Concurrent Care**
  Within 24 hours of receipt of the request (Commercial and CHIP)
  Within 1 business day of receipt of request (STAR and STAR Kids)

- **Non-Urgent Concurrent**
  Within 1 business day

c) Retrospective Review Time Frames

Within 30 calendar days from the receipt of request

d) Pharmacy Time Frames

- For Medicaid and CHIP, Immediately, if the prescriber's office calls Navitus Health Solutions at 1-877-908-6023
- For all other Medicaid and Commercial prior authorization requests, Navitus notifies the prescriber's office no later than 24 hours after receipt
- If Navitus cannot provide a response to the pharmacy prior authorization request for Medicaid within 24 hours after receipt or the prescriber is not available to make a prior authorization request because it is after the prescriber's office hours and the dispensing pharmacist determines it is an emergency situation, Community First and Navitus allows the pharmacy to dispense a 72-hour supply emergency supply at the discretion of the dispensing pharmacist

Extension Conditions

Members or their authorized representative may agree to extend the time frame for urgent, preservice and retrospective requests. Community First may also extend decision time frames under the following conditions:

a) <u>Urgent concurrent and urgent preservice requests</u> for Medicaid and CHIP

- Urgent concurrent and urgent preservice time frames may be extended, once due to lack of information, for up to 14 calendar days, if the Member requests the extension. Community First documents that it made at least one attempt to obtain the necessary information.

- Community First may extend the time frame by up to 14 calendar days if it needs additional information and notifies the Member and the Member's authorized representative of its decision as expeditiously as the Member's health condition requires, but no later than the expiration of the extension.

b) <u>Urgent concurrent</u> requests for Commercial

a. Community First may extend the decision notification time frame if the request to extend urgent concurrent care was not made prior to 24 hours before the expiration of the previously approved period of time or number of treatments. Community First may treat the request as urgentpreservice and send a decision notification within 72 hours.
b. Community First may extend the decision notification time frame for an urgent concurrent request if the request is related to care not approved by Community First previously. Community First has up to 72 hours tosend a decision notification.
c. Community First may extend the decision notification time frame once due to lack of information if it documents that it made at least one attempt to obtain the necessary information within 24hours of the request, but was unable to. Community First has up to 72 hours to send a decision notification.

c) <u>Urgent preservice</u> requests for Commercial

Community First may extend the urgent preservice time frame once due to lack of information, for 48 hours,under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, Community First asks the Member or the
  Member's representative for the information necessary to make the decision, and
- Community First gives the Member or the Member's authorized representative at least 48 hours to
  provide the information, and
- The extension period, within which a decision must be made, begins on the sooner of:
  - The date when Community First receives the Member's response (even if not all of the
    information is provided), or
  - The last date of the time period given to the Member to provide the information, even if no response is received from the Member or the Member's authorized representative.

d) <u>Nonurgent preservice and post-service</u> requests. If the request lacks clinical information, Community First mayextend the nonurgent preservice or post-service time frame up to 15 calendar days, under the following conditions:

- Before the end of the time frame, Community First asks the Member or the Member's representative
  for the information necessary to make the decision, and
- Community First gives the Member or the Member's authorized representative at least 45 calendardays to provide the information.
- The extension period, within which a decision must be made by Community First, begins on the soonerof:
  - The date when the organization receives the Member's response (even if not all of the information is provided), **or**
  - The last date of the time period given to the Member to supply the information, even if no response is received from the Member or the Member's authorized representative.

Community First may deny the request if it does not receive the information within the time frame, and theMember may appeal the denial.

e) Extension for other reasons

In a situation beyond Community First's control (e.g., waiting for an evaluation by a specialist), Community First may extend the nonurgent preservice and post-service time frames once, for up to 15 calendar days.

- Within 15 calendar days of a preservice request, Community First notifies the Member (or the Member's authorized representative) of the need for an extension and the expected date of the decision.
- Within a 30 calendar days of a post-service request, Community First notifies the Member (or the Member's authorized representative) of the need for an extension and the expected date ofthe decision.

Clinical Review Criteria

Community First utilizes InterQual® review criteria in the process of managing utilization for prospective, concurrent and retrospective review. Other evidence-based criteria that may be used include the Community First medical policy, Texas Medicaid Provider Procedure Manual, Lexicomp®, Micromedex®, and Hayes, Inc. Community First may develop its own clinical review criteria where the Medical Director determines existing clinicalreview criteria to be inadequate. For LTSS Services, the STAR Kids screening and assessment instrument (SAI) performed by the Service Coordinator, along with provider notes, etc. determines medical necessity for the LTSS services.

Clinical review criteria used to make medical necessity determinations is available upon request.

Resources:
Texas Standard Prior Authorization Request Form for Health Care Services
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Access to UM Review Staff

Community First serves Texas counties in the Central Time Zone only. The PHM staff are available Monday - Friday, 8:30 a.m. to 5 p.m. CST, excluding legal holidays, to respond to utilization review inquires by phone at 1- 210-358-6050 or 1-800-434-2347 – for STAR Kids at 1/855-607-7827 or 210-358-6403.

Communication with UM Staff

Hours to receive communications:

- Community First receives communications from providers and Members during the business day and after business hours. Mechanisms for receipt of communications include telephone, facsimile, web-based authorization portal, and USPS mail. Requests for authorizations maybe submitted 24 hours a day, seven days a week at the following numbers:

  STAR/CHIP /HMO
  Outpatient Fax: 1-210-358-6040 or 1-800-887-7974
  Inpatient Fax: 1-210-358-6388
  Phone: 1-210-358-6050

STAR Kids
Fax: 1-844-358-6382 or 1-210-358-6382
Phone: 1-855-607-7827 or 210-358-6403

Pharmacy Information
Assistance for members - phone: 1-210-358-6050
Assistance for prescribers/providers - phone: 1-877-908-6023

- An after-hours recording prompts caller to select option for an on-call nurse who is available 24 hours a day, seven days a week, for calls received after hours.
- The Behavioral Health Hotline is staffed by trained personnel 24 hours a day, seven days a week, toll-free throughout the service area.

Community First responds to communications within one (1) business day. Messages received after business hoursare responded to on the next business day. Voice mail messages are responded to within one (1) business day. An after-hours recording prompts the caller to the nurse on call for services or inquiries after business hours.

Notification for Incomplete Prior Authorizations – STAR and STAR Kids

When a request for prior authorization for a STAR or STAR Kids Member is incomplete, the following process is conducted:

<u>Incomplete or Insufficient Documentation Provided – effective 4/1/2021</u>

- Community First will no longer utilize the 16-hour of 7-day letter for those requests dated 04/01/2021 and moving forward in which additional clinical information is needed.
- Community First will instead issue a 3 Business day letter to providers for outpatient requests in which additional clinical information is necessary to process the request
- The 3 Business day letter includes language for an opportunity to contact the Peer-to-Peer line at 210-358-6020 should the provider wish to schedule a discussion with a Medical Director
- If the provider contacts the Peer-to-Peer line within the 3 Business day timeframe to request a peer-to-peer discussion, an appointment will be scheduled prior to issuing a determination.
- No additional peer-to-peer letter will be sent.

The process for incomplete or insufficient documentation for STAR and STAR Kids goes as follows:

- A letter is sent within 3 business days for the prior authorization request. The letter indicates the missing information needed and the timeframe by which to return the information (3 business days).
- If the information is not provided by the end of the 3rd business day after the letter is sent, and the request will result in an adverse benefit determination, the request is referred to a Community First medical director for review. This referral must occur no later than 7 business days after the original prior authorization Receive Date.
- Within 3 Business Days of the referral for medical director review, but no later than the 10th Business Day after the prior auth Receive Date, Community First must make a final decision on the prior authorization request.
- A peer-to-peer consultation can occur at any time during the prior auth request process after a medical director review. Community First must offer an opportunity for a peer-to-peer consultation to the requesting physician no less than one Business day before an Adverse Benefit Determination is issued.

Note: For all lines of business, a peer-to-peer letter is sent to the requesting provider for those outpatient requests in which all the necessary information was provided but medical necessity could not be established and the Community First Medical Director has requested a peer-to-peer offering before making a final decision.

Prior Authorization Statistics - 2020 Results for Community First
STAR
STAR Kids
CHIP
HMO