Prior Authorizations with InterQual Integration

May 2018 Webinar
Class Description

• This class will provide general information regarding the prior authorization process when InterQual integration is required.

• Prior authorizations related to behavioral health, dental, DME, therapy (OT/PT/ST), pharmacy and waiver are not included.

• Recommended audience: all providers who request prior authorizations through the OHCA medical authorization unit.
Disclaimer

• SoonerCare policy is subject to change.

• The information included in this presentation is current as of May 2018.

• Current information can be found on the OHCA public website: www.okhca.org.
Agenda

- Steps before submitting.
- **InterQual integration.**
  - About InterQual.
  - Prior authorization submission.
- Reminders.
- Resources.
Steps Before Submitting

• Check the member’s eligibility.
• Verify if the procedure requires a prior authorization.
• Review guidelines for the requested service.
Steps Before Submitting

• Determine if OHCA forms or specific documentation is required for the PA review.

• Locate other additional supporting documentation.

• Make sure all documents are in electronic format and meet file size and file type requirements.
InterQual Integration
InterQual Procedure and Imaging Criteria
About InterQual Criteria

InterQual criteria:

• Are the most widely used tools in the industry for providers, health plans, payers and government entities.

• Are evidence-based, clinical content that help determine medical necessity of care and treatment.

• Support clinical rationale for decision-making.

4,600+ hospitals

Nearly 300 health plans
Procedures and Imaging Criteria

• InterQual imaging criteria support reviewers’ decisions about the appropriateness and optimal sequencing of imaging studies.

• InterQual procedures criteria support reviewers’ decisions about the appropriateness of surgical and invasive procedures.
Questions Answered by Criteria

Criteria help answer questions like these:

• Is the proposed procedure or imaging study the most appropriate intervention for the patient?
• Is a more cost-effective or less risky intervention appropriate?
• Was conservative therapy attempted, if indicated, prior to performing the requested intervention?
• Is the timing or sequencing of the intervention appropriate?
The Question and Answer Format

• Criteria in a Q&A format are presented in a series of simple, rules-driven questions.

• Answers to questions about the patient’s clinical presentation lead to the recommended imaging study or studies.

• Recommendations are based on the best available medical evidence and current clinical practice for the clinical scenario presented.
InterQual Integration

• OHCA has implemented InterQual guidelines in the current prior authorization request process.

• InterQual evidence-based questions and answers will be embedded into the SoonerCare provider portal prior authorization function.

• This will help to automate the prior authorization process by shortening the average review time.

• The current implementation phase began with total knee and hip arthroplasty surgeries.
Prior Authorization Submission
Prior Authorization Submission

Select the prior authorizations tab.
Prior Authorization Submission

Create authorization – select medical.
Prior Authorization Submission

Requesting provider information – this section automatically populates the provider logged in.

Member information – enter the SoonerCare member ID.
Prior Authorization Submission

Service Provider Information

Service Provider may be required depending on the type of Assignment Code selected. To use a new service provider, enter either a valid NPI or SoonerCare Provider Number. To use an existing Service Provider and have the fields auto-populate, either click the Service Provider same as Requesting Provider checkbox or select a provider previously saved to the favorites list using the Select from Favorites dropdown. To add a new provider to the favorites list, click the Add to Favorites checkbox. Service Provider is required, the servicing provider cannot be a group, clinic or PLLC, etc., or the PA will be denied. To use a new service provider, enter either a valid NPI or SoonerCare Provider Number. To use an existing Service Provider and have the fields auto-populate select a provider previously saved to the favorites list using the Select from Favorites dropdown. To add a new provider to the favorites list, click the Add to Favorites checkbox.

Service Provider same as Requesting Provider
No favorite providers available.
Provider ID
ID Type
Name
Add to Favorites
Zip Code
Contract Code
Taxonomy
SC Provider Number

Service Provider Information is only required for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), home health, hospice, specialized nursing and vision care services. All other types must be left blank.
Prior Authorization Submission

- Assignment code – select the appropriate assignment code.
- Managed care, fund and letter – leave blank.
Prior Authorization Submission

Diagnosis code – enter the primary ICD-10 diagnosis code without the decimal point, then click add.
Prior Authorization Submission

From date and to date – enter the date range.

- Therapy – no retro.
- Imaging – MRA, MRI, CT and PET, three day retro only.
- All other services – 30 day retro.
• Code type – select procedure code or revenue.
• Code – enter the procedure code.
• Thru code – allowed only for enteral formula B4149-B4162.
Modifiers – use appropriate modifiers, if applicable. Up to four modifiers can be entered.

- If using a TC and 26 modifier, two separate lines must be submitted. First line – enter the code with the TC modifier. Second line – enter the same code with the 26 modifier.

- TC/26 modifier entered on the same line item of the PA will cause claims to deny.
Prior Authorization Submission

- Units – enter the number of units.
- Remarks (optional) – for items listed as miscellaneous, enter the line item and description in the remark field. If uploading electronic documentation through the provider portal, enter a contact name and phone number.
Prior Authorization Submission

- Attachments – click the + sign to designate how the attachments will be sent.
- Attachments must be added before the first service line.
Transmission Method:

EL = Electronic Only.

- Accepted document types: JPG, PDF, TIFF and XPS.
- 10 MB upload limit.
- Only the first line item requires attached documents.
Prior Authorization Submission

- **Upload File** – select browse to locate attachments.
- **Description** – enter a brief description of the documentation. Click add.
If the electronic file upload is successfully attached to the PA request, it reflects the transmission method, file and control number.

If additional documents are needed, the system will populate another blank section for documents to be added.
Prior Authorization Submission

Click add service once the documentation is attached and the service detail section is complete.
Prior Authorization Submission

If the code entered requires InterQual review, the page will be directed to the InterQual website.
Prior Authorization Submission

- A warning message will appear. At the end of the review, within the recommendation screen, only one code must be selected.
- Click OK to continue.

Message from webpage

Please only select one code on the recommendation screen, if more than one code is required, you will need to enter that code on another line item.
The procedure code entered in the provider portal is passed into InterQual for review.
Prior Authorization Submission

Select the version from the results list.

<table>
<thead>
<tr>
<th>Subset</th>
<th>Product</th>
<th>Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Replacement, Wrist (Custom) - HCA</td>
<td>CP:Procedures</td>
<td>Client Defined 2017.2</td>
</tr>
<tr>
<td>Reconstruction, Temporomandibular Joint (TMJ) (Custom) - HCA</td>
<td>CP:Procedures</td>
<td>Client Defined 2017.2</td>
</tr>
<tr>
<td>Removal and Replacement, Total Joint Replacement (TJR), Hip (Custom) - HCA</td>
<td>CP:Procedures</td>
<td>Client Defined 2017.2</td>
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<tr>
<td>Removal and Replacement, Total Joint Replacement (TJR), Knee</td>
<td>CP:Procedures</td>
<td>Client Defined 2017.2</td>
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<tr>
<td>Removal and Replacement, Total Joint Replacement (TJR), Shoulder</td>
<td>CP:Procedures</td>
<td>Client Defined 2017.2</td>
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<tr>
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<tr>
<td>Total Joint Replacement (TJR), Knee (Custom) - ENT</td>
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</table>
Prior Authorization Submission

- The screen will provide notes about the selected subset.
- Click begin medical review.
Medical Review Questions

Answer the medical review questions based on the clinical scenario:

• Questions address symptoms and findings, prior imaging or testing results and conservative treatment.

• Questions are in yes/no, choose one (radio button) or multiple-choice (choose all that apply) format.

• Follow the rules associated with multiple-choice questions. Rules appear in brackets next to the question.
Medical Review Questions

Answer the medical review questions based on the clinical scenario:

• For questions that require more than one answer, click next to advance to the next question.

• In many questions, the last answer choice is other clinical information (add comment). This answer is only selected when the clinical scenario does not support the other answer choices.

• Reviewer comments can be added during the review to support answer selections.
Prior Authorization Submission

If the save review button is selected during the review, above message will appear. Click OK to continue.
Prior Authorization Submission

If the cancel medical review button is selected during the review, the above message will appear.
Prior Authorization Submission

After all questions have been answered, select the view recommendations button.
Recommendation

Any of the following recommendations may present:

• One imaging study or procedure is recommended.

• More than one imaging study or procedure is recommended, but only one should be selected (mutually exclusive).

• Two or more imaging studies or procedures are mutually recommended.

• Current evidence does not support testing in this clinical scenario.

• A test is flagged as Ltd (limited evidence).
Prior Authorization Submission

Select the procedure within the recommended services box.

Please view the instructions above and make a selection before proceeding.
Prior Authorization Submission

Click the CPT tab and select the appropriate code, then click complete.
Completing the medical review will be locked and no further edits can be made. Click yes to continue.
Prior Authorization Submission

The disclaimer box will appear. Click OK.
Prior Authorization Submission

Click save PA line item.

Please note: if this button is selected prior to clicking the review summary button, the review summary sheet will not be available.
Once the save PA line item button is selected, the page will redirect back to the provider portal.
Prior Authorization Submission

- If additional service codes need to be added, the portal will populate a blank section.
- Select the submit button.
Select the confirm button to submit the prior authorization.
Authorization receipt – the portal generates a prior authorization number and confirms the request submitted successfully. This does not mean the prior authorization is approved.
Reminders
Reminders

• There is a three day retro limitation for imaging.

• There is a 30 day retro limit for all other services.

• Cancelled or denied prior authorization’s are subject to retro limitations and must be submitted as a new request.
Reminders

• Emergent or urgent prior authorizations are medical conditions that are defined as loss of life or limb – not due to a scheduling issue.

• For emergent or urgent prior authorization requests:
  – Submit the prior authorization with supporting documentation.
  – E-mail the MAUAdmin@okhca.org with the subject EMERGENCY PA.
  – Include the prior authorization number, reason for the emergency.
  – Provide a contact name and telephone number.
Reminders

• Prior authorizations cannot have overlapping dates for the same service.

• Diagnostic radiology services for the facility and physician must be submitted on one prior authorization as two separate lines with the appropriate modifiers and units.
Reminders

• Prior authorizations are not required for members with Medicare part A and B if the services are covered and paid by Medicare.

• Services not covered by Medicare are subject to normal OHCA prior authorization requirement restrictions.
Medical Prior Authorization Resources

For medical prior authorization inquiries regarding clinical documentation or urgent requests, please contact MAUAdmin@okhca.org.

*Additional resources are available at www.okhca.org/MAU.*
Portal Resources

For portal related inquiries such as claim submissions or uploading documents, please contact the internet helpdesk at 800-522-0114 option 2,1.
Claims Resources

For claim adjudication or policy inquiries, please contact OHCA provider services at 800-522-0114.