Point32Health



Navigating the prior authorization process

Quick Reference Guide

Our utilization management (UM) program helps ensure members receive medically necessary care that is consistent with clinical guidelines and aligns with their health plan benefits. We also aim to make it as easy as possible to work with us to provide members with the care they need. This flyer walks you and your office staff through the prior authorization (PA) process step by step.

Tips for a smoother PA experience

We'll delve into this in greater detail below, but here are some quick tips to keep in mind.

- **Gather information:** Verify patient eligibility, benefits, and prior authorization requirements.
- **Review applicable medical necessity guidelines (MNGs),** as these policies outline clinical coverage criteria.
- **Collect required information to document medical necessity** (ex: patient information, medical history, clinical notes, photographs, elements of the medical record, etc.)
- **Submit your request electronically.** Use our electronic tools — including our secure portals HPHConnect and the Tufts Health Plan secure portal and MHK for speed and efficiency whenever possible.
- **Include all required information** to enable us to review the PA request:
  - Be sure all fields on the intake form are complete.
  - Include the correct NPI or TIN.
  - Add all appropriate clinical documentation.
  - If an InterQual Smartsheet is available, complete that electronic questionnaire.
- **Allow for adequate review and response time.** Submitting duplicate requests may delay processing times.

Read this article from *Insights and Updates for Providers* for additional information and best practices about Point32Health's UM program.

Getting started: Understanding PA requirements and policies

It's important to understand which services require PA, and our Medical Necessity Guidelines (MNGs) are the primary source for that information. Our Provider Manuals, prior authorization grids, and vendor program resources also offer important PA information.

Medical necessity guidelines

Our MNGs document if PA is required and the clinical criteria for coverage. Our internal clinical team or one of our vendor program partners use MNGs in their review of PA requests to help make coverage decisions.

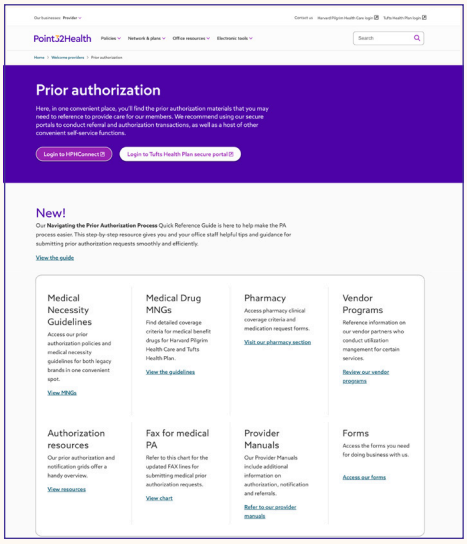
We group MNGs in three buckets:

- Medical Necessity Guidelines Criteria for medical and behavioral health services.
- Pharmacy Medical Necessity Guidelines Criteria for drugs covered under the member's pharmacy benefit.
- Medical Drug Medical Necessity Guidelines Criteria for provider-administered drugs covered under the member's medical benefit.

To review the applicable MNG to ensure that you are aware of the clinical coverage criteria – including variations by plan/line of business or state – and any PA requirements, visit the Policies & Forms section of the Point32Health provider website. Our policy pages allow you to filter results by line of business and include a search bar where you can search by name of the service, code, or brand or generic drug name or generic name of a drug.

One handy spot! Looking for links to our various PA resources?

We've gathered those in one handy place. Visit our Prior Authorization overview landing page for quick navigation to all the resources noted here and more!



Other resources

- Provider Manuals Our Provider Manuals include important notification and PA information, including requirements, process and timelines, and more.
- Prior authorization grids These handy grids give guidance on services that require prior authorization and notification by Plan. These lists and grids are meant as a resource to assist providers and may not note all services requiring authorization.

Vendor programs

For some services, we work with trusted vendors to conduct utilization management. These partners bring specialized expertise that helps improve quality and efficiency.

In most cases, vendors maintain the clinical coverage criteria, which is accessed on their websites or secure portals, and authorization requests must be directed to them.

Review the Vendor programs page on the provider website for details about our current vendor programs, including an overview of the services that the vendor reviews, information on requesting PA through the vendor, and links to their websites/resources.

Submitting Prior Authorization Requests

If PA is required, you'll need to submit a PA request to us or to one of our vendor programs. Before submitting the request, collect any required information and documentation to demonstrate the services meet the medical necessity criteria documented in the MNGs. This may include patient information, medical history, clinical notes, photographs, and other elements of the medical record.

Preferred option: electronic submission

We encourage you to submit PA requests electronically for speed, ease, and efficiency. The primary channels for electronic PA requests for medical and behavioral health services are:

HPHConnect	Use HPHConnect to submit PA requests for medical and behavioral health requests members of Harvard Pilgrim Health Care plans.
Tufts Health Plan secure Provider Portal	Use THP secure Provider Portal to access MHK the prior authorization transaction service/portal for medical and behavioral health requests for Tufts Health Plan members for all products other than Tufts Health Senior Care Options (SCO).
Electronic Data Interchange (EDI)	Submit authorization requests and receive instant confirmation of receipt by EDI for Harvard Pilgrim Health Care and Tufts Health plans.
PromptPA	Utilize PromptPA to make PA requests for pharmacy and medical drugs for all Harvard Pilgrim Health Care and Tufts Health Plan members.
Vendor sites	Each vendor program utilizes its own direct portal to submit prior authorization requests. For most of these programs, you can access the vendor site via single sign on through the HPHConnect and Tufts Health Plan secure portals.

If you need to change your authorization request

Submit a new prior authorization request to us if there are any changes to a service that we've already authorized, for example a change in the procedure code, units of service, or date of service.

If the details on an approved authorization do not match the services billed on a claim, the claim may deny.

Go to the Provider training guides page to find user guides that offer step-by-step instructions for submitting PA request via HPHConnect and the Tufts Health Plan secure portals!

InterQual Medical Review

We use InterQual medical review as part of our UM process for certain services, as documented in the service's MNG. Embedded within HPHConnect and the Tufts Health Plan secure Provider Portal, InterQual allows you to review criteria and complete a medical review questionnaire, called a SmartSheet, to process the medical review. If medical necessity can be determined from the answers, you receive instant PA approval. If not, the request pends and you may upload clinical documentation for further review.

Submit by fax

While we strongly encourage electronic submission, you may opt to submit by fax.

- **Medical and behavioral health services**
  - Go to the Forms page on the provider website to locate the correct behavioral health or medical service prior authorization form.
  - Review this Fax lines flyer to find the correct fax number for the service and member's plan.
- **Pharmacy and medical drug services**
  - Go to the Requesting authorization for pharmacy and medical drugs page on the provider website to find the forms and fax numbers for the member's plan.



Tracking the status of your PA request

Our UM teams begin their review when we have received all medical information needed to evaluate the PA request. We make decisions in a timely manner that accommodates the clinical urgency of the care and are consistent with applicable state regulations. Please allow for adequate review and response time. Our Provider Manuals list response time by product and service type if you need more specifics.

The easiest way to track the status of a PA request is via our secure provider portals.

If your PA request is approved, be sure the date of services falls within the date span on the approved authorization. If a request for coverage is denied, you have the right to initiate a UM appeal – also referred to as a clinical appeal or pre-service appeal – to have the denial reconsidered. This is a formal request for a second review of the decision. For information on the UM appeals process, please refer to the Understanding the utilization management appeals process flyer.

For help with anything you're unable to do using our self-service tools, please contact the appropriate Provider Service Center listed on the Key contact information for providers page of the provider website.