**PT/ST/OT Prior Authorization FAQ**

**Q1. What is changing with Humana Healthy Horizons in Oklahoma's prior authorization process?**

**A1.** For the first 90 days of the SoonerSelect program, during the transition of care period, Humana Healthy Horizons in Oklahoma adopted a policy of leniency in our review of outpatient service prior authorization requests. We approved prior authorization requests even if all required documentation to support the request was not submitted to ensure enrollee care was not disrupted. Beginning July 1, we will require all supporting documentation be submitted with the prior authorization request. If documentation is missing or the clinical review team is unable to determine the request meets the clinical criteria for the service requested, the prior authorization may be denied.

**Q2. What services require a prior authorization?**

**A2.** Services listed on Humana's prior authorization list (PAL) will require submission of a prior authorization request and supporting clinical documentation. Humana's PAL can be found at this link:

www.Humana.com/pal

**Q3. What is the required supporting documentation you are referring to?**

**A3.** Great question. There are three primary documents required:

1) A dated prescription or order from a qualified health professional (MD, DO, PA, CNP, APRN.)
2) Clinical documentation that supports the medical necessity of the services being provided. The type of clinical documentation required varies based on the type of authorization being submitted. The clinical documentation should demonstrate those elements identified in the clinical review criteria (see Q4) as required for authorization.
3) For pediatric patients, you must submit parental consent documentation as part of the prior authorization request. You may use the OHCA SoonerCare parental consent form (SC-15) you've previously submitted to OHCA, or you may submit your own parental consent form that clearly shows a parent consented to treatment. If you do not submit the parental consent documentation, your prior authorization request will be denied.
    - The SC-15 form can be found here: Therapy (oklahoma.gov).

**Q4. What clinical guidelines/criteria do you use to determine medical necessity?**

**A4.** For Outpatient Therapy requests, OHCA criteria will be utilized and can be found at: Therapy (oklahoma.gov)

Please note that if the criteria indicates a requirement of a specific OHCA form, this completed form is required to be submitted to Humana as part of the required clinical documentation.

**Q5. How do you submit clinical documentation?**

**A5.** The answer depends on how you submit your prior authorization request.

**Availity**

Supporting clinical documentation can be attached to the prior authorization request when submitted via our Availity online portal at Revenue Cycle Management | Healthcare | Availity.

If unable to submit clinical documentation via Availity, this can be faxed to the Clinical Intake Team at 1-833-558-9712.

**Telephone**

Prior authorization requests submitted via telephone will require supporting clinical documentation to be faxed to the Clinical Intake Team at 1-833-558-9712.

**Fax**

Prior authorization requests submitted via fax should include the supporting clinical documentation in the same fax transmission as the authorization request form.

a. Prior authorization request forms for fax submissions can be found at Oklahoma SoonerSelect: Prior Authorization (humana.com).

**Q6. Can an authorization for therapy be transferred from one provider to another?**

**A6.** A member can transfer to a different provider during approved dates of a current auth, but a new authorization will be required to be submitted with the new provider's information on it. Along with the new auth, required documentation outlined in the applicable OHCA policies (see Q4) will need to be submitted.

**Q7. Can additional codes or units be added to an already approved authorization?**

**A7.** No, if the authorization is already approved and additional units or CPT/HCPCS codes need to be added, a new auth will need to be requested for these additional units/codes.

**Q8. Can authorizations be submitted that include a request for more than 1 discipline?**

**A8.** No, authorizations should only include a request for 1 discipline. If a request for a different discipline is needed, this should be submitted on a separate auth.

**Q9. How long does it take to get an authorization decision?**

**A9**. Standard outpatient prior authorizations are determined within 72hrs of receipt. Urgent requests will be determined within 24 hours of submission of receipt and must meet the following: Following standard time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

**Q10. What is the maximum length of time an auth for therapy services can be requested for?**

**A10.** This depends on which discipline/type of therapy is being requested. See the specific guidance (Continuation Criteria or Approval Period) in the applicable OHCA criteria.

**Q11**. **Should the units of the treatment codes be submitted in 15-minute increments or visits?**

**A11.** If the code description indicates a time (15 minutes) the units should be submitted as 15-minute increments. If the code does not specifically indicate a time, the units should reflect the number of visits.

**Q12. What if I forgot to submit required documentation?**

**A12.** We will reach out to you to alert you that some documentation is missing or if we need something additional. We must make decisions on prior authorizations within 72 hours of receipt of the request, so our clinicians are trained to make 2 requests for clinical documentation, 2 hours apart, before completing the review with the existing documentation. If adequate supporting documentation is not submitted, the authorization may be denied.

**Q13. What happens if my prior authorization request is denied? Can I resubmit or ask for reconsideration?**

**A13**. Yes, there are options like peer-to-peer consultations and reconsiderations**.** All options are outlined in detail in the provider manual linked here: Oklahoma SoonerSelect: Provider - Documents and Forms (humana.com)

Humana
Healthy Horizons®
in Oklahoma

**DME Prior Authorization FAQ**

**Q1. What is changing with Humana Healthy Horizons in Oklahoma's prior authorization process?**

**A1.** For the first 90 days of the SoonerSelect program, during the transition of care period, Humana Healthy Horizons in Oklahoma adopted a policy of leniency in our review of outpatient service prior authorization requests. We approved prior authorization requests even if all required documentation to support the request was not submitted to ensure enrollee care was not disrupted. Beginning July 1, we will require all supporting documentation be submitted with the prior authorization request. If documentation is missing or the clinical review team is unable to determine if the request meets the clinical criteria for the service requested, the prior authorization may be denied.

**Q2. What services require a prior authorization?**

**A2.** Services listed on Humana's prior authorization list (PAL) will require submission of a prior authorization request and supporting clinical documentation. Humana's PAL can be found at this link:

www.Humana.com/pal

**Q3. What is the required supporting documentation you are referring to?**

**A3.** Clinical documentation that supports the medical necessity of the services being provided. The type of clinical documentation required varies based on the type of authorization being submitted. The clinical documentation should demonstrate those elements identified in the clinical review criteria (see Q4) as required for authorization.

**Q4. What clinical guidelines/criteria do you use to determine medical necessity?**

**A4.** Humana will use the following hierarchy of guidelines: OHCA guidelines (Medical Authorization Unit (MAU) (oklahoma.gov),) Milliman Care Guidelines (https://humanabh.access.mcg.com/index,) and Humana clinical policies.

**Q5. How do you submit clinical documentation?**

**A5.** The answer depends on how you submit your prior authorization request.

**Availity**

Supporting clinical documentation can be attached to the prior authorization request when submitted via our Availity online portal at Revenue Cycle Management | Healthcare | Availity.

If unable to submit clinical documentation via Availity, this can be faxed to the Clinical Intake Team at 1-833-558-9712.

**Telephone**

Prior authorization requests submitted via telephone will require supporting clinical documentation to be faxed to the Clinical Intake Team at 1-833-558-9712.

**Fax**

Prior authorization requests submitted via fax should include the supporting clinical documentation in the same fax transmission as the authorization request form.

a. Prior authorization request forms for fax submissions can be found at Oklahoma SoonerSelect: Prior Authorization (humana.com).

**Q6. Can an authorization for DME be transferred from one provider to another?**

**A6.** A member can transfer to a different provider during approved dates of a current auth, but a new authorization will be required to be submitted with the new provider's information on it. Along with the new auth, required documentation outlined in the applicable clinical guidelines/criteria (see Q4) will need to be submitted.

**Q7. Can additional codes or units be added to an already approved authorization?**

**A7.** No, if the authorization is already approved and additional units or CPT/HCPCS codes need to be added, a new auth will need to be requested for these additional units/codes.

**Q8. How long does it take to get an authorization decision?**

**A8**. Standard outpatient prior authorizations are determined within 72hrs of receipt. Urgent requests will be determined within 24 hours of submission of receipt and must meet the following: Following standard time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

**Q9. Is submission of a delivery received receipt required for payment of DME claims?**

**A9**. Delivery receipts should be submitted via Availity and are required for payment of DME claims.

**Q10. What do we do if the request includes more CPT/HCPCS codes than allowed to submit on the auth?**

**A10.** If more than 10 CPT/HCPCS codes are needed, additional codes can be included in the Notes section on Availity or on the fax cover sheet. A separate auth is not needed. All codes related to one another should be included on the same auth.

**Q11. What if I forgot to submit required documentation?**

**A11.** We will reach out to you to alert you that some documentation is missing or if we need something additional. We must make decisions on prior authorizations within 72 hours of receipt of the request, so our clinicians are trained to make 2 requests for clinical documentation, 2 hours apart, before completing the review with the existing documentation. If adequate supporting documentation is not submitted, the authorization may be denied.

**Q12. What happens if my prior authorization request is denied? Can I resubmit or ask for reconsideration?**

**A12.** Yes, there are options like peer-to-peer consultations and reconsiderations**.** All options are outlined in detail in the provider manual linked here: [Oklahoma SoonerSelect: Provider - Documents and Forms (humana.com)]

# BH Outpatient Prior Authorization FAQ

**Q1. What is changing with Humana Healthy Horizons in Oklahoma's prior authorization process?**

**A1**. For the first 90 days of the SoonerSelect program, during the continuity of care period, Humana Healthy Horizons in Oklahoma adopted a policy of leniency in our review of outpatient service prior authorization requests. We approved prior authorization requests even if all required documentation to support the request was not submitted to ensure enrollee care was not disrupted. Beginning July 1, we will require all supporting documentation be submitted with the prior authorization request. If documentation is missing or the clinical review team is unable to determine the request meets the clinical criteria for the service requested, the prior authorization may be denied.

**Q2. What services require prior authorization?**

**A2.** Services listed on Humana Healthy Horizons in Oklahoma's prior authorization list (PAL) will require submission of a prior authorization request and supporting clinical documentation. Humana's PAL can be found at www.Humana.com/pal

**Q3. What clinical guidelines/criteria do you use to determine medical necessity?**

**A3.** Humana uses MCG evidence-based criteria to make medical necessity decisions. MCG criteria can be requested here: https://humanabh.access.mcg.com/index

**Q4. What is the required supporting documentation you are referring to?**

**A4.** Clinical documentation that supports the medical necessity of the services being provided. The type of clinical documentation required varies based on the type of authorization being submitted. The clinical documentation should demonstrate those elements identified in the clinical review criteria (see Q3) as required for authorization.

**Q5. What is the required supporting documentation needed for psychological testing?**

**A5.** Clinical documentation of symptoms, behaviors, or functional impairments that have been identified which require psychological testing to determine treatment needs or an evaluation/referral recommending psychological testing requested by a physician, psychiatrist, psychologist, or a licensed mental health professional.

**Q6. What is the required supporting documentation needed for Partial Hospitalization?**

**A6.** Symptoms, behaviors, daily living skills, and/or functional impairments related to underlying behavioral health or substance use disorder. Please include any relationship, work, and/or school issues. Appropriate documentation may include treatment plan, referral from IP or OP provider for PHP services, intake assessments, BH or SUD assessments, progress notes (doctor/nurse/therapy), medication list, progress, or lack of progress towards goals, anticipated discharge date, anticipated discharge plan and potential barriers to discharge.

**Q7. What is the required supporting documentation needed for ABA services?**

**A7.** Targeted symptoms, behaviors, or functional impairments that are appropriate for ABA and how they impact the member's daily living. A comprehensive diagnostic evaluation dated within the last 2 years. Treatment plan including progress or lack of progress towards measurable goals.

*Requests for ABA should be submitted in units.

**Q8. How does Humana determine how many days/services will be authorized?**

**A8**. Humana utilizes licensed clinicians to make determinations of medical necessity using evidence-based care guidelines. Additionally, this team reviews the authorization request, clinical documentation, and individual member circumstances to make decisions about length of authorization. They may reach out to your team to request additional information, if needed.

Upon receiving all the clinical information needed, generally, you should expect to receive the following lengths of authorizations:

Applied Behavioral Analysis and Psychological/Neurological testing authorizations are generally up to 6 months.

Partial Hospitalization authorizations will generally be authorized up to 14 days.

*Certain Partial Hospitalization Programs may be eligible for up to 30-day authorizations.

**Q9. How do we submit clinical documentation?**

**A9.** The answer depends on how you submit your prior authorization request.

**Availity**

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**Q10. What if I forgot to submit required documentation?**

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**Q11. Can additional codes or units be added to an already approved authorization?**

**A11.** No, if the authorization is already approved and additional units or CPT/HCPCS codes need to be added, a new auth will need to be requested for these additional units/codes.

**Q12. How long does it take to get an authorization decision?**

**A12.** Standard outpatient prior authorizations are determined within 72hrs of receipt. Urgent requests will be determined within 24 hours of submission of receipt and must meet the following: Following standard time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

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**Q14. What happens if my prior authorization request is denied? Can I resubmit or ask for reconsideration?**

**A14. Yes, there are options like peer-to-peer consultations and reconsiderations. All options are outlined in detail in the provider manual linked here:** Oklahoma SoonerSelect: Provider - Documents and Forms (humana.com)


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