

PRIOR AUTHORIZATION & REFERRALS

PRIOR AUTHORIZATION FOR MEDICAL SERVICES

MEDICAL REFERRALS OR PRIOR AUTHORIZATIONS

Phone: 414.847.1776 or 888.999.2404

IVR: 414.847.1790

BEHAVIORAL HEALTH PRIOR AUTHORIZATION: 877.491.0322 (*see Behavioral Health section of this manual for details*)

Abri utilizes Medicaid and Milliman Care Guidelines[®] in the administration of utilization management as well as other evidence based best practice guidelines.

UM POLICIES FOR REFERRALS

Abri believes that establishing a relationship with a primary care physician (PCP) who becomes the common point in a member's health care provides better quality of care. The PCP is then in the best position to evaluate all care that a member is receiving from various specialists and not only prevent duplication of services but be able to see the whole picture and help ensure that problem areas are being addressed. Requiring referrals for most specialist services helps to create that common point in the PCP.

Please note that: ***Requests for retroactive referrals will not be approved.***

Referrals are generally required for specialists prior to performing services except in the following instances:

- Abri female members may self refer to an in-network OB/GYN provider for routine annual gynecological exams, pregnancy and any other OB/GYN medical related issues or may select an OB/GYN as a Primary Care Physician.
- Abri female members may self refer to any Medicaid Family Planning provider.
- Chiropractic services do not require a referral.
- Dental services do not require a referral except for oral surgery or other services specified in the DentaQuest contract.
- Routine vision services do not require a referral.
- In certain situations specific provider contracts either waive or contain different rules for referrals. If you are unsure about your particular contract, please call Provider Relations at 414.847.1776.

All referrals must be initiated by the member's primary care physician (PCP), regardless of whether or not the specialist being referred to is within or outside of the PCP's office except in the following instances:

- OB-GYNs may refer for genetics or perinatology services.
- OB-GYNs operating in a PCP capacity may refer to other specialists.

NOTE: While no actual referral is *required* for pregnancy we ask that you call and notify us as soon as possible in the member's pregnancy so that we can initiate pre-natal Case Management services. This will also allow us to put in a tentative authorization for the estimated date of delivery. Abri is committed to working with you and our members to ensure healthy birth outcomes. At the end of this user manual section, is a ***Pregnancy Notification Form***. Please complete and fax to Abri at 414.847.1778.

No requests for referral or prior authorization are approved immediately. All requests are reviewed prior to determination of approval. You may be required to submit medical records.

REFERRALS TO PHYSICIANS WITHIN CONTRACTED NETWORKS

Most referrals will be approved for a maximum of six visits, not to exceed six months.

Dermatology and Genetics or Perinatology referrals will be approved for a maximum of three visits with a six-month maximum. If more visits are requested, a treatment plan must be submitted for review by Abri's Medical Director.

The diagnosis must be consistent with the type of specialist to whom the referral is written.

Dietary consultations will be approved with a PCP's written order for five visits for a maximum of six months. If more visits are requested, a treatment plan must be submitted for review by Abri's Medical Director.

OUT OF NETWORK REFERRALS

Abri believes in preserving continuity of care for our members and providing them with the most appropriate specialty services. Referrals to non-network physicians are normally considered for approval in the following instances:

The out of network physician performed prior medical care, which, necessitates that the same physician provide the follow-up care.

OR

There are no in-network member physicians that can provide the necessary service(s).

Call us if you have any concerns or you would like us to consider an out of network referral based on your patient's special needs at 414.847.1776 or 888.999.2404 and select the Medical Management option.

UM POLICIES FOR PRIOR AUTHORIZATION

Prior authorization/notification is required for all elective and non-emergency hospital admissions including obstetrical deliveries by the second trimester if feasible. Emergency admissions should be reported within 48 hours after admission. For elective admissions please notify us at least 5 days in advance, if possible.

In addition, the following day surgery and outpatient procedures must be prior authorized:

Arthroscopy	IntraVenous ImmunoGlobulin (IVIG) Therapy
Colonoscopy	Plasmapheresis
Dental Surgery in a hospital setting	PT, OT, ST after initial patient evaluation
Dialysis	Rhinoplasty
Endoscopic sinus surgery	Septoplasty
EGD (esophogogastroduodenoscopy)	Sleep study
Frenotomies (tongue clipping)	Sterilizations
Gastric bypass surgery	Tonsillectomy/adenoidectomy
Hernia repair over age 16	Tubal ligation in conjunction with delivery
Home health care	Tympanostomy
Hysterectomy	

The following items must also be prior authorized:

- Home Health
- DME Services or Purchase or total rental of an item that will equal or exceed \$1000
- Chemotherapy Supplies
- Oxygen or Related Supplies
- Synagis administration in home or office

Services that require prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for non-emergency services. Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the provider office. If coverage is denied, the treating Provider may be financially responsible.

State required consent forms for procedures resulting in sterilization must be submitted with the request for prior authorization.

Criteria for common procedures and services requiring prior authorization follow but are not meant to be an all inclusive list. Abri does not require prior authorization on as many services as Fee for Service Medicaid. However, Abri applies the same criteria and determination of medical necessity for approval of those things that it does require prior authorization on as Fee for Service Medicaid.

SPECIAL REQUIREMENTS FOR REDUCTION MAMMOPLASTY

Prior approval from the Abri Medical Director and documented medical necessity is required for a reduction mammoplasty. A letter from the surgeon or PCP must be submitted to the Medical Director including documentation that the member meets all five criteria listed below.

- Bra shoulder strap pain
- Inability to fit into clothes
- Backache
- Maceration of skin
- That at least 300gms of tissue will be removed from each breast

Pictures must accompany authorization request. This information will be reviewed by the Abri Medical Director who may make the decision or refer the case to the Medical Review Committee for a decision.

REQUIREMENTS FOR PRIOR AUTHORIZATION OF A MOTORIZED WHEELCHAIR OR SCOOTER

Abri conforms to the Prior Authorization Guideline Manual published by the Department of Health and Family Services, which regulates Medicaid services when considering requests for prior authorization of a motorized wheelchair or scooter. The following requirements must be met before approval.

Approval Criteria for a scooter includes:

1. At least one of the following diagnoses or clinical conditions
 - Arthritis – Rheumatoid
 - Cerebral Palsy
 - Friedreich's Ataxia
 - Multiple Sclerosis
 - Muscular Dystrophy
 - Poliomyelitis
 - Quadraplegia

2. The request must indicate that the recipient has severely involved upper and lower extremities with muscle strength below fair range, severe spasticity or nonfunctional range of motion.
3. The request indicates that the recipient is involved in regular educational, vocational or volunteer efforts including sheltered workshops.
4. The request indicates that the recipient can be expected to use a power wheelchair/power operated vehicle indefinitely.
5. The request suggests that provision of the requested wheelchair/power operated vehicle will prevent institutionalization by providing independent mobility within the home and community.
6. The request indicates that the provision of this wheelchair/power operated vehicle will eliminate the need for continuous attendant care.
7. The request indicates that the recipient has had a trial period (or past use of) the power wheelchair/power operated vehicle and can maneuver the power wheelchair/power operated vehicle independently.
8. The request suggests that the recipient's home is accessible.
9. The request suggests that the recipient has a means of transportation for the power wheelchair/power operated vehicle.

Denial Criteria for a scooter includes:

10. The prior authorization request does not meet Approval Criteria #1, 2, 4, 7, 8 and 9 and either 3, 5 or 6.
11. The request does not provide sufficient medical facts to support the medical necessity for a power wheelchair/power operated vehicle.

REQUIREMENTS FOR PRIOR AUTHORIZATION OF A GASTRIC BYPASS OR RELATED SURGICAL PROCEDURES

Abri conforms to the Prior Authorization Guideline Manual published by the Department of Health and Family Services, which regulates Medicaid services when considering requests for prior authorization of a gastric bypass or similar surgical procedures. The following requirements must be met before approval

Approval criteria for gastric bypass surgery includes:

- Candidate has a BMI of 40 or greater **OR**
- The BMI is between 35 and 39 with documented high-risk, co-morbid medical conditions that have not responded to medical management and are a threat to life, such as but not limited to: clinically significant obstructive sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy, coronary heart disease, or medically refractory hypertension.
AND

- The candidate has attempted weight loss in the past without successful long-term weight reduction. These attempts may include, but are not limited to, diet restrictions/supplements, behavior modification, physician supervised plans, physical activity programs, commercial or professional programs, pharmacological therapy, etc.
AND
- All candidates should have clinically documented evidence of a minimum of six months of demonstrated adherence to a physician-supervised weight management program including at least three consecutive months of participation in a weight management program prior to the date of surgery in order to improve surgical outcomes, reduce the potential for surgical complications and establish the candidate's ability to comply with post-operative medical care and dietary restrictions. A physician's summary letter is not sufficient documentation. Documentation should include assessment of the patient's participation and progress throughout the course of the program. The patient must also agree to attend a medically supervised post-operative weight management program for a minimum of six months post surgery for the purpose of ongoing dietary, physical activity, behavioral/psychological, and medical education and monitoring.
AND
- The candidate should receive a pre-operative evaluation by an experienced and knowledgeable multidisciplinary bariatric treatment team composed of health care providers with medical, nutritional and psychological experience.

This evaluation should include at a minimum all of the following:

- a complete history and physical examination, specially evaluating for obesity-related co-morbidities that would require pre-operative management.
- evaluation for any correctable endocrinopathy that might contribute to obesity
- psychological/psychiatric evaluation and clearance to determine the stability of the patient in terms of tolerating the operative procedure and post-operative sequelae, as well as the likelihood of the patient participating in an ongoing weight management program following surgery.
- patients receiving active treatment for a psychiatric disorder must receive evaluation by their treatment provider prior to bariatric surgery, and be cleared for bariatric surgery.
- dietary assessment and counseling.

AND

The recipient must be 18 years of age or older and have completed growth.

Denial Criteria for gastric bypass surgery includes:

- Does not meet the Approval Criteria as determined by Abri's Medical Director.
- The following procedures are considered investigational, inadequately studied or unsafe and will not be covered:
 - gastric balloon
 - biliopancreatic bypass
 - biliopancreatic bypass with duodenal switch
 - loop gastric bypass

EMERGENCY OR URGENT AUTHORIZATIONS

In an **emergency** situation, the need to prior authorize services is waived. An Emergency is defined as treatment to ameliorate pain, infection, swelling, uncontrolled hemorrhage and traumatic injury that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment or would place the person's health in serious jeopardy. These services will be reviewed retrospectively for medical necessity.

EMERGENCY ADMISSIONS

Emergency admissions, defined as those situations in which the patient requires immediate medical intervention, do not require prior authorization. However, Abri should be notified by the admitting hospital within 24 hours following admission or by the next business day if on a weekend or holiday.

Abri should be notified within 24 hours of an emergency admission or by next business day by the admitting physician. Information required includes:

- Patient's name and member number
- Admitting diagnosis
- Treatment plan
- Date of Admission

Emergency review will be done retrospectively at the time the admission review is done by the Medical Services staff.

After review, the Medical Services staff will determine if:

- There is criteria compliance
- Criteria compliance is questionable
- The review gives evidence that criteria has not been met for admission

In cases where the criteria are met, the Medical Services staff may authorize the admission. This information is relayed to the admitting physician and hospital.

In cases where criteria compliance is questionable or not met, the Medical Services Department contacts the admitting physician for further information. If, after speaking with the admitting physician, criteria are still not met, the case is referred to the Abri Medical Director who will discuss the case with the physician personally.

Final determination is made by the Abri Medical Director.

PRIOR DAY ADMISSIONS

Day prior admissions for procedures are **not** a covered benefit unless the physician can document an expected **improved outcome** from the day prior admission. Requests for day prior admission are evaluated on a case-by-case basis by Abri. The admitting physician must provide supporting documentation. If the extra day meets designated criteria for inpatient stay, the day prior to admission will be approved. If the extra day does not meet the designated criteria, the Abri Medical Director will review the request and make a final decision.

DELIVERY AND LENGTH OF STAY

Postpartum length of stay is based on the type of delivery and other services provided. Postpartum discharge will be routinely assumed to occur at two days for vaginal delivery, and at four days for cesarean delivery. Postpartum tubal ligations should be done within 24 hours of delivery. Total length of stay for delivery with postpartum tubal ligations should not exceed 48 hours.

HOME VISIT FOR ONE-DAY OB STAY

When the length of stay for an OB delivery is only 1 day for a normal uncomplicated vaginal delivery or only 3 days for an uncomplicated cesarean delivery, pediatricians, family practitioners, or obstetricians must order follow-up in-home visits for baby and mom. The home visit will consist of a maternal/child assessment of both mom and baby and education on baby care.

REFERRAL OR PRIOR AUTHORIZATION SUBMISSION

If a referral is required for the services desired, it must be made to specialists within the same network as the Primary Care Physician. If the desired specialty is not located within that network, or for other out-of-network referrals, contact Abri Medical Services for assistance 414.847.1776 or 888.999.2404.

Please note that: ***Backdated referrals are not permitted.*** Primary Care Physicians must submit referral information in a timely fashion to allow for processing time. Unless a referral is not required in a specific situation, specialists may not see members without an approved referral. Please see UM Policies for Referrals.

Abri has contracted with certain providers for ancillary medical services which must be used. The use of these providers enables the provision of quality, cost effective care. A listing is provided in this manual for your convenience. All providers may be found in the Abri Provider Directory or on the website: www.abrihealthplan.com.

Providers may also call Customer Service at 414.847.1776 or 888.999.2404 to obtain information on providers.

Referrals or Authorizations may be submitted by utilizing Abri Health Plan's Interactive Voice Response (IVR) system using a touch-tone phone. Please refer to the IVR section included in this manual, or the Abri Health Plan website www.abrihealthplan.com, for complete instructions. The IVR line is 414.847.1790 and is active 24 hours a day.

All Referrals and Authorizations will be reviewed by the Medical Management staff using criteria established by State of Wisconsin Medicaid guidelines, Milliman Care Guidelines and Abri Policy. If documentation is incomplete, the request for authorization will be denied administratively. ***You must receive confirmation of approval prior to performing a service.***

The referral or authorization will be approved as a covered benefit if the requested service and submitted documentation is consistent with clinical guideline. If the requested service requires the determination of medical necessity or the appropriateness of care, the request will, on the same day, be referred to one of Abri's Medical Directors for review and determination within the next business day. All decisions to deny, or reduce the duration, amount or scope of a requested authorization must be reviewed and signed off by a Medical Director. The Medical Director who makes the decision on a denial or reduction in services will have the appropriate clinical expertise in an area relevant to the member's condition or disease.

TIME FRAMES

Referral requests should be made 2 to 3 working days prior to a scheduled appointment.

Authorization requests should be made 7 to 10 working days prior to an elective admission or outpatient procedure, and within 24 to 48 hours after emergency admissions.

If expedited service is required for either a referral or authorization, please call Abri at 414.847.1776 and let us know.

Determination will be made within 2 business days unless the nature of the admission or procedure requires review of medical records. The Medical Management staff will make every effort to expedite the review process and many times determination will be made the same day as the request.

Urgent prior authorization requests will be determined and the provider notified within one calendar day. (NCQA standard UM 4.1.4)

Urgent or **Emergent** Prior Authorizations, unless defined otherwise by a state are defined as those requests for services to treat situations which involve the resolution of acute pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person, or
- Serious disfigurement of such person.

NOTIFICATION

The outcome of the reviews will be communicated by Abri in writing to the Provider within two (2) business days. This communication will also contain information on Provider appeal rights. The criteria used for determination of medical necessity will be clearly documented in the notification letter to the provider and member. For any services that are denied or reduced, Abri's Medical Director will review and sign off on the request.

Abri sends a denial letter to the Member, within two (2) business days, and it states clearly the reason for the denial and all Member appeal rights. This includes but is not limited to filing a complaint, grievance or a request for a State Fair Hearing, if applicable. This letter comes from the Abri Medicaid Advocate.

Abri sends a denial letter to the Provider requesting the referral or prior authorization, within two (2) business days, and it states clearly the reason for the denial and outlines the Provider's appeal rights. This includes but is not limited to submitting an appeal (in writing) to the Department of Health Services (DHS). This letter comes from the Director of Provider Relations.

The criteria used to determine medical necessity is determined by current Prior Authorization Guidelines published by Wisconsin Department of Health & Family Services and defined in HFS 101.03 (96m) as a medical assistance service under ch. HFS 107 that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
 - Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
 - Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
 - Is appropriate with regard to generally accepted standards of medical practice;

- Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
- Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
- Is not duplicative with respect to other services being provided to the recipient;
- Is not solely for the convenience of the recipient, the recipient's family or a provider; With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
- Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Abri shall provide to the Provider and the Member, upon request, a copy of the review criteria utilized in benefit determination and the qualifications of the medical professional that made the determination to deny it.

No requests for referral or prior authorization are approved immediately. All requests are reviewed prior to determination of approval. You may be required to submit medical records.

RETROSPECTIVE REVIEW OR POST SERVICE

All urgent or emergent prior authorization will be reviewed retrospectively.

The Provider must send in the appropriate documentation marked "Retrospective Review" along with all necessary documents to be reviewed after treatment has been provided. The retrospective review is completed by the nurse to determine coverage and to certify that the services were urgent or emergent in nature. The clinical criteria utilized in the retrospective review are the same criteria utilized in the prior authorization process to determine medical necessity and appropriateness of care. All decisions to deny, or reduce the duration, amount or scope of a requested authorization must be reviewed and signed off by a Medical Director. The Medical Director who makes the decision on a denial or reduction in services will have the appropriate clinical expertise in an area relevant to the member's condition or disease.

TIME FRAMES FOR RETROSPECTIVE REVIEW OR POST SERVICE

All retrospective reviews shall be determined within thirty (30) business days from the initiation of the UM process unless a more stringent standard applies per regulation. Provider notification of denied or reduced determinations will be made within two (2) business days of the decision by Abri.

CHECKING THE STATUS OF A REFERRAL OR AUTHORIZATION

Prior to receiving notification, the PCP or person requesting Authorization may call Abri Health Plan at 414.847.1776 or 888.999.2404 and speak with the Customer Service Staff. Status of submitted Referrals and Authorizations can be obtained through the IVR system by entering the Referral or Authorization number. Please refer to the IVR section of this manual or the Abri Health Plan website www.abrihealthplan.com for complete instructions.



PREGNANCY NOTIFICATION FORM

Please Fax to 414-847-1778
Attention: RN Case Manager

Member Information

Last Name: First Name: DOB: ID#:
Address: City: Zip: Phone #:
Date of Initial Prenatal Visit: Completion date of Pregnancy Form:

Current Pregnancy

Gravida Para LMP EDC Blood Type
Multiple Gestation this pregnancy
Maternal age <= 16 years
Maternal age >= 35 years of age

Previous Pregnancies

Multiple Gestations previous pregnancy Previous C-Section Hx of Placenta Previa
Hx of SAB/TAB/Fetal Demise Preterm Labor/Delivery Hx of Post Partum Depression
Week of demise Week of delivery

Medical History (Check all that apply)

- Cardiac Disease (Current/Past) Clotting Disorders (Current/Past) Diabetes/Gestational Diabetes (Current/Past)
HIV Testing (Current/Past) Hypertension or PIH (Current/Past) Incompetent cervix (Current/Past)
Mental Illness (Current/Past) Neurologic Disorders (Current/Past) Respiratory Conditions (Current/Past)
Sickle Cell Anemia (Current/Past) STD (Current/Past)

Psycho/Social Issues (Check all that apply)

- Drug Abuse(Current/Past) Alcohol Abuse (Current/Past) Smoker (Current/Past) Domestic Abuse (Current/Past)
Housing Issues Lack of Support System

Prenatal Care and Nutrition (Check all that apply)

- Missed several medical appointments Currently Enrolled in WIC

Description of above or other unlisted conditions:

List of Medications:

Provider Information

Provider Signature Provider Printed Name
Provider Address Provider Phone #
Delivery Hospital Provider Fax #



ABRI AUTHORIZATION FORM

Date: _____

Patient Name: _____

Patient ID #: _____

Referred By (PCP): _____

Phone: _____

Fax: _____

Referred To (SPEC): _____

Requested Dates: From: _____

To: _____

Units/Visits: _____

Diagnosis (ICD-9): _____

Procedure (CPT/HCPCS): _____

Type of Authorization:

- | | | |
|--|---|---|
| <input type="checkbox"/> 23 Hour Observation | <input type="checkbox"/> Pre-Authorization | <input type="checkbox"/> Subacute Admission |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Referral | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Maternity | <input type="checkbox"/> Second Opinion | |
| <input type="checkbox"/> Outpatient Surgery | <input type="checkbox"/> Skilled Nursing Facility | |

The following authorizations require the additional documentation listed to be faxed along with this form:

- Diagnostic Procedure - Physician Order
- Durable Medical Equipment (Purchase or Rental) - Physicians Order & State Prior Auth/Oxygen Attachment
- Durable Medical Equipment (Repair) - Work Order
- Home Health - 485 Form
- Hospice - State Physician Certification & Recertification of Terminal Illness
- PCW - PA/RF & HCAF & 485 & PCW Instructions
- Rehabilitation - Physician Order & Initial Evaluation
- RN Supervisory - PA/RF & HCAF & 485 & PCW Instructions
- Therapy (PT/OT/SP) - Physician Order & Initial Evaluation

FAX Form and other pertinent documents to IPN at (414) 771-1159

Please Note:

- All authorizations must be faxed to Abri and approved before services are provided.
 - All requests for out of network authorizations must be faxed to Independent Physicians Network at 771-1159 prior to services being rendered.
 - A authorization does not guarantee coverage beyond Abri Benefit Contract Terms.
 - Benefits are dependent on member eligibility on the date of service.
-

*****For Abri Use Only*****

Authorization Approved: _____ Yes _____ No Date Approved/Denied: _____ Initials: _____

Approved Authorization Confirmation # _____ Authorization Expiration Date: _____

Reason for Denial: _____

Fax Number Confirmation Sent To: _____ Date: _____ Initials: _____

(No authorization may exceed six months from date authorized)