# Authorizations and Predeterminations

This eBinder provides a link to instructions that are helpful when obtaining an authorization or predetermination. The objective of this policy is to partner with clinics in reducing high volume of rejections for no authorization/referral by understanding the importance of being able obtain this data.

Authorizations and Predeterminations Policy and Procedure:

**Objectives for Auth/Pre-Determinations Collaboration Project:**

**No Auth/Referral:**

**Objective:** To partner with clinics in reducing high volume of rejections for no authorization/referral by understanding the importance of being able obtain this data.

**Pre-determinations:**

**Objective:** Clinics will be able identify services that need a benefit check to ensure providers are paid for services rendered.

**Definition:**

**Pre-authorization:** A prospective process to verify coverage of proposed care and establish covered length of stay.

**Pre-certification:** A utilization management program that requires the member or the physician to notify the health insurer prior to a hospitalization, diagnostic test or surgical procedure. The notification allows the health insurer to provide an authorization number.

**Pre-determinations:** Is a review by medical staff to determine if the service you are requesting is appropriate for your medical needs. Predeterminations are done prior to services so that you will know in advance if the procedure is covered. The predetermination of benefits is dependent upon information submitted before the services are rendered. Payment is dependent upon the information submitted after the services are rendered.

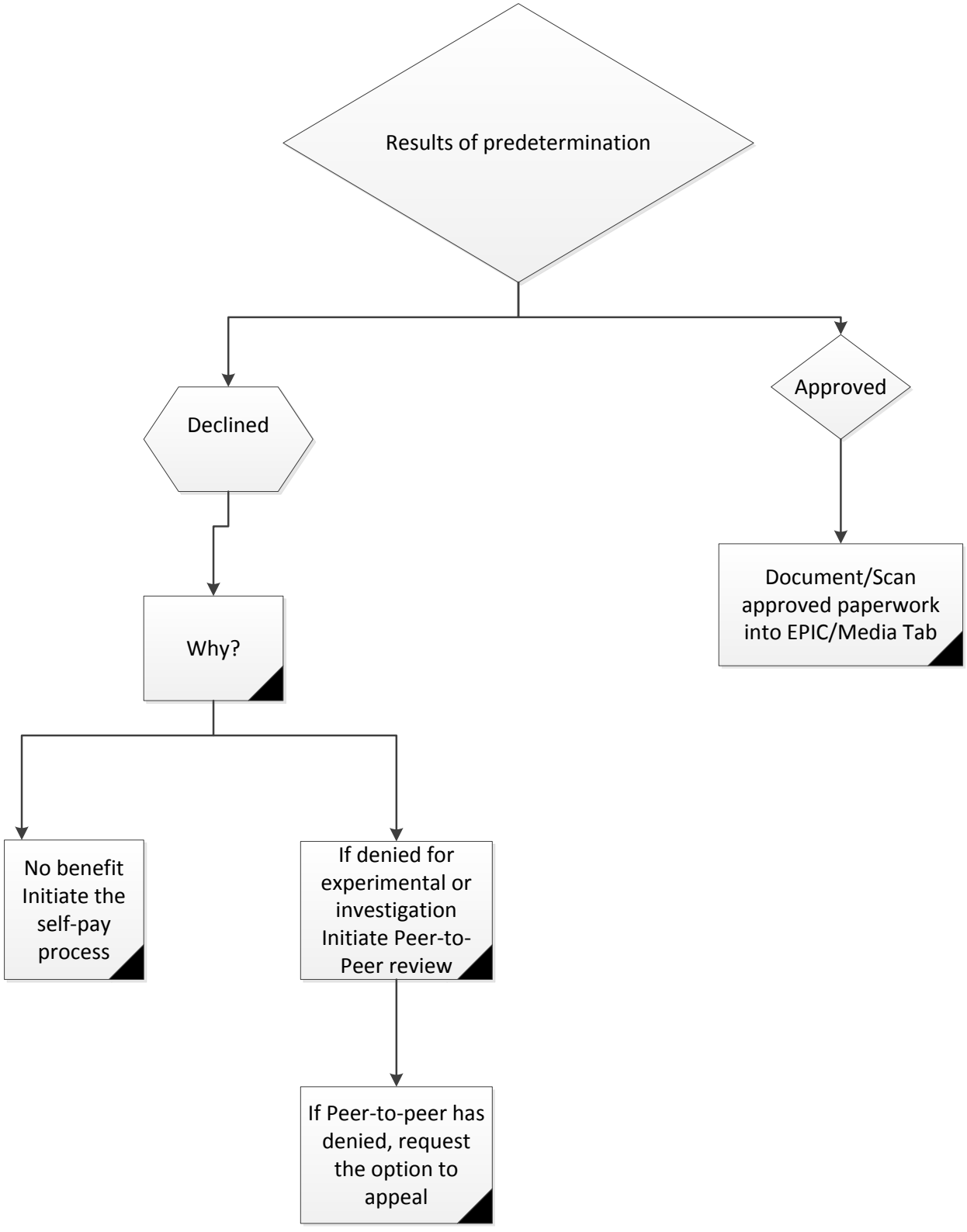
**Predetermination/Precertification Process**

I. Initiate authorization – Clinic/Surgery Scheduler

II. Check benefits specific to patients plan – patients insurance card will provide benefit phone number – Clinic/Surgery Scheduler
    a. Anthem – verify with Home Plans

III. Initiate Pre-Determination/Precertification/Utilization process
    a. Some payers will need a form filled out and/or the payer will communicate internal process such as writing a letter of medical necessity for a nurse to review – Clinic/Surgery Scheduler
        i. Include consults notes, referring physician notes, X-rays, MRI, CT, conservative measures (PT, Chiropractic, Medication therapy & Injections) and any outside physician notes (neurologist, etc.)
    b. Ask for time frame to process Pre-determination/Precertification
        i. If surgery is scheduled before time frame ask for **Urgent Request!**
    c. Document reference numbers, customer service representative, dates and times.
    d. List out all possible CPT and Diagnosis codes on the request
        i. For unlisted codes give a description of the procedure
    e. State if patient will be In-patient, Out-patient, etc.

**Note: Each payer has individual processes, it is important to initiate guidance on the process and build a cheat sheet for each payer and the process that is required for appropriate compliance in procedures.




Updated 10/03/2016

# Code of Colorado Regulations

Regulation 4-2-17 PROMPT INVESTIGATION OF HEALTH CLAIMS INVOLVING UTILIZATION REVIEW AND DENIAL OF BENEFITS AND RULES RELATED TO INTERNAL CLAIMS AND APPEALS PROCESSES

**Section 6 Standard Utilization Review**

Q. "Prospective review" means, for purposes of this regulation, a utilization review conducted prior to an admission or course of treatment, also known as a "pre-service review".

A. A carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.

B. Prospective review determinations.

1. Time period for determination and notification.

a. Subject to subparagraph b. of paragraph 1., a carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) calendar days after the date the carrier receives the request. Whenever the determination is an adverse determination, the carrier shall make the notification of the adverse determination in accordance with subsection E.

b. The time period for making a determination and notifying the covered person of the determination pursuant to subparagraph a. of paragraph 1. may be extended one (1) time by the carrier for up to fifteen (15) calendar days, provided the carrier:

(1) Determines that an extension is necessary due to matters beyond the carrier's control; and

(2) Notifies the covered person prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.

c. If the extension under subparagraph b. of paragraph 1. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

(1) Specifically describe the required information necessary to complete the request; and

(2) Give the covered person at least forty-five (45) calendar days from the date of receipt of a notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline shall be extended to the next business day.

2. Failure to meet the carrier's filing procedures.

a. Whenever the carrier receives a prospective review request from a covered person that fails to meet the carrier's filing procedures, the carrier shall notify the covered person of this failure and provide in the notice information on the proper procedures to be followed for filing a request.

b. Required notice.

(1) The notice required under subparagraph a. of paragraph 2. shall be provided, as soon as possible, but in no event later than five (5) calendar days following the date of the failure.

(2) The carrier shall provide the notice in writing.

c. The provisions of paragraph 2. shall apply only in the case of a failure that:

(1) Is a communication by a covered person that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

3. For an adverse determination regarding a prospective review decision that occurs during a covered person's hospital stay or course of treatment, the health care service or treatment that is the subject of an adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the carrier.

4. The requirements of subsection B. apply to all written requests involving utilization review received by the carrier which are submitted by a covered person, the covered person's designated representative, **or provider requesting a determination of coverage for a specific health care service or treatment for a specific member.**

## *Fax Cover Sheet verbiage:*

**REQUEST FOR PREDETERMINATION**

**Please see the attached request for predetermination. This is a written request sent on behalf of University of Colorado Hospital (tax ID ) and University Physicians (tax ID 74-2161737) for a prospective review of the listed services. Per Code of Colorado Regulations, Regulation 4-2-17, this review should determine whether the services are a covered under a patient's health benefit plan and whether the services meet the guidelines of medical policy. Predetermination approvals and denials are based on a review of relevant medical policies. Please notify us upon completion of this predetermination.**

**Thank you,**