Department:	Utilization Management	**Original Approval:**	08/16/2022
Policy No:	UM443	**Last Approval:**	08/22/2023
Policy Title:	Honor Authorizations and Authorizations for Incarcerated Members Policy and Procedure		
Approved By:	Clinical Services Leadership Team		
Dependencies:	Medical Appropriateness for Service or Medication Policy (UM200)		

Purpose

The purpose of this policy is to describe the prior authorization process for Medicaid members whose benefits are currently suspended due to incarceration or placement at a State Mental Health Hospital (Western or Eastern).

Policy & Procedure

Process

When a member is currently ineligible due to suspension of benefits for incarceration or state hospital placement, Community Health Plan of Washington (CHPW) will process authorization requests for medical necessity even though the member will likely show as not eligible. This is to facilitate coordination of care to support transfer or release for the member back to the community and reinstatement of benefits with CHPW. The provider will submit a Prior Authorization request with clinical records supporting the request prior to date of service or planned admission. Once they leave jail or the hospital and admit to the facility, their eligibility will be reinstated with CHPW. If the member for any reason is switched to another MCO for coverage after release, CHPW will forward any honor authorizations for that member to the members new MCO for coverage.

The honor authorization process is used for prior authorization of inpatient, outpatient, and infused and injected medications. This process is used to also address any situation where access to specific healthcare services is a condition for release.

Procedure

Community Health Plan of Washington will use the following guidelines to process medical necessity decisions for honor authorizations.

- The provider submits prior authorization (PA) request, including clinical records such as diagnoses precipitant to admission, current treatment plan, initial discharge plan, and other pertinent records supporting the request. These will be submitted to the dedicated Utilization Management (UM) fax line.

    - PA form for incarcerated members should indicate that **"*member's benefits are currently suspended, and the request is for a planned placement or service until member's eligibility can be reinstated*."**

    - PA form for members in a State Hospital should indicate ***"Honor Authorization for a member with Benefits suspended due to state hospital stay."***

- UM Staff validates if Medicaid member has IMC benefit but is currently showing as not eligible.

- UM Staff will forward the request to the first-level reviewer for medical necessity review.
    - If the criteria meet medical necessity, CHPW will fax back the PA form with the following statement:

        *"This is a notification of **approval** contingent upon the member's reinstatement of benefits at Community Health Plan of Washington (CHPW).*

        The member meets the medical necessity criteria for the requested service. Once benefits are officially reinstated, authorization numbers and details will be provided.

        Once the member admits, please notify CHPW of the admission date via fax at (206) 652-7067. Please indicate on the fax that this is an honor authorization."

    - If criteria do not meet medical necessity, CHPW will contact the provider to get additional information. When additional information is still not meeting medical necessity, a secondary review will be conducted. If the secondary reviewer denies the service requested, the clinician reviewer will communicate via phone call the determination to the provider (or liaison who sent the request).

- When the service is approved and the member admits or presents to the facility for treatment, the provider should fax the approved PA notification to confirm the member's admission or date of treatment and reinstatement of benefits.

    - Once CHPW has received and confirmed, UM staff will fax back a subsequent approval letter, including the authorization number, date span, and the date of the following continued stay review if member service is inpatient level of care.

    - If the member is with another MCO, UM Staff will collaborate for a warm handoff by faxing an "Honor Auth" letter to the MCO. If the assigned MCO did not complete the initial review, they would honor the initial MCO authorization.

    - When CHPW receives an honor auth approved by another MCO or FFS Medicaid for a member who is now under CHPW eligibility, CHPW will honor those other entities authorization including dates of service, timeframe, authorized codes or services, and place of service/provider. Once the honor authorization is received from the other entity, CHPW will create an authorization for those services to facilitate care for the new CHPW member and will work directly with the other MCO or FFS Medicaid to facilitate care coordination.

Definitions

Adverse Benefit Determination: means any of the following (42 CFR § 438.400(b)): the denial or limited authorization of a requested service, including determination based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the denial of request for "good cause" designation that would preclude usual third-party liability procedures; the failure to provide services or act in a timely manner as required herein, including failure to issue an authorization or denial within required timeframes; failure of the Contractor to act within the timeframes for disposition, resolution, and notification of appeals and grievances; the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and for a rural area resident with only one Managed Care Organization (MCO) available, the denial of an Enrollee's request under 42 CFR § 438.52(b)(2)(ii) to obtain services outside the Contractor's network; or, for a plan's denial of coverage by an out-of-network provider when the in-network providers do not have the needed training, experience, and specialization, or do not provide the service the enrollee seeks, when receiving all care in-network would subject the enrollee to unnecessary risk, or when other circumstances warrant out-of-network treatment.

Honor Authorization: Approval of PA services where the plan will provide notification of contingent approval to the provider coordinating the discharge plan. This approval is based upon the individual's eventual reinstatement of benefits.

Medically Necessary: means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this Contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

First Level Reviewer Utilization Management (UM) staff member who has been appropriately trained in the principles and standards of utilization and medical necessity review that may make authorization decisions but not medical necessity denial decisions. First level reviewers include UM Intake Coordinator, UM Nurse Reviewer, Behavioral Health clinician, Social Worker, and UM Clinical Supervisory staff.

Second Level Reviewer: Appropriate licensed practitioner(s) who are able to make authorization and denial decisions consistent with their licensure. Second level reviewers include Physicians, Clinical PhD, Psychologist (PsyD), and registered pharmacists. If the request is for Behavioral Health (BH) services, a board-certified or board-eligible physician in General Psychiatry, Child Psychiatry, Addiction Medicine, a subspecialty in Addiction Psychiatry, or other recognized behavioral health specialty can perform the BH authorization and/or denial decisions for Medicaid members.

Service Authorization: Request for services from a provider or member that requires prior authorization or notice.

Medically Necessary: means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this Contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

List of Appendices

A. Detailed Revision History

Citations & References

CFR		
WAC		
RCW		
LOB / Contract Citation	☒ **WAHIMC**	§ 14.18.3.3.3; § 14.18.3.3.4
	☐ **BHSO**	
	☐ **MA**	
	☐ **CS.**	
Other Requirements		
NCQA Elements		

Revision History

SME Review:	08/15/2022; 07/14/2023
Approval:	08/16/2022; 08/22/2023

Appendix A: Detailed Revision History

Revision Date	Revision Description	Revision Made By
08/15/2022	Policy creation	Yves Houghton, RN; CJ Bruner, LMHC; Justin Fowler, RN
08/16/2022	Approval	CMO Cabinet
07/14/2023	Updated section when additional information is requested, and the service does not meet medical necessity Removed citation under BHSO.	Yves Houghton, RN
08/08/2023	Approval	Ma'ata Hardman
08/22/2023	Approval	Clinical Services Leadership Team