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Utilization Management Referral and Preauthorization General Guidelines

Silverback's Utilization Management referral and preauthorization program is designed to improve communication among primary care physicians, specialists, and other healthcare providers involved in the care continuum.

Glossary

- **Referral** – The classification of an approval by the PCP for a specialist to see a member enrolled in an HMO insurance plan
- **Precertification** – The classification on an authorization that allows a physician to perform specified procedures in defined setting.
- **Out-of-Network (OON)** – The provider is not contracted with the member's health plan
- **Network Deficiency** – The inability to provide three (3) contracted specialists/ sub-specialists within the CMS regulated Health Service Delivery (HSD) radius of the member's residence.
- **Continuity of Care (COC)** – The member is undergoing active treatment for a serious chronic condition that prevents the transition of care.
- **Unit(s)** – In the context of this document, a unit is defined as the amount of requested service(s). e.g., procedure, visit, injection, etc.
- **Global Period** – CMS specified timeframe after a surgical procedure in which all services related to the procedure rendered by same physician are covered under procedure costs for the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician
- **Impending Denial** - Notification provided to requesting physician prior to adverse determination by an organization
- **Peer to Peer** – Discussion taking place amongst equally qualified individuals, in this context two physicians specializing in the same area of medicine
- **Appeal** – Request review of adverse organization determinations of health care services by a third party

Turn-Around Times

The below outlines the CMS turn-around time based on priority of the request, please review to ensure your requests are submitted timely not to delay patient care. Requests that are incomplete or require additional information may be delayed in order to obtain the required information.

Pharmacy Requests

1. A standard pharmacy request has an average turn-around time of 72 hours.
2. An expedited pharmacy request has a turn-around time of 24 hours.
    a. CMS defines expedited requests as a determination that "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function"
    b. If the request needs to be treated as expedited, **clinical justification must be provided** along with explanation as to why applying the standard time for making a determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Priority	CMS Turn-around Time
Pharmacy Expedited	24 hours
Pharmacy Standard	72 hours
Concurrent	72 hours
Precertification Expedited	72 hours
Precertification Standard	14 days
Retro	30 days

Expedited Requests

1. An expedited request has a turn-around time of 72 hours.
2. CMS defines expedited requests as a determination that "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function"
3. If the request needs to be treated as expedited, **clinical justification must be provided** along with explanation as to why applying the standard time for making a determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Referral Submission Guide

Referral Requirements

1. **HMO Products**: Referrals for specialist visits are required for all HMO plans. The referral must be initiated by the member's Primary Care Physician (PCP) in order for the services to be eligible for payment. This includes, but is not limited to, E&M visits, technical services, and procedures that do not require precertification. Once a referral has been approved from the member's PCP to a specialist, the approval will be honored for the date range and units noted on the approved referral.

   If a member's assigned PCP changes within the approved date range, the member may continue to see the specialist who was requested on the approved referral. Once the referral expires or visits are exhausted, the member's new assigned PCP must initiate a new referral.

2. **PPO Products**: Referrals are not required for members with PPO health plans and are considered courtesy notifications. However, the member out-of-pocket expense is greater with utilization of OON benefits.

3. **OON referrals**: All referral requests for a specialist that are OON will require review by Silverback to determine if the case meets criteria for Network Deficiency or Continuity of Care. All requests that do not meet the stated criteria will be reviewed for redirection to a contracted provider.

Referral Guidelines

1. In instances where the member needs to see another specialist, the member's PCP must submit a new referral. Specialists to specialist referrals are not permitted.

2. For residents of a Long Term Care facilities (LTC), the attending physician at the LTC/SNF can submit referral requests as the member's PCP.

3. If a member was treated in an Emergency Room and subsequently underwent a *surgical procedure*, the member may see the treating specialist without obtaining a referral during the Global Period. If a member only received consultation services from a physician in the Emergency Room or in an in-member setting, this would not qualify for the Global Period and a referral would be required for any in-office follow-up care.

4. Please review the referral requirements for the following specialties and circumstances:
    1. **Optometry:** Routine vision exams
        i. If the visit is for a medical reason, or any reason other than a routine vision exam, a referral is required.
        ii. A referral is **always** required for Ophthalmology.
    2. **OB/GYN:** Preventive services
        i. If the visit is for a medical reason, or any other reason other than a wellness exam or preventative care services, a referral is required.

3. **Behavioral Health:** Non-Facility Outpatient psychotherapy (United Healthcare (UHC))
    i. For UHC, the above referrals are handled by a separate vendor.
        i. United Health Care: 800-430-0033
    ii. Referrals are required for Care N' Care and Humana
4. **Physical Therapy:** Referrals are not required for Physical Therapy.
5. **Nutrition/Dietitian:** Referrals are not required for Nutrition/Dietitians.

5. Silverback **does** accept referrals to Mid-Level providers such as nurse practitioners (NPs) or physician assistants (PAs) if they are contracted with the payor.

6. Silverback **does** accept Group NPIs if the group NPI is contracted with the payor.

7. Silverback **does** accept retrospective referral requests **prior to a claim being submitted**.

Referral Update Guidelines

1. A PCP is allowed to request an extension on a referral as long as the referral has not expired or is less than 30 days past expiration
    a. For example, a referral was approved for a date range of 07/01/18 - 11/01/18. The request for an extension must be received no later than 12/01/18
    b. A referral extension will extend the time period on the referral, but it will not add additional visits. Additional visits must be submitted by the PCP as a new referral request.

2. If the PCP wants to add, remove or change a diagnosis code, the existing referral request can be updated.

3. If the PCP wants to change a provider on an approved referral, the following applies:
    a. If the provider is In-Network → PCP must notify Silverback and an update will be made to the existing authorization
    b. If the provider is OON → PCP must submit a new request

Precertification Submission Guide

Precertification Overview

1. A standard precertification is a request for one (1) unit over a six (6)-month period, unless specified on the request

2. Silverback only accepts requests within 90 days of the start of care as the patient may experience a change in condition which impacts the clinical review and determination process.

3. Precertification requests and supporting documents can be received via Acuity Connect or fax submission.

4. Precertification will need to have supporting clinical documentation to support medical necessity need. If clinical information is not included, this may result in a delayed response time.

5. Precertification requests can come from all provider types including PCPs, specialists or rendering facilities.

6. **OON Precertification**: All precertification requests for a provider that is OON will require review by Silverback to determine if the case meets criteria for Network Deficiency or Continuity of Care. All requests that do not meet the stated criteria will be reviewed for redirection to a contracted provider.

7. Silverback **does** accept referrals to Mid-Level providers such as nurse practitioners (NPs) or physician assistants (PAs) if they are contracted with the payor.
8. Silverback **does** accept Group NPIs if the group NPI is contracted with the payor.

9. Silverback **does** accept retrospective precertification requests **prior to a claim being submitted**.

Precertification Updates

1. If a provider wants to change or add services, a new precertification request is required.

2. Updates to diagnosis codes
    a. If a provider wants to add diagnosis code, no new precertification request is required.
    b. If a provider wants to change or removed an originally submitted diagnosis code, the change can happen within a week of the received date. If a provider is requesting to change after the week of the received date, a new precertification request will be required.

3. If the Provider wants to change a provider on a precertification, the following inpatient and outpatient requirements apply:
    a. If the provider is in-network → the provider must notify Silverback and an update will be made to the existing authorization
    b. If the provider is OON → the provider must submit a new request

Requests for Dental Care

Silverback will review requests for dental and oral surgery that are for treatment of **medical conditions**. Dental procedures are not covered. Examples of non-covered services are items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

Covered services listed below are reviewed by Silverback and are covered if criteria are met:

- **Dental Services or Oral Surgery**
    - Setting of the jaw or facial bones (includes wiring of the teeth when performed in connection with the reduction of a jaw fracture)
    - Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor
    - Extraction of teeth to prepare the jaw for radiation treatments of neo-plastic disease
    - Reconstruction of the jaw when medically necessary
    - Inpatient hospital services in connection with dental services if underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization
    - Insertion of metallic implants if implants are used to assist or enhance the retention of a dental prosthetic as a result of a covered service under the member's medical plan
    - Biopsy of gums or soft palate (e.g., for the diagnosis of a suspicious lesion for cancer)
    - Treatment of maxillofacial cysts, including extraction and biopsy
    - Oral or dental examinations prior to Kidney Transplantation or Heart Valve Replacement (but not treatment)
    - Facilities and anesthesia charges in a contracted facility when dental procedure cannot be performed in a dental office due to an underlying medical condition
    - Dentures as part of the prosthesis when dentures or a portion of dentures is integral part (built-in) of an obturator which fills an opening in the palate.

- **Temporomandibular Joint (TMJ)**
  - Oral medications (Member must have Part D plan coverage)
  - Manipulation of the head
  - TMJ devices and supplies
  - Arthrocentesis
  - Treatments such as the injection of corticosteroid, physical therapy, arthroscopy, or arthroplasty
  - Sodium hyaluronate injections

- **Orthognathic Surgery**
  - Repair of maxillary fractures
  - Repair of mandibular fractures
  - Mandibular maxillary osteotomy and advancement for obstructive sleep apnea
  - Genioglossus advancement surgery for obstructive sleep apnea, with or without, hyoid suspension
  - Setting of the jaw or facial bones (includes wiring of the teeth when performed in connection with the reduction of a jaw fracture)
  - Reconstruction of the jaw or facial bones as part of a facial tumor removal
  - Reconstruction of the dental arch and alveolar ridge that is performed as a result of the surgical removal of a tumor

Home Health and DME Requests

Home Health Requests

1. A home health request must come from the servicing home health agency.

2. A home health request will need to have the physician's order. If the physician's order is not included, this may result in a delayed response time.

3. If a provider wants to change the home health agency, a new home health request will be required. Discharge from the previous home health agency on file must be confirmed prior to issuing authorization to a new agency if the dates run concurrently.

4. Silverback processes requests for home health care for the following modalities:
   - PT: Physical therapy
   - OT: Occupational therapy
   - ST: Speech therapy
   - HHA: Home Health Aide
   - MSW: Social worker
   - RN: Skilled Nursing

DME Requests

1. Silverback processes requests for both DME rental and purchase items.
2. A DME request will need to have the physician's order. If the physician's order is not included, this may result in a delayed response time.
3. A DME request should be submitted by the DME provider supplying the equipment.
4. Preauthorization requirements are determined by the prior authorization list. For a prior authorization list and further details, contact the patient's health plan.
5. For health plans that utilize a dollar threshold for precertification requirements, the fee schedule published by CMS is used to determine the billed amount for the requested items.

Invalid Submissions

Any missing required information in order to build or process the request is considered an invalid request. Two outreach attempts, one phone and one written (Fax or Acuity Connect Message), will be made to obtain missing information. We will hold a standard request for 1 calendar day and any expedited request for 4 hours. After that time, if the missing information is not provided, you will resubmit with a new valid request.

Required Information:

1. Patient Information, we must have two identifiers
    a. Name, Patient Date of Birth, Patient Identification Number
2. Providers
    a. Requesting Physician NPI
    b. Treating/Specialist Provider individual NPI or Facility NPI
3. Type of setting
4. Procedure Code (i.e. CPT Code)
5. Diagnosis Code (i.e. ICD-10 Code)

Invalid Member Initiated Organization Determination (MIOD)

For Member Initiated Organization Determination (MIOD), if the required information is not obtained after 3 outreach attempts, one phone and two written. Please note the timeframes to the left based on the priority of the request. After the outreach attempts, if the information is not obtained, the request will be dismissed, and the member will receive the appropriate dismissal letter.

Priority	Time Frame
Pharmacy Expedited	4 Hours
Pharmacy Standard	24 Hours
Precertification Expedited	24 Hours
Precertification Standard	3 Business Days

Adverse Determinations (Denial of Services)

Impending Denial

Prior to denying inpatient services, Silverback will fax a Notice of Impending Denial to the requesting physician. Upon receipt of this notification, the requesting physician must call to schedule the peer to peer before the deadline provided in the letter. To initiate this review, contact the reviewing physician phone number provided in the Impending Denial letter, or compliance at 817-632-2101. If a peer to peer is not requested within this timeframe, it will be assumed the requesting physician has waived the peer to peer opportunity; denial of authorization will be complete, and notices provided.

Please note that for expedited requests, the timeframe for peer to peer review will be shorter due to CMS requirements for member notification within 72 hours from the date/time the request was made.

Denied Services

In the event Silverback denies requested services, denial notification will be faxed to the requesting physician as well as mailed to the member. This notification will include:

- requesting physician's name
- the service(s) being denied
- rationale for denial
- appeal rights, whom to contact and the timeframe for filing. The criteria used to make an adverse determination is available on request.