Frequently Asked Questions

Prior Authorization for Medical Oncology

What are HealthHelp's hours of operation?
The WebConsult site is available 24 hours a day, 7 days a week. HealthHelp representatives and physicians are available via phone Monday through Friday from 7 a.m. to 7 p.m. Central Time and Saturday from 7 a.m. to 5 p.m. Central Time. Requests submitted after regular business hours and on weekends, will be processed by our after-hour team in accordance with the specified turnaround time of the request.

Who requires an authorization?
Authorizations are required for Medicare members.

Does HealthHelp check the eligibility of the patient?
Yes, HealthHelp receives weekly eligibility files from the Health Plan. If the member is not in the eligibility file, HealthHelp has the ability to add member records after confirming with the Health Plan's Customer Service Department.

What information should our office provide when submitting a procedure/treatment request for authorization?
Relevant clinical information includes the diagnosis, ICD-10 code, name of the ordered procedure/treatment, CPT code, reason for the procedure/treatment, duration of symptoms, prior imaging studies, laboratory studies, medications, prior treatments, and notes from last two office visits.

What procedures require an authorization?
You can find a list of the procedures that HealthHelp reviews by visiting the Essence Consult page at the following link and selecting the "Procedure Codes" link to download the PDF reference: www.healthhelp.com/Essence

Does HealthHelp supply CPT or ICD-10 codes once a diagnosis is given? To expedite the clinical review process, it is best if the physician's office is prepared to deliver this type of information. However, this information is available when using WebConsult online.

How does the authorization request process work?
The ordering physician's office engages HealthHelp prior to scheduling the procedure/treatment to be ordered. HealthHelp collects all relevant clinical information and reviews it alongside evidence-based guidelines. HealthHelp programs follow URAC and NCQA guidelines for utilization management.

When the clinical rationale is inconsistent with the guidelines, a board-certified specialist consults with the ordering physician to evaluate available diagnostic/treatment opportunities. When in doubt or when ordering a procedure or treatment that carries significant risk, the ordering physician may benefit from the knowledge of an expert in the specialty field. The collaborative, educative process helps physicians make the best decisions for their patients.

The clinical review process is completed in a timely manner upon receipt of all clinical information needed to make a determination.

An authorization confirmation, including an Essence tracking number, is then faxed to the provider's office.

How does the authorization make it into the Essence system?

The authorization is entered into the Health Plan's claims system via delivery of a daily authorization file.

Can I check to see if an authorization has already been obtained for a member?

Yes. When you are logged into the HealthHelp website click the "Request Status" link at the top of the page. A provider may search for a request by entering the tracking number, authorization number, member's name, and/or member number. Overall, for best search results, please make sure the spelling of any name is accurate, the member number is correct, and the date range is consistent with the date the request was made. You may also check the status of a prior authorization by calling HealthHelp's inbound call center at 888-285-6772.

Does the number have an expiration date?

Yes, 90 days after the date of authorization for Radiation Therapy and Sleep modalities; 30 days after the date of authorization for diagnostic modalities and 180 days after the date of authorization for medical oncology modalities.

Are retroactive procedure/treatment requests reviewed for authorization?

Yes. They have to be obtained within 30 days from the date of service.

Does this mean that HealthHelp will preauthorize or deny services?

HealthHelp will authorize requests that are medically appropriate and provide educational consultation for those that do not meet clinical guidelines. Certain modality requests that do not meet clinical guidelines will be referred to the health plan for final determination.

What if I want to speak to a Physician Reviewer or Medical Director?

If you would like to speak with a Physician Reviewer or the Medical Director, you can do so by calling HealthHelp's customer's service line at 888-285-6772. A customer service agent will assist with facilitating the call with a nurse reviewer who will review the procedure. If unable to provide an approval, the nurse reviewer will coordinate with our Physician Reviewer or Medical Director, as appropriate.

What are the clinical criteria used for HealthHelp's programs in determining the appropriateness for ordering procedures/ treatments?
HealthHelp's programs use CMS NCD and LDC guidelines when available; when there is not a CMS NCD or LCD associated with the request; HealthHelp will use its own proprietary clinical guideline. These clinical guidelines are updated regularly with peer-reviewed literature from the industry. Determinations and recommendations are made in accordance with acceptable medical standards and appropriateness-of-care guidelines.

Are these InterQual criteria?
No. HealthHelp's clinical guidelines are based on current peer-reviewed literature.

How are your criteria developed? HealthHelp's proprietary clinical review criteria are developed using existing guidelines (e.g., American College of Radiology, National Comprehensive Cancer Network), current medical literature, and regionally accepted practice protocols for particular diagnosis codes and procedures/treatments.

Can I get a copy of your criteria?
Yes, criteria can be accessed on HealthHelp's website at: https://www.healthhelp.com/resources/. They are also available by calling HealthHelp's Clinical Guidelines Department at (877) 685-5264.

Are the criteria current?
Yes, all existing criteria are reviewed at least annually.

Can I suggest a change to your criteria?
Yes, we welcome your suggestions. Please submit any suggestions with supporting peer reviewed literature to CGDevelopment@healthhelp.com or/and 877-685-5264. The package will be reviewed for appropriateness and submitted to the physician advisory committee for acceptance. We will respond to you within sixty days.

How do I request a Peer-to-Peer after an adverse determination?
If a provider is seeking a post-denial peer-to-peer request, they can access the Provider Peer-to-Peer Request Form on the landing page at: www.healthhelp.com/Essence. A Peer-to-Peer can be requested within 5 (five) days of the initial notification for pre-service medical necessity adverse decision. Please be sure to fill out the request form completely and include any additional clinical information to support medical appropriateness. Once complete, please fax the Peer-to-Peer request form to the fax number noted at the top of the form: 888-265-0013. Please be sure to list the date(s), time(s), and time zone for your request to ensure a HealthHelp physician is able to connect.

How can I contact HealthHelp?
HealthHelp can be contacted in three ways:

- Web – www.healthhelp.com/Essence
- Phone – 888-285-6772

- Fax – 888-285-6851
- Expedited– Fax 877-391-7292