Ascension
Personalized Care

Ascension
Care Management

Prior Authorization Requirements

Utilization Management Program

Ascension Personalized Care Utilization Management (UM) Program is designed to manage the use of health care resources and to maximize the effectiveness and quality of the care provided to its members. It is designed to promote appropriate, safe and consistent utilization management decision-making. The program includes pre-service, concurrent and post-service review components. Program activities are completed in a manner that is consistent with the applicable policies, procedures, and standards of the state and federal regulatory agencies. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization.

Ascension Personalized Care will ensure that services for members are sufficient in the amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The health plan will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member (42 CFR §438.210 (a) (ii)).

Ascension Personalized Care has appropriate personnel available at a toll free telephone line to provide determinations at a minimum from 8:00 a.m. to 5:00 p.m. of each normal business day in each time zone where Ascension Personalized Care conducts at least two percent of its review activities.

Ascension Personalized Care has the capability of accepting or recording incoming inquiries from providers and members during the business day and after business hours. Ascension Personalized Care responds to communications within one (1) business days after receiving the communication and conducts its outgoing communications related to utilization management during providers' reasonable and normal business hours, unless otherwise mutually agreed. TDD/TTY services and language assistance services are available for members as needed, free of charge.

For questions about the UM process, including requesting a free copy of our UM criteria/guidelines, call Provider Services at 833-600-1311.

Submission Timelines

Initial requests
Prior authorization with all supporting documentation is recommended to be submitted a minimum of three business days prior to the start of care. Failure to comply with notification rules may result in an administrative denial. Additional information is available in the Administrative Denials section of this document.

The start of care (SOC) date is the date agreed to by the physician, the private duty nursing (PDN) provider, and the member or responsible adult and is indicated on the submitted plan of care (POC) as the SOC date. SOC date may include prior authorization requests for home health skilled nursing, aide service and PDN. These services may require that the provider assess the member and initiate care prior to submitting a prior authorization request within three business days of the SOC date for initial or new PDN services. During the prior authorization process, providers are required to deliver the requested services from the SOC date. Exceptions to the start of care date may include requests for home health skilled nursing, aide services and private duty nursing. Additional information regarding exceptions is discussed below.

Exceptions:

- **Home Health Skilled Nursing:** Following the RN's initial assessment or evaluation of the client in the home setting for home health service needs, the agency-employed RN who completed the home evaluation must contact Ascension Personalized Care for prior authorization within three (3) business days of the start of care (SOC).
- **Private Duty Nursing:**
    - Initial requests must be submitted within three business days of the SOC date.
    - Initial requests may be prior authorized for a maximum of 90 days.
    - Completed initial requests must be received and dated by the Ascension Personalized Care Prior Authorization department within three business days of the SOC. The request must be received by the Ascension Personalized Care Prior Authorization department no later than 5 p.m., Central time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 PM, Central time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Prior authorization recertification process
A physician or health care provider can submit a medical prior authorization recertification request at least 60 calendar days prior to the expiration of the current authorization of service(s) on file.

Exceptions:

Ascension Personalized Care requires the following prior authorization recertification requests be received up to 30 calendar days before the expiration of the current authorized service(s)

- **Private Duty Nursing (PDN)/Prescribed Pediatric Extended Care Centers (PPECC):**
    - A recertification request must be submitted at least seven calendar days before, but no more than 30 calendar days before a current authorization period will expire**.**
    - All authorization timelines apply to recertifications.
    - Completed extension requests must be received and dated by the Ascension Personalized Care Prior Authorization department at least seven (7) calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by the Prior Authorization department no later than 5 p.m., Central time, on the seventh day, to be considered received within seven (7) calendar days. If a request is received less than seven calendar days before the current authorization expiration date, or after 5 p.m., Central time, on the seven day, authorization is given for dates of service beginning no sooner than seven (7) calendar days after the receipt of the completed request by the Prior Authorization department.

Clinical Information and Documents to Support Medical Necessity

Ascension Personalized Care may request any combination from the following list of clinical information and documents to support medical necessity of requested services. All information and documents should be current and legible with appropriate ordering physician signature dated within the past 90 days where applicable. Providers need to submit only the applicable documents listed below related to the requested services.

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
All Inpatient, and Outpatient Requests for Services (in addition to items listed below)	Essential Information to initiate authorization referral request: ● Member name ● Member or Medicaid number ● Member date of birth ● Requesting provider name ● Requesting provider National Provider Identifier (NPI) ● Service requested- Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT) ● Service requested start and end date(s) ● Quantity of service units requested based on the CPT, HCPCS, or CDT requested
Inpatient and Observation Requests	Information and documents should relate to current admission/stay. In addition to documents listed above: ● Admission Notification and/or Face Sheet ● Behavioral Health Inpatient Admission Notification Form ● Diagnosis ● History and Physical ● Progress Notes ● Consult Notes and/or Reportsfrom Specialists ● Behavioral Health Inpatient Extended Stay Form ● Physician Orders ● Radiology/Imaging Results ● Laboratory Results ● Blood Glucose Testing ● Vital Sign Reports ● Medication Administration Records ● Discharge Summary ● Behavioral Health Discharge Summary Form

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Prosthetics Requests	Information and documents should relate to current requests for services. In addition to applicable documents listed above: ● A recent clinical note from a physician/appropriate specialist (Examples: Neurology, Orthopedics, Sports Medicine) that documents the specific functional deficits, diagnosis and need for the requested prosthetic (note should be less than three (3) months old) ● Clear description and justification of item(s)/accessories being requested ● Documentation of medical necessity that includes description of member's function with and without the prosthetic being requested ● History and status of any previously used/trialed prosthetic and outcome of its use for custom and off the shelf items; including medical necessity for duplication of item(s) ● Description of surgery and or injury including dates that relates to the referral ● Description of the least supportive device that will meet this member's needs ● Description of setting this item(s) will be used ● Documentation of patient's/family's willingness to comply with requested item(s)/plan of care (if applicable)
Durable Medical Equipment Requests	Information and documents should relate to current requests for services. In addition to applicable documents listed above: ● A recent clinical note from a physician/appropriate specialist (Examples: Neurology, Orthopedics, Sports Medicine) that documents the specific functional deficits, diagnosis and need for the requested piece of equipment (note should be less than three (3) months old) ● Member age, height, weight, diagnoses impacting mobility related activities of daily living, diagnoses affecting instrumental activities of daily living, current functional skill sets with and without equipment ● Durable medical supplier history of equipment purchases, quote/description/justification in detail for current equipment request, growth potential of requested equipment, home accessibility/ equipment compatibility, justification for repairs/ modifications, state of the equipment

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Durable Medical Equipment Requests	● Description of whether item(s) is for purchase or rental and duration of need ● Description of medical necessity for all accessory components and modifiers ● Description of skin integrity, sensation, and pain perception including how it is impacted by current and requested equipment
Speech Generating Devices Requests	Information and documents should relate to current request for services. In addition to applicable documents listed above: ● A recent clinical note from a physician/appropriate specialist that documents the specific functional deficits and diagnosis (note should be less than three (3) months old) ● Description of any underlying medical conditions and prognosis for development of verbal speech ● Description of whether item(s) is for rental or purchase (initial or replacement) ● History of any previous speech generating devices purchased, date of previous purchase, type of device previously purchased, why a new device is needed ● Hearing testing: ○ **If hearing testing has not yet been submitted to Ascension Personalized Care or has a medical diagnosis that is prone to hearing loss:** Documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech (note should be less than twelve (12) months old) ○ **If the member has a diagnosed hearing loss or failed a hearing screening:** A recent clinical note from an Ear, Nose, Throat specialist and/or Audiologist documenting an examination,treatment plan and/or outcome of a hearing aid/cochlear implant follow up visit for aided hearing testing and to determine if devices are working properly. (note should be less than three (3) months old) ● Language/Augmentative Communication Evaluation completed by a speech-language pathologist and signed by the referring physician that includes:

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Speech Generating Devices Requests	○ The member's medical history, including any underlying diagnosis or condition that impacts speech and language development ○ The history of any prior speech therapy treatment with a description of the response to traditional therapy approaches versus treatment focusing on augmentative communication ○ **Bilingual:** The language exposure in the home, educational setting and community. Language used for formal testing, the amount of translation required if a bilingual assessment was used and planned language for therapy; if exposed to multiple languages, testing in both languages or use of a bilingual test (Example: Preschool Language Scale -5 Spanish) is required ○ Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements) ○ A description of specific functional communication skills and deficits observed during completion of Activities of Daily Living (ADLs) both verbally and with the chosen device ○ A detailed description of communication impairment (diagnosis,severity, language skills, cognition, anticipated duration) ○ Description/comparison of other devices considered and why they would not meet the member's communication needs ○ Rationale for the specific device chosen including gross motor skills, fine motor skills and cognitive abilities that make the device appropriate ○ Outcome/summary of a three (3) month trial with the chosen device including description of device use in the home during activities of daily living, and description of independent use of the device for expressive communication at the start and end of the trial ○ A description of caregiver training related to use and programming of the device (if applicable)

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Speech Generating Devices Requests	○ Short and long-term treatment goals which are related to use of the speech generating device, functional, appropriately attainable, measurable and include baselines/timeframes ○ Responsible adult's expected involvement in the member's treatment (if applicable) ○ Signature of the licensed speech pathologist and date

Determination Timelines

Utilization review timelines standards are as follows:

State	Authorization Type	Decision Time Frame
Kansas & Tennessee	Urgent/Expedited	72 Hours
Indiana	Urgent/Expedited	As soon as possible but not later than the second working day after the date of the request
Texas	Post-stabilization Care or a Life-Threatening Condition	1 hour
Kansas	Routine/Non-Urgent	15 Calendar Days
Indiana, Texas & Tennessee	Routine/Non-Urgent	2 Business Days
Kansas, Indiana & Tennessee	Routine/Non-Urgent Extension	Can be extended for up to 15 Calendar Days

State	Authorization Type	Decision Time Frame
Texas	Routine/Non-Urgent Extension	Can be extended for up to 14 calendar days
Kansas, Indiana, Texas & Tennessee	Retrospective	30 Calendar Days
Kansas, Indiana, Texas & Tennessee	Retrospective Extension	Can be extended for up to 15 Calendar Days
Kansas, Indiana & Tennessee	Concurrent	24 Hours, if the request for extension was received at least 24 hours before the expiration of the currently certified period OR 72 Hours, if the request for extension was received less than 24 hours before the expiration of the currently certified period
Texas	Concurrent	24 Hours

Requesting a Prior Authorization

To request a prior authorization the following may be utilized:

1. Fax a completed Prior Authorization Form to **512-380-7507**
2. Call Ascension Personalized Care at **512-324-2362** or **1-844-995-1145**
3. Email Ascension Personalized Care at **SHP-Authorization@ascension.org**

For a comprehensive list of procedures with the appropriate ICD-10 or CPT codes, please refer to the most recently published PriorAuthorization Code List posted at **ascensionpersonalizedcare.com**