

Objective:

- I. To ensure appropriate utilization of Tuality Health Alliance (THA) resources, including the resource networks available through Providence Health Plan (PHP) and the Oregon Health Plan (DMAP) as specified by “delegation of Utilization Management activities.”
- II. To simplify the referral/pre-authorization process while providing appropriate service utilization by the member, Primary Care Provider (PCP), and Specialist.
- III. To create a mechanism by which pertinent member information and recommendations will be communicated between the PCP, Specialist, and THA.

Policy:

- I. For the referral to be valid, the member needs to have been evaluated by their Primary Care Physician at some time during the previous twelve (12) months.
- II. For DMAP members the THA PCP/Specialist Communication/Referral Form must be used for all requests for professional consultations or referrals and prior authorization of services. The referral form must be filled out completely and accurately to ensure timely processing.
- III. For PHP Members: All members, qualified member representatives, and/or providers acting on the member’s behalf, have the right to request prior authorization of service. The request can be submitted verbally, followed by all the information necessary to make the determination or written with the information included.
- IV. Providers should submit requests for “urgent” or “expedited” referrals or pre-authorizations to the THA Referral office on the referral form by checking “Expedite” and submitting the form via fax or phone. The THA Referral Specialist, Care Coordination Specialist or THA Case Manager will make a determination following the Timeliness of Referral Policy.
- V. The THA Pre-Authorization list is utilized for all THA lines of business.
 - A. National Guidelines are utilized for establishing medical

appropriateness.

- B. OHP guidelines will be used to confirm that the diagnosis is funded and that the treatment procedures pair with the diagnosis.
 - C. Specific health plan criteria may also be used as a reference.
- VI. Members are not to be seen by a specialist prior to receiving a THA PCP Communication referral/pre-authorization form from the PCP.
- VII. Pre-authorization requests must be current and complete in order to provide timely responses to providers and members. The referral should include (but is not limited to):
- A. Copies of legible office notes, lab or radiology reports, consults, etc. may be used.
 - B. Labs and diagnostics are to be done at TCH unless otherwise approved.
 - C. The member's name and birth date must be clear on all papers.
 - D. A current ICD-9 code that accurately reflects the condition for which the member is being referred and any CPT or HCPCs code(s) if appropriate.
 - E. Upon approval, the following steps are followed:
 - 1. Initial referrals are approved for an evaluation and one follow-up unless specified otherwise.
 - 2. Continuation of the referral depends on prior authorization requirements, medical appropriateness, and benefit restrictions
 - 3. Exceptions may be made with case management review.
- VIII. Authorization numbers are not required for specialists that are Full/Associate or Preferred to see a THA OHP member. Providers shall verify before rendering services that the THA OHP member is eligible for services on the date of the service and that the service to be rendered is covered under the OHP Benefit package of covered services.
- IX. Services that require a prior authorization:
- A. An "out-of-plan" specialist-refers to out of Tuality network
 - B. Requests for procedures on the pre-authorization list.
 - C. Plastic surgery procedures

- D. Neurosurgery procedures
 - E. Outpatient therapies for chronic conditions
 - F. Neuropsychology for any diagnosis other than dementia
 - G. Requests for procedures for members who have DMAP with the Standard Plan Benefit.
 - H. All inpatient procedures
 - I. Blepharoplasty
 - J. Genetic Testing- according to DMAP Guidelines
 - K. Pet Scans
 - L. Hemophilia Factor
 - M. DME equipment not ordered from TMES
 - N. Hysterectomies
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- X. When THA does not have the necessary THA Specialists, out of plan specialists may be considered.
 - XI. Case Managers will review these referrals according to established Referral Guidelines. Authorization numbers will be required for referrals to “contracted extended’ providers. Authorization numbers provide the assurance that the member may be seen by the specialist with no cost to the member.
 - XII. Except for DMAP members (whose benefits are based solely on eligibility dates), approved authorizations are honored for 5 days following issue without regard to retroactive changes in eligibility.
 - XIII. Second Opinion
 - A. The purpose of a second opinion is to obtain more information when indications are not clearly established, or when the indications given for a procedure or treatment do not clearly meet approved criteria.
 - B. When the THA Medical Director requests a second opinion, the PCP will be consulted. The member will be contacted with instructions regarding the process
 - C. The following information may be needed for the appointment:
 - 1. History
 - 2. Laboratory and diagnostic imaging information
 - D. Participating providers must provide this information at no cost to second opinion providers.

- E. If the member's PCP refuses to allow a second opinion, THA Case Management will advocate to the PCP on the member's behalf when possible to facilitate the second opinion as this is the member's right.
 - F. If a THA OHP member so requests, he/she has the right to a second opinion at no cost to them. A THA case manager will assist in coordinating that referral as needed. However it is the expectation that the PCP will work with the member to initiate the appropriate referral. The referral should be clearly marked as a 'second opinion'.
- XIV. Providing services that require preauthorization after hours and on weekends.
- A. If a provider renders services to a member without pre-authorization, in the event of an emergency, that provider may request a retroactive review. The THA Referral Office will need to be notified the next working day. National Guideline criteria will be used (in the case of a procedure or hospitalization) to determine the appropriateness of services rendered when considering the authorization.
 - B. In the event of an emergency THA will authorize one follow-up visit to the physician who provided care in the Emergency Department (ED) for continuity of care or to whom the member was directed from the ED.
 - C. If the service is an out of plan referral for THA-OHP members, and is not emergent, THA reserves the right not to authorize the service. For Providence Health Plan, specific health plan restrictions apply.
- XV. A Notice of Action with Appeal rights is sent to the DMAP member when the determination is made to deny payment for the requested service. Timelines are noted in THA's Timeliness of Referrals and Denial policy.

Refer: THA Policy VI-10 Timeliness of Referrals
THA Policy VI-7 Denials
OAR 410-141-0420
42 CFR 438.206 (b)(3)
42 CFR 438.210(d)
42 CFR 422.568
THA DMAP 2010 Contract Exhibit B Part 1 Section 3

Subject: Member Pre-Authorization

Page 5 of 5

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THA Plan Director

THA Medical Director