PROVIDER Bulletin

March 28, 2017

This Provider Bulletin applies to the lines of business and provider types checked below:

☒ **PHP (Medicare)** ☒ **Primary Care Physicians** ☒ **Specialists**
☒ **PHC (Medicaid)** ☒ **Ancillary** ☒ **Hospitals**

PHP/PHC Utilization Management has an established process for implementing and maintaining an effective and efficient utilization management system. It is a collaborative effort between PHP/PHC, providers and physicians and is designed to assist our providers with the organization and delivery of appropriate health care services within the structure of the member benefit plan. To best serve all of our members and providers, we have reviewed our standard versus expedited criteria. While we have not made any changes, it was evident a number of requests were marked urgent which do not meet the urgent criteria established. In addition, authorizations are able to be processed more timely if all the necessary information is supplied at the time of request. To avoid having to resubmit your request which may delay authorization, please review the below definitions and submit all necessary information.

Standard Service Authorization –. Prior authorization decisions for non-urgent services are made within **14** calendar days of receipt of the request for services. An extension to the response time may be granted for an additional seven calendar days if the member or the provider requests an extension or if PHP/PHC justifies a need for additional medical information and the extension is in the member's best interest. Currently most requests are processed within 5- 7 days

Expedited /Urgent Service Authorization – In the event the provider indicates and PHP/PHC determines, that following the standard timeframe could seriously jeopardize the Member's life or health, PHP/PHC will make an expedited authorization determination and provide notice within 72 hours. PHP/PHC may extend up to two additional business days if member or the provider requests an extension, or if PHP/PHC justifies a need for additional information and the extension is in the member's interest.

Some prior authorization guidelines to note are:

- The referral and/or prior authorization request should include the diagnosis to be treated and the CPT and HCPCS code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required.
- An authorization and/or referral may be **given for a series of visits or services related to an episode of care**. The authorization and/or request should outline the **plan of care including the frequency and total number of visits requested and the expected duration of care**.

PHP/PHC providers are required to comply fully with utilization management programs administered by PHP/PHC including:

- Obtaining authorizations and/or providing notifications, depending upon the requested service.
- Providing clinical information to support medical necessity when requested.
- Permitting access to the member's medical information.
- Providing a plan of treatment, progress notes and other clinical documentation as required.

Failure to obtain a prior authorization for the procedures requiring authorization may result in the member and/or provider being held financially responsible for the procedure.

Authorization and/or referral request must be submitted to fax number: 888.972.5340.

This Provider Bulletin is not intended to replace or conflict with any requirements outlined in your signed Agreement with AHF, PHP or PHC. If you have any questions or suggestions contact the Provider Relations Department at 954.522.3132 or email to remon.walker@positivehealthcare.org .