Government Business Division
Policies and Procedures

Section (Primary Department) Health Care Management		SUBJECT (Document Title) Precertification Committee	
Effective Date 10/21/2009	**Date of Last Review** 02/28/2019	**Date of Last Revision** 12/18/2019	**Dept. Approval Date** 12/18/2019
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☒ Arkansas	☒ Indiana	☒ Minnesota	☒ Tennessee
☒ **Medicare**	☒ California	☒ Iowa	☒ Nevada	☒ Texas
☒ **MMP/Duals**	☐ Colorado	☐ Kansas	☒ New Jersey	☒ Virginia
	☒ District of Columbia	☒ Kentucky	☒ New York – Empire	☒ Washington
	☒ Florida	☒ Louisiana	☒ New York (WNY)	☒ Wisconsin
	☒ Georgia	☒ Maryland	☒ South Carolina	☒ West Virginia

POLICY:

This P&P is also applicable to Medicare.

To define the role and responsibility of the Precertification Committee and to outline the steps in the precertification rule change management process.

Background: The Precertification Committee (PCC) serves as the official precertification rule decision-making body for the Company's Government Business Division (GBD), which consists of Medicare, Medicaid and Medicare-Medicaid Plan (MMP). The committee reviews current rules periodically for potential changes and reviews/makes decisions on requests to add, delete or change precertification rules for the organization. Changes to the precertification rules are not to be operationalized via system changes or manual processes without PCC approval.

DEFINITIONS:

E-Vote: An e-Vote is defined as a decision or action taken by the PCC without holding a formal meeting; the Committee receives the required materials via email and a vote is responded to electronically via email. Once a quorum is achieved, the decision is considered binding and is reported back to the PCC during the next meeting.

Practitioner: A professional who provides health care services. Practitioners are usually licensed as required by law.

Provider: An institution or organization that provides health care services for members. Examples of providers include - hospitals and home health agencies.

Proxy: Voting proxy is the power given by a voting member to another person to vote in his or her stead. The proxy is designated by the voting member and must be disclosed to the committee.

Quorum: A quorum is defined as having 50% plus one (1) representation from the key

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operational departments and divisions as outlined in item Number 4 of the procedure section below.

Voting Member: Voting members shall consist of associates selected from the key operational departments and divisions as outlined in number 4 of the procedure section below. Each voting member is entitled to one vote.

PROCEDURE:

1) The PCC is responsible for reviewing all requests for the addition of new precertification rules and/or revisions to existing rules. This includes authorization waivers and managing Provider status.

2) PCC decisions are evidence based. The requestor is required to submit an analysis to demonstrate the effects on the business operations, and provide a summary on how the change will impact the health plan/division.

3) The PCC under the leadership of the corporate Chief Medical Officer (or designee) is made up of participants representing a cross section of health plan clinical leaders, Medical Directors and corporate associates representing Health Care Management (HCM) corporate leadership, UM Operations, Provider Services Organization (PSO), Pharmacy Management, Reimbursement Policy Management (RPM), the National Customer Care (NCC) Precertification team, Health Plan Services (HPS), and Medical Finance. Committee participants may rotate on an annual basis.

4) Each of the following departments holds voting rights:
   a) Behavioral Health
   b) Claims – Medicare and Medicaid
   c) UM Operations
   d) HCM
      i) Medicaid - two (2) representatives, both hold voting rights
      ii) Medicare
      iii) LTSS
   e) Health Plan
   f) HPS
   g) RPM
   h) Medicaid Medical Director - two (2) health plan representatives (each holds voting rights), and a National Medical Director
   i) Medicare Medical Director -two (2) representatives, each holds voting rights
   j) NCC
   k) Pharmacy
   l) National Provider Relations – Medicaid and Medicare
   m) MMP

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The Committee includes representation from other key departments/divisions who are considered non-voting members

5) The PCC meets on a bi-weekly basis.

6) To initiate a request to change precertification rule(s), the requestor submits a completed PreCert Request Form to the Committee's SharePoint site, along with all the required documentation. The requestor appears before the PCC to explain the request in detail and answer any questions the PCC may have related to the request.

7) The PCC reviews and evaluates the request, including all required documentation (as outlined on the PreCert Request Form), and verifies that the analysis demonstrates operational efficiency and/or meets business needs.

8) New requests are reviewed by the PCC during the next scheduled committee meeting. The completed form must be received at least one (1) week prior to the next scheduled committee meeting. Requests received after the deadline are presented at the next scheduled meeting.

9) Expedited reviews are completed within three (3) business days – typically using the e-Vote approval process.

10) Once reviewed, the PCC approves, denies, or pends the request for further information.

11) Upon approval the UM Operations department takes the following actions:
    a) Notifies all affected health plans/corporate departments within two (2) business days, (this includes HPS for approved changes requiring system configuration and/or Claims for approved claim processing exceptions).
    b) Confirms all State and Regulatory requirements are met by working with Regulatory Services,
    c) Drafts and submits the Provider Communications to CMAP for State Approvals, if the approved requests are for all markets and Lines of Business, tracks the progress and notifies the PreCert Liaison when complete so requests can then be submitted for configuration, (Provider Communications for Specific rule changes are managed by the respective local health plan), and
    d) Confirms configuration occurs, is tracked and achieved. Confirms within GBD Facets that the rule is configured as requested.

12) In the event a request is denied, the requester is entitled to one level of reconsideration. The requestor completes the "reconsideration" section of the original PreCert Initial Request and Reconsideration Form and submits to Staff VP UM Operations.

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13) The second level review is scheduled as soon as all parties are available, and is attended by the PCC Chairperson, the original requestor, and the relevant Health Plan's Chief Medical Officer/Medical Director. The PCC Chairperson makes the final determination and communicates the decision to the PCC within one (1) business day of the meeting.

14) Additional procedures for Gold or Green Card status:
    a) Provider Data Management only accepts PCC-approved requests from HPS or UM Operations to make changes to a provider's precertification requirement status in the claims payment system.
    b) NCC Vendor Relationship Managers or their designee must verify PCC approval prior to sending notification of Green, Gold or Platinum Card status approval.
    c) If PCC approval is not in place, the appropriate Plan/Vendor Account Manager is advised to request approval from PCC.
    d) The UM Operations Department audits the Gold Card status providers annually to verify PCC approval.

15) UM Operations maintains a decision log documenting all PCC determinations. The log is also used to track, report and proactively monitor expiring exceptions, green, gold or platinum card decisions. The Committee liaison maintains a public calendar to initiate timely Committee review.

REFERENCES:

Kentucky Medicaid Managed Care Contract §21.2, 30.13
Kentucky Revised Statute 304.17A-603

Related Materials:
PreCert Change Request Form

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management

Secondary Department(s):
Medicaid Business Support
NCC Vendor Relationship Managers
Provider Data Management
Provider Relations Health Plan
Provider Services Organization - National Provider Relations

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EXCEPTIONS:

Kentucky:
The PCC will submit a request for global or local precert changes for the Kentucky market to the health plan. The health plan designee will review the request and provide feedback to the PCC. If the change request is approved, the PCC will submit for creation of the provider notification. The provider notification is submitted to the Department for approval of the updated changes to precert. Configuration of the medical management authorization system and Precertification Lookup Tool (PLUTO) is completed once the timeframe for provider notification is met.

For up-to-date precertification requirements, providers are encouraged to utilize the list of services and codes for which preauthorization is required on the health plan's publically accessible website (https://mediproviders.anthem.com/ky/pages/precert.aspx). The Precertification Lookup Tool is available on the health plan's provider website.
The written precertification procedures are readily accessible on the health plan's website for providers at https://mediproviders.anthem.com/ky/pages/precert.aspx; a link to these procedures is provided to covered and authorized persons at https://mss.anthem.com/ky/care/referrals-preapprovals.html.

REVISION HISTORY:

Review Date	Changes
01/01/2014	• Added Kentucky health plan.
12/03/2015	• Off-cycle edits to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.
01/28/2016	• Biennial review by PPOC and MOC • Added CA, TX & VA MMP as applicable markets • Revised policy and definitions section • Procedure section revised entirely
09/25/2016	• Off-cycle edit to add KY exception language
02/23/2017	• Annual review • Added CA, IN, WNY, SC, WI & WV as applicable markets • Revised Clinical Ops to UM Ops throughout; Added dept. abbreviations • Added Provider Communication approval step • Added KS exception
02/26/2018	• Annual review • Updated related P&Ps
08/10/2018	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
12/13/2018	• Off-cycle edit to add DC as an applicable market. Updated MN go-live

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	date to 1/1/19.
01/25/2019	• Off-cycle edit to add AR as an applicable market. No content edits.
02/28/2019	• Annual review • Removed KS as an applicable market • Added KY contract reference • Revised KY exception language; removed KS & MN exception language
12/18/2019	• Off-Cycle Review • Revised KY exception language