Authorization Tip Sheet

CLINICAL REVIEW CRITERIA

SilverSummit Healthplan follows American Society of Addiction Medicine (ASAM) criteria and other nationally recognized assessment and placement tools, such as InterQual, to guide evidence-based clinical decisions. Clinical documentation received from providers is carefully reviewed using these tools to support the review process and to ensure Members receive the most appropriate care based on their strengths and presenting needs.
The information below is intended as a guide for preparing the required documentation for services requiring Prior Authorization. While not all the information below will be relevant to all services, Providers are encouraged to focus on those elements which are applicable to the service being requested.

PRIOR AUTHORIZATION PROCESS

If you need to look up a service that requires prior authorization, start by viewing the **Prior Authorization Prescreen tool**. For Member-specific information, log into the **provider portal**, or register for Availity for both authorization and member eligibility queries.

Failure to obtain the required approval or pre-certification may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

SUBMITTING A REQUEST

Administrative and clinical staff can use the provider portal to submit prior authorizations. Register and log in at **Provider.SilverSummitHealthplan.com**. Prior authorization requests can also be faxed directly to:

Medical Requests Fax: 1-844-367-7022	**BH OP (PHP, IOP and LLOC) Request Fax: 1-855-868-4940**
Transplant Request Fax: 1-833-414-1503	**BH Discharge Summaries should be faxed to: 1-866-535-6974**
BH IP (IP and RTC) Request Fax: 1-833-840-0459	

TIMEFRAMES FOR AUTHORIZATION REQUESTS AND NOTIFICATIONS

Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for prior authorization and notification.

Service Type	Timeframe
Scheduled admissions	Prior Authorization required at least five business days prior to the scheduled
Elective outpatient services	Prior Authorization required at least five business days prior to the elective outpatient
Emergent inpatient admissions	Notification within one business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater 48 hours	Requires inpatient prior authorization within one business day

Emergency room and post stabilization, urgent care and crisis intervention	Notification within two business day
Maternity admissions	Notification within one business day, with delivery outcome
Newborn admissions	Notification within one business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day

CHECK THE STATUS OF YOUR AUTHORIZATION REQUEST

Use the Authorization Look Up function to check the status of a request. Providers will be notified and will receive a singular notification via fax and mail for any request that may be denied.

REVISING AN AUTHORIZATION REQUEST

- An authorization should be revised when a change is needed before services are rendered.
  Example: Date change, facility change, changes or corrections to procedure code.
- Providers may go into the provider portal to request a revision to an Existing Auth and upload additional clinical information as soon as the need is known.
- It's Important to indicate Circumstances / Reason for Revision in the Remarks Section.
- An authorization revision can only be requested up until a determination is rendered. Requests for an extension of end date (not additional days/units) can be submitted no later than the authorization term date.

APPEALING AN AUTHORIZATION DECISION

- To appeal a denied authorization decision, you should first review the denial letter for specific reasons and deadlines, then gather supporting medical documentation, and finally, submit an appeal outlining why the denial should be overturned
- Requests for appeal must include:
  1. Reason for appeal
  2. Whether a standard or expedited appeal is being requested
  3. Authorized Representative Designation Form (complete w/ Member signature)

- Submit via mail or fax to:

SilverSummit HealthPlan Appeal Department
PO Box 10378
Van Nuys, CA 91410-0378

Phone 1-844-366-2880
Fax 1-866-714-7991

GENERAL GUIDELINES

- **Legibility:** All clinical information must be legible.
- **Provider Licensing:** All providers must be licensed for the level of care they are requesting.
- **Synopsis:** Provide a synopsis of the clinical information instead of attaching the entire chart.
- **Pertinent Notes:** Attach most current MD notes, pertinent nursing notes, and family sessions/collateral information. For groups notes, only include Member specific notes relevant to the continued stay request.
- **Clarity:** Be clear in the level of care requested and submit the correct CPT codes.

SUBMITTING CLINICAL DOCUMENTATION

Required Information

- **Member Information:** Name, Date of Birth, Medicaid/Member ID.
- **Provider Information:** Name, NPI, TIN.
- **Level of Care:** Specify the level of care requested e.g., Psychiatric Inpatient, Psychiatric Residential, Withdrawal Management, Residential-Rehab (Substance Use Rehab).
- **Provider Contact Information:** Phone and Fax Numbers

Initial Review (typically all included in the assessment/evaluation)

- Clinical information compiled from the Member and all available sources to determine Member is appropriate for the specific Level of Care. The initial evaluation must contain the following information:
  - The Member's chief complaint and include Member's understanding of the factors that lead to requesting services (i.e. the "why now" factors)
  - The history of the presenting illness
  - Mental status evaluation
  - The Member's current level of functioning
  - Urgent needs including those related to the risk of harm to self, others, or property
  - Psychiatric and medical histories including the histories of substance use, abuse and trauma
  - Co-occurring behavioral health and physical conditions
  - The Member's history of behavioral health treatment
  - Pertinent current and historical life information including the Member's: age, gender, sexual orientation, culture, spiritual beliefs, educational history, employment history, living situation, legal involvement, family history, relationships with family, friends and others.
  - The Member's strengths
  - Barriers to care
  - Member's instructions for treatment or appointment of an agent to make treatment decisions
  - The Member's broader recovery, resiliency and wellbeing goals
- Initial program assessments demonstrating Member's level of care must be submitted with the initial request
- Clinical information to be included at initial review for SUD services: (matches ASAM dimensions)
  - Precipitating event
  - Urine drug screen/blood alcohol level
  - History of substance use (substance(s), amount, frequency, age of first use, last use)

- Substance use treatment history
- Longest period of abstinence
- Triggers for use
- Stage of change
- Current withdrawal symptoms (if applicable)
- COWS/CIWA score (if available)
- Vitals (for inpatient only)
- Medications
- Detox protocol being used
- Medical history
- Psychiatric history
- Family history of substance use or mental health issues
- Support system
- Legal issues
- Education/employment

Treatment Plan (initial and continued stay reviews)

- The short- and long-term goals of treatment;
- The expected outcomes for each problem that are measurable, functional, time-framed and relevant
- How the Member's family and other natural resources will participate in treatment when indicated
- How treatment will be coordinated with other providers, agencies or programs
- Includes interventions that further engage the Member in treatment that promote the Member's participation in care, promote informed decisions and support the Member's broader recovery and resiliency goals.
- Treatment focuses on the "why now" factors to the point that the Member can be safely treated in a less intensive level of care or treatment is no longer required
- The provider informs the Member of safe and effective alternatives, potential risks and benefits
- A change in the Member's condition prompts a reassessment of the treatment plan and re-evaluation

Continued Stay Review

- Individual counseling for evaluation of the treatment and whether changes in the treatment plan are needed at least 2 times per week for Residential and at least weekly for PHP
- Updated daily clinical information reflecting active treatment is being delivered
- Clinical best practices are being provided timely with sufficient intensity to address the Member's treatment needs and reasonably expected to stabilize the Member's condition and/or the precipitating factors
- The Member's family and other natural resources are engaged to participate in the Member's treatment as clinically indicated.
- Clinical information to be included at concurrent review for SUD services:
  - Urine drug screen/blood alcohol level
  - Problem statement from treatment plan
  - Primary treatment goal (include target and completion dates)
  - Objectives (include target and completion dates)
  - Interventions
  - Stage of change
  - Progress or non-progress (as evidenced by)
  - Discharge plan
  - Barriers to community tenure

FOR ADDITIONAL INFORMATION

Contact Provider Service at 1-844-366-2880 or email us at **NVSS_ProviderRelations@SilverSummitHealthPlan.com.**