POLICY - PROCEDURE			
Effective Date: Not Set			
Business Owner:	Honig, Deronda	**Approver:**	Russo, Amy
Line of Business:	Arkansas PASSE		
Department:	Utilization Management	**Policy Number:**	TBD

Scope:

This Policy and Procedure document applies to all CareSource business operations as necessary to comply with all local, state and federal regulations, as well as contractual and accreditation standards.

Purpose:

To manage the gold card exemption process through the monitoring of prior authorization data to determine when a health care practitioner is provided an exemption for prior authorization requirements.

Policy Statement:

Healthcare coverage is limited to items and services that are included in a defined benefit package and that are medically necessary. Participating (in-network) providers that consistently submit prior authorization requests that meet medical necessity, within the parameters set by the State of Arkansas are eligible for Gold Card status to diminish the burden on physician requestors and enhance the delivery of member care. A qualified health care provider with a proven record of exercising prudent judgment in the referral or delivery of a medically necessary particular health care service may be approved to participate in the Prior Authorization Exemption Program.

Some services are excluded from the prior authorization exemptions including, but not limited to, Home and Community Based Services (HCBS), IMD, and IDD. The plan has the right to approve, deny, or rescind prior authorization exemptions for qualifying providers as outlined in House Bill 1271 now known as Act 575.

Process Steps:

1. Initial Evaluation for prior authorization exemption

a. A health care provider may qualify for the Prior Authorization Exemption Program if, within the designated six-month evaluation period:

   i. The health care provider has more than five prior authorization requests received during the evaluation period; and

   ii. At least 90% of the prior authorization requests were approved.

b. The health care provider is not required to request participation in the Prior Authorization Exemption Program.

c. If the health care provider does not choose to participate in the Prior Authorization Exemption Program, they must notify the health plan of their decision.

d. The plan may extend an exemption to a group of health care providers under the same tax identification number if:

   i. A health care provider with an ownership interest in the entity to which the tax identification number is assigned does not object; or

   ii. The tax identification number is associated with a hospital licensed in this state and the chief executive officer of the hospital agrees to the exemption.

2. Prior Authorization Exemption Notifications to Health Care Providers

a. The plan allows health care providers to designate an email address or a mailing address for communications regarding prior authorization exemptions, denials, and rescissions.

3. Prior Authorization Exemption Approvals

a. When granting a prior authorization exemption, the plan provides notice to the health care provider that includes a plain language explanation of the effect of the prior authorization exemption and any claim coding guidance needed to document the prior authorization exemption.

   i. The effective date and duration of the approved prior authorization exemption for the health care provider.

   ii. The approved prior authorization exemption remains in place for twelve months unless rescinded. If a healthcare provider's use for a particular health care service increases by twenty-five percent (25%) or more during the period between January 1, 2025, and June 30, 2025, based on a review of the health care provider's utilization of the particular healthcare service from January 1, 2024, through June 30, 2024, then [insert PASSE] may disallow the exemption from prior authorization requirements for the healthcare provider for the particular healthcare service. Future rescission evaluations will be made by comparing the current evaluation period to the previous evaluation period.

b. In order to retain a prior authorization exemption, a health care provider must continue to maintain medical records adequate to demonstrate that health care services meet medical guidelines. In the absence of adequate records during an evaluation or appeal, an exemption may be rescinded.

c. The plan may not require prior authorization requirements for any service that is included in a value-based reimbursement arrangement with any health care provider participating in the value-based reimbursement.

d. If CareSource offers multiple health benefit plans, determination of exemption from prior authorization requirements shall be applicable for all health benefit plans and health care provider networks for the health care provider.

e. If a health care provider that has an approved exemption submits a prior authorization request for a particular health care service for which the health care provider qualifies for an exemption from prior authorization requirements, the plan promptly provides a notice to the health care provider that includes the following information.

    i. A statement that the health care provider qualifies for an exemption from prior authorization requirements.

    ii. A statement of the duration of the exemption; and

    iii. A notification of the plan's payment requirements.

4. Prior authorization Exemption Rescissions

CareSource may rescind an exemption from prior authorization requirements if a retrospective review of a random sample of claims selected by CareSource during the most recent evaluation period shows that CareSource would have fully approved fewer than 90% of claims based on application of clinical criteria. For a health care provider who does not meet the 90% during an evaluation period they will be reviewed again during the following evaluation period to see if they qualify for the exemption then. This will occur each evaluation period going forward.

If CareSource finds that a health care provider's exemption should be terminated, it shall comply with the following requirements:

1. Determinations made regarding the rescission of a health care provider's exemption from prior authorization requirements shall be made by a physician who possesses a current and unrestricted license to practice medicine in the state of Arkansas and has the same or similar specialty as the health care provider.

2. When rescinding a prior authorization exemption, the plan provides notice to the health care provider before the end of the current exemption period and provides time for the health care provider to appeal the decisions and is not less than 25 days before the proposed rescission is to take effect.

3. The Notice includes the following:

    i. Notification that the prior authorization exemption is being rescinded, the date the notice is issued, and the date the rescission is effective.

    ii. A plain language explanation of how the health care provider may appeal and seek an independent review of the determination, the date the notice is issued,

    iii. CareSource's address and contact information for returning the form by mail or electronic means to request an appeal.

    iv. A statement of the total number of payable claims submitted by or in connection with the health care provider during the most recent evaluation period that were eligible to be evaluated with respect to the rescission, the number of claims included in the random sample, and the sample information used to make the determination, including:

        a. Identification of each claim included in the random sample,

b. The issuer's determination of whether each claim met the plan's screening criteria; and

c. For any claim determined to not have met the plan's screening criteria:

1. The principal reasons for the determination that the claim did not meet the plan's screening criteria, including, if applicable, a statement that the determination was based on a failure to submit specified medical records.

2. The clinical basis for the determination that the claim did not meet the plan's screening criteria.

3. A description of the sources of the screening criteria that were used as guidelines in making the determination; and

4. The professional specialty of the health care provider who made the determination.

d. Includes a space in the form to be filled out by the health care provider that includes:

i. The name, address, contact information, and identification number of the health care provider requesting an independent review.

ii. An indication of whether the health care provider is requesting that the independent review organization review the same random sample or a different random sample of claims, if available; and the date the appeal is being requested; and

iii. An instruction for the health care provider to return the form to the issuer before the date the rescission becomes effective and to include applicable medical records for any determination that was based on a failure to provide medical records.

a. The plan will notify the health care provider of the plan's determination to rescind the exemption at least 25 days prior to the rescission effective date.

b. If the plan does not finalize a rescission determination, then the health care provider is considered to have met the criteria to continue to qualify for the exemption. A health care provider shall not rely on another health care provider's exemption except when the health care provider with an exemption is the health care provider that orders the service(s) that are rendered by a health care provider without an exemption.

c. The insurance commissioner may refuse, suspend, revoke, or not renew a license or certificate of authority to the plan if the plan has 50% of appeals overturned in a 12-month period by an IRO (Independent Review Organization).

6. Effect of prior authorization exemption

a. The plan shall not deny or reduce payment to a health care provider for a health care service for which the health care provider has qualified for an exemption from prior authorization requirements, including a health care service performed or supervised by another health care provider, if the health care provider who ordered the health care service received a prior authorization exemption based on medical necessity or appropriateness of care unless the health care provider:

i. Knowingly and materially misrepresented the health care service in a request for payment submitted to the plan with the specific intent to deceive the plan and obtain an unlawful payment from the plan.

ii. Substantially failed to perform the health care service.

iii. If the plan has a reasonable cause to suspect a basis for denial based on item i. or ii. the plan may perform a retrospective review and may reduce or deny payment.

Definitions

Prior Authorization: obtaining advance approval from a health insurer about the coverage of a service or medication.

Random Sample: Means at least five claims but no more than 20 claims selected without method or conscious decision.

Value-based Reimbursement: A reimbursement that ties a payment for the provision of health care services to the quality of health care provided; rewards a health care provider for efficiency and effectiveness; and may impose a risk-sharing requirement on a health care provider for health care services that do not meet the [insert PASSE]'s requirements for quality, effectiveness, and efficiency.

REVIEW/REVISION HISTORY	
Date	Description of changes
mm/yyyy	Initial release