Sonder Health A Medicare Advantage Company	
Department: Health Services Department - Utilization Management	**Number:** HS-016
Title: Outpatient Prior Authorization and Redirection Process	
Original Effective Date: 12/30/2024	**Latest Revision Date:** 12/30/2024

Purpose:

The purpose of this policy is to establish a standardized process for prior authorization (PA) of outpatient procedures and, where appropriate, the redirection of services from hospital-based facilities to freestanding facilities. The intent is to ensure that outpatient services are medically necessary, cost-effective, and provided in the most appropriate care setting in accordance with applicable CMS and industry standards.

Definitions:

- **Prior Authorization:** A process by which a health plan reviews the necessity of medical services before they are provided to ensure the services are covered and meet plan criteria.
- **Freestanding Facility:** A non-hospital, independent healthcare facility that provides outpatient services, including diagnostic imaging centers, ambulatory surgery centers (ASCs), and independent therapy centers.
- **Hospital-Based Facility:** A facility affiliated with or part of a hospital, providing outpatient services.
- **Redirection Process:** The process by which a request for an outpatient service at a hospital-based facility is reviewed and, when appropriate, redirected to a lower-cost freestanding facility without compromising quality of care.

Policy Statement:

Prior Authorization is required for specific outpatient procedures as outlined in Sonder Health Plans ("SHP") plan benefits/policies and/or as further outlined in CMS and/or applicable state regulations. The prior authorization process ensures that outpatient services meet medical necessity criteria and are provided in the most cost-effective setting.

When an outpatient service is requested for a hospital-based facility, SHP's Utilization Management (UM) staff will review the medical necessity of the service and may determine whether the service can be safely and appropriately performed at a freestanding facility. If a freestanding facility is available within a reasonable distance and can provide the service at a lower cost, SHP may redirect the service to that facility to ensure cost-effective care. The redirection process will consider the member's clinical needs, location, and the availability of quality alternative providers.

Procedures:

I. <u>Initiating the PA Process</u>

A. The treating provider or their staff submits a Prior Authorization request to SHP's UM Department via secure online portals, fax, phone, or mail. The request must include the following details:

i. Member Name, SHP Policy ID Number, and date of birth.

ii. Service requested (including CPT/HCPCS codes)

iii. Clinical documentation supporting the medical necessity of the requested service.

iv. Preferred facility (hospital-based or freestanding)

II. Initial Review of Documentation:

A. The UM staff reviews the request and ensures that all required information is included.

B. The UM staff will make reasonable and diligent outreach efforts to the treating provider's office when there is insufficient information to make a decision and document those efforts.

III. Classification of Prior Authorization Request

A. UM staff will assess whether the prior authorization request is or should be classified as standard or expedited and initiate their workflow accordingly to meet the CMS and SHP requirements outlined in the Notification and Documentation section below.

B. For standard prior authorization requests, the UM staff will ensure the member (or their provider) is provided notification of a decision as quickly as the member's health condition requires, but no later than 14 calendar days from the date of the request. This can be extended up to an additional 14 days if the member requests an extension or the organization needs more information, and the extension is in the member's interest.

C. For expedited prior authorization requests and where the member's health condition could be seriously jeopardized by the standard timeframe, the UM staff will ensure that a decision is issued within 72 hours (24 hours for Part B drugs) of receiving the request. This decision can be extended by up to an additional 14 days if more information is required.

D. For expedited organization determination, if medical information is needed from a non-contract provider, the MA plan must request the necessary information within 24 hours of receipt of the request.

IV. Eligibility Verification:

A. The UM staff verifies the member's eligibility for the requested procedure under the SHP plan for which the member is enrolled.

B. The UM staff confirms that the request is for a covered outpatient procedure that requires prior authorization.

V. Medical Necessity Review and Re-direction Assessment

A. Initial Medical Necessity Review:

A UM registered nurse or clinical staff member assesses whether the requested outpatient service (hospital-based or freestanding) meets SHP's medical necessity criteria based on clinical guidelines, evidence-based practices, and CMS rules.

B. Re-direction Assessment:

If the service is medically necessary, the UM staff may also review whether the initial PA request for the procedure/service to be provided at a hospital-based facility can be performed at an in-network freestanding facility using established CMS guidelines (such as those in Chapters 6, 15, and 16 of the Medicare Benefit Policy Manual) and clinical criteria. The UM Staff will identify procedures suitable for re-routing based on safety, efficacy, and member outcomes.

VI. Consultation with Medical Director:

A. UM Staff will refer the PA request to a medical director if the initial reviewer identifies potential for re-routing.

B. The medical director will assess the clinical appropriateness of performing the procedure in a freestanding facility versus a hospital-based facility.

VII. Decision Making

A. Approval:

If the PA request meets medical necessity criteria, is approved by the Medical Director (as applicable), and the setting (hospital-based or freestanding) are approved, the UM staff will issue a prior authorization approval according to the SHP and CMS timeframe requirements. The authorization will specify the facility where the service is to be performed, including any redirection to a freestanding facility.

UM staff will notify the treating provider and patient of the approval and the designated facility using the notification and documentation requirements below.

B. Redirection Recommendation:

If the UM staff determines that the service can be provided at a freestanding facility without compromising member safety or quality of care, the redirection process may be initiated.

The UM staff will communicate the redirection to the treating provider and the member using the notification and documentation requirements outlined below and offering alternative in-network freestanding facilities that meet the CMS time and distance requirements. (Refer to the HSD Policy on CMS Time and Distance Requirement referenced in the Related Policy section below).

The treating provider can discuss the redirection with SHP's medical director in a Peer-to-Peer Review if they believe the service must be provided at the hospital-based facility due to clinical reasons.

If the treating provider agrees with the redirection recommendations, the UM staff will obtain the provider's written agreement to reroute the procedure.

If the treating provider does not agree with the redirection recommendation and the Peer-to-Peer Review with the Medical Director (if requested by the treating provider) results in a denial, a denial notification will be provided to the treating provider and the member as outlined below.

VIII. Denials:

A. If the PA request is denied, UM staff will issue a denial notice to the treating provider and the member, explaining the reasons for the denial and providing instructions on the appeals process.

B. UM staff will provide guidance in the denial notice on alternative options if applicable.

IX. Notification and Documentation

A. Communication with Provider and Member:

The UM Staff will notify the treating provider and member of the decision (approval, redirection recommendation, denial, or request for more information) within the regulatory timeframe. The UM Staff will provide clear instructions on next steps and any changes to the procedure location.

B. Documentation:

The UM Staff will Document all communications, decisions, and clinical justifications in the member's record for compliance and audit purposes.

X. Appeals and Peer-to-Peer Review

A. If the treating provider disagrees with the decision to redirect the service to a freestanding facility, he/she may request a Peer-to-Peer Review within 3 business days of receiving a notification of denial or partial approval of a prior authorization request.

B. After 3 business days, providers must follow the appeal process included within the Notice of Denial of Medical Coverage.

XI. Responsibilities:

A. Treating Provider:

Responsible for submitting timely and complete prior authorization requests with supporting documentation.

Must engage in the Peer-to-Peer Review (if requested) or appeal process if they disagree with a redirection or denial.

B. Medical Director/Clinical Review:

Responsible for conducting thorough reviews of prior authorization requests and ensuring compliance with Plan policies and CMS regulations.

Must provide clear communication and documentation when recommending redirection to a freestanding facility.

C. Utilization Management Staff:

Responsible for processing prior authorization requests and implementing the redirection process when appropriate.

Must ensure timely communication with providers and members regarding authorization outcomes and redirection outcomes.

XII. Compliance

A. All aspects of the prior authorization and redirection process must comply with CMS regulations, including guidelines related to medical necessity, network adequacy, and member protections. SHP's providers and staff are expected to act in the best interest of the member while maintaining cost-effectiveness in service delivery.

Attachment(s): N/A

Statutory Reference(s):

Federal:

- 42 CFR § 422.568 – Standard Timeframe and Notice Requirements for Organization Determinations
- 42 CFR § 422.570 – Expedited Certain Organization Determinations
- 42 CFR § 422.572 - Timeframes and notice requirements for expedited organization determinations.
- Applicable sections of 42 CFR Parts 482 (Conditions of Participation for Hospitals)
- Applicable sections of 42 CFR Parts 416 (Ambulatory Surgical Services)
- CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
- Medicare Benefit Policy Manual – Chapters 6, 15, 16

State of Georgia:

- Georgia Insurance Code and Department of Community Health regulations (Sections on Ambulatory Surgical Centers, Hospitals, and Health Maintenance Organizations)

Contract Reference(s):

- Medicare Advantage D-SNP Health Plan Agreement Between Georgia Department of Community Health and Sonder Health Plans, Inc.

Element Reference(s):

N/A

XIII. Related Policy(s): (will update with policy id # once finalized)

- Processing Standard Organization Determinations
- Processing Expedited Organization Determinations
- Utilization Management Compliance with CMS Provider Time and Distance Requirements