Prior Authorization for Specific Services

- Authorizations allow us to verify eligibility, assess medical necessity, establish appropriate location for services and identify members who would benefit from Case Management. It is important for prior authorizations to be accompanied by complete clinical information supporting the specific services being requested.
- The ordering Provider is responsible for obtaining authorization.
- Refer to the Authorization Quick Reference Guide included in both the Medicaid and Medicare Assured℠ HMO Gateway at A Glance for a listing of services which require precertification. NOTE: ALL services provided by a non-participating provider require prior authorization.

Prior Authorization Timeframe – Medicare Assured℠

- Gateway requires that inpatient authorizations be submitted in advance. In the event of an emergency, the authorization must be submitted within three business days of the admission.
- Non-urgent precertification decisions and notifications will be made no later than 14 calendar days from the receipt of the request.
- Urgent precertification decisions and oral notifications are made as urgently as the member’s condition requires.
- Concurrent decisions and oral notifications are made in 1 calendar day from receipt of the request; written notification will follow within 3 calendar days.
- Expedited decisions and oral notification will be made within 72 hours; written notification will follow within 3 calendar days.
- Failure to prior authorize may result in an administrative denial of the claim with no review of medical necessity.
- Retrospective authorization request claims are denied - Authorization not timely.

Prior Authorization Timeframe – Medicaid

- Gateway requires that inpatient authorizations be submitted in advance. In the event of an emergency, the authorization must be submitted within three business days of the admission.
- Gateway makes non-urgent precertification decisions and oral notification within 2 business days from receipt of the request with complete clinical information.
- Urgent decisions and oral notifications are made as urgently as the member’s condition requires, but no later than 3 calendar days from receipt of the request.
- Concurrent decisions and oral notifications are made in 1 calendar day from receipt of the request; written notification will follow within 3 calendar days.
- Please note, if a member is admitted less than 24 hours, prior authorization request is not required for observation.
- Inpatient stays will not be reviewed until after 24 hours have passed from the time that the admission order is written.
Submitting Authorization Requests Electronically Via NaviNet

- Participating providers who currently have access to NaviNet are eligible to submit certain authorizations electronically via NaviNet. Participating provider types who do not have access to NaviNet will have to go through the existing process of submitting authorization requests via phone or fax.
- Failure to prior authorize may result in an administrative denial of the claim with no review of medical necessity.

**Tips for Submitting a Prior Authorization Request**

- Listen carefully to the voice options on phone message.
- Fax number for Utilization Management is 1-888-245-2034 (all states) and must include the following clinical documentation:
  - Demographic information (Name, address, telephone number and date of birth)
  - Other insurance if applicable
  - Type of admission (elective versus emergency)
  - Date and time of admission
  - Diagnosis and surgical procedures (applicable only if surgical admission)
  - Admitting physician
  - History including age and gender, past medical history, treatment as outpatient, treatment in ED with results of labs, diagnostic testing and medications given
  - Signs and symptoms including presenting symptoms, length of symptoms and vital signs
  - Treatment after admission including bed type, admission orders, consultations, diagnostic testing, lab work, medications, X-rays, respiratory treatments, plan of treatment and results of any labs or tests
  - Psychosocial assessment including any behavioral, economic, environmental, medical, social or spiritual problems. Expectation of discharge needs including home health visits, therapy (PT, OT or Speech) needs, IV infusion setup or enteral feeding requirements, durable medical equipment and placement in a skilled nursing facility or rehabilitation facility

**Criteria for Services**

In addition to Medicare National and Local Coverage Determinations, Gateway uses McKesson InterQual criteria and written medical policy. Gateway’s medical policy are available on the website. If a request for a covered service does not meet the criteria requirements, a Gateway Medical Director will review for a medical necessity determination. An opportunity to discuss the request with the Medical Director will also be provided to the ordering physician.

**Ambulance**

Emergency ambulance authorizations are not required.

**Direct Admit**

- The office must have the admission orders when calling for authorization.
- Emergent and/or urgent hospital admissions do not need precertification. The hospital may phone the assigned reviewer with clinical information.
- Gateway utilizes Medicare guidance, InterQual criteria and written policy for precertification. If the RN cannot approve a request with application of criteria, the request is referred to the Medical Director for review.
**Durable Medical Equipment (DME)**
- Prior authorization is required for a rental or a purchase of a single item or multiple quantities of a single item that is $500 or above.
- All equipment being supplied by a non-participating DME provider requires prior authorization.
- The following items also require an authorization: oxygen-oxygen concentrators and stationary oxygen, cough stimulating devices, respiratory assistive devices, total electric hospital beds, heavy duty extra wide hospital beds and powered air flotation devices
- The following information will be needed in order to submit a prior authorization request: DME order, member info, equipment or medical supply (appropriate codes), cost, rental or purchase, amount of items (period of time using) and clinical information to support request.

**Therapy Evaluations and Re-Evaluations**
- An authorization is not required for therapy initial evaluation or re-evaluation for PT, OT and ST. Therapy sessions do require authorization.
- Therapy services are authorized for a specific timeframe. If the service is unable to be performed within the timeframe, the provider will need to call UM or the claim will deny.
- Initial evaluations and re-evaluations cannot be done on the same day that the member also received a therapy service, or the claims will deny.

**Case Management**
- Gateway understands that many factors impact the ability and desire for members to focus on their health. Case Managers intervene with members who have complex medical or social issues.
- Our Case Management Dept. has expertise in the following areas: Oncology, Medically Fragile Children, Medical/Surgical, HIV/AIDS, Obstetrics and MH/MR. Case Management services are available to assist in the care of any member, regardless of diagnosis.

**Coordination of Care**
Communication with the PCP is critical for overseeing patients care. Hospitals and specialists must send all records and test results to the member’s PCP.

**Maternity**
Maternity Outcome Authorization Form to be faxed to 1-855-888-8252. The form notifies Gateway UM that a Mom has delivered and helps to ensure payment for delivery charges. UM responds by faxing the form back to the hospital with an authorization number to cover the delivery.