Frequently Asked Questions

Prior authorization process: Advanced radiology/imaging, cardiology, sleep, and musculoskeletal services

Q. What is HealthHelp?

A. HealthHelp is a specialty benefit management company. HealthHelp is working with UPMC Health Plan to administer a consultative prior authorization program for advanced radiology/imaging, cardiology, sleep, and musculoskeletal services.

Q. What is HealthHelp's program for UPMC Health Plan?

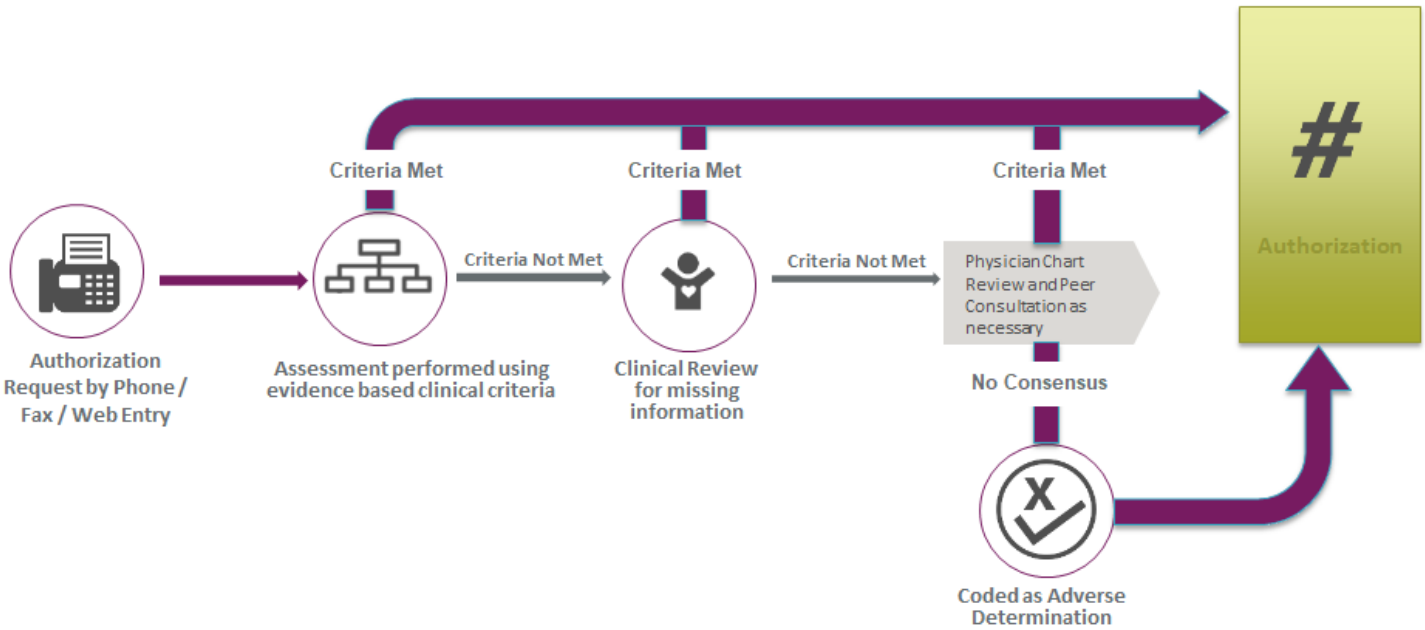
A. HealthHelp's consultative, educational prior authorization program will involve evaluating requests for in-scope outpatient procedures against evidence-based clinical guidelines. This will be done to determine their medical appropriateness.

The ordering physician or designee will enter member and clinical information into the system. A large percentage of the procedures (about 70 percent) will automatically be authorized. Those that are not will be reviewed by a clinical nurse, and additional information may be gathered.

If the requested service cannot be approved after the nurse's review, the request will progress to a Level 3 review. This will involve a specialty physician performing a chart review and, if necessary, consulting with the ordering physician to determine the appropriateness of the ordered procedure.

If the procedure was requested by a UPMC physician, the peer consult will generally be performed by a UPMC specialty physician. If the procedure was requested by a non-UPMC physician, a physician from HealthHelp's panel of subspecialty physicians will conduct it.

Clinical review process:



UPMC HEALTH PLAN

Q. What tests and procedures within each specialty would require prior authorization?

A. Beginning June 1, 2019, ordering physicians will be required to obtain prior authorization for the following procedures unless the services are rendered in an emergency or inpatient setting:

- **Advanced radiology/imaging:** CT, CTA, MRI, MRA, PET, cardiac nuclear medicine
- **Cardiology:** Cardiac catheterization, cardiac implantable devices, and wearable cardiac devices (e.g., LifeVest)
- **Sleep:** In-lab polysomnography
- **Musculoskeletal:** Arthroplasty, arthroscopy, open joint surgery, arthrodesis, laminotomy, laminectomy, corpectomy, foraminotomy, discectomy, kyphoplasty, and vertebroplasty

NOTE: *Many codes that previously did not require prior authorization will now require it. A complete list of procedure codes requiring prior authorization can be found at* **upmchp.us/medicalpriorauth.**

Q. Will a prior authorization review be required for all in-scope tests and procedures?

A. Yes. Prior authorization and an associated number are required to ensure successful processing of claims payment. Beginning on June 1, 2019, all tests and procedures identified above and in the referenced, detailed list will require prior authorization through the HealthHelp process.

Q. I am a provider who has not been required to submit prior authorization requests in the past for the identified procedures. How will this new requirement affect me?

A. Providers treating UPMC Health Plan members will be required to submit prior authorization requests for advanced radiology/imaging, cardiology, sleep, and musculoskeletal services. HealthHelp's process for evaluating prior authorization requests includes collecting relevant clinical information from the ordering/treating physician's office, reviewing this information alongside current evidence-based guidelines, and conducting peer-to-peer consultations to confirm medical appropriateness of requested procedures (when necessary).

Q. How do providers request prior authorization for advanced radiology/imaging, cardiology, sleep, or musculoskeletal services?

A. Ordering physicians can request prior authorization for advanced radiology/imaging, cardiology, sleep, and musculoskeletal services using one of the following methods:

- **Internet:** UPMC Health Plan Provider OnLine
- **Fax:** 1-877-637-6938
- **Fax Expedited:** 1-877-685-5253
- **Phone:** 1-888-717-9655

NOTE: The most efficient method for obtaining a prior authorization number is through Provider OnLine, which can be accessed directly or through NaviNet. You can access the fax forms at ***upmchp.us/medicalpriorauth*** *or under Documents and Forms on Provider OnLine.*

Q. How can I obtain a log-in to submit my requests via HealthHelp's online system?

A. All requests for access to HealthHelp's online system must be submitted through Provider OnLine, which can be accessed directly or through NaviNet. If you forgot your Provider OnLine user ID or need help registering as a first-time user, please call the Provider OnLine Help Desk at 1-800-937-0438.

Q. What do I do once I am logged in to Provider OnLine?

A. Once you are logged in to Provider OnLine, click the Auth Entry/Inquiry button in the left navigation panel. This will direct you to the landing page you will use to submit prior authorizations through HealthHelp. Please note, you will be redirected via a secure link.

Q. What information is needed to initiate a prior authorization request for advanced radiology/imaging, cardiology, sleep, or musculoskeletal services?

A. The following information is required for all requests and should be available in the patient's chart:

- Member's name and ID number
- Ordering physician's name
- Ordering physician's telephone and fax numbers
- Member's diagnosis or clinical indication
- Test, device, or procedure being ordered (CPT code)
- Reason for test, device, or procedure
- Member's symptoms and duration
- Prior related diagnostic tests
- Laboratory studies
- Member's medications and duration
- Prior treatments
- Summary of clinical findings
- Member's risk *(primarily applies to imaging requests related to cancer screening indications)*

For cardiology, musculoskeletal, or sleep services, include the following information in addition to items listed above:

Cardiology

- High- or low-risk indication, pretest probability (low, intermediate, or high), and supporting clinical information

Musculoskeletal

- Body site (spine, hip, knee, or shoulder)
- Physical and/or neurological symptoms
- Physical exam findings
- Prior surgical intervention
- Supporting clinical information on imaging, physical therapy, medication

Sleep

- Relevant physical exam findings (hypertension, BMI, neck circumference)
- Risk questionnaire (snoring, snorting, gasping/choking)

Q. How long does the authorization approval process take?

A. If appropriate clinical criteria have been met and the necessary information is provided, prior authorization requests submitted through Provider OnLine can automatically be authorized. If additional levels of review are required, prior authorization will be processed in accordance with UPMC Health Plan's standard prior authorization turnaround times. These align with regulatory requirements for each line of business.

Q. Can I check to see whether a prior authorization has already been obtained for a member?

A. Yes. When you are logged in to the HealthHelp website through Provider OnLine, click the Web Status link at the top of the page. You may search for a request by entering the member's name, date of birth, and/or member ID number. (Make sure the spelling of the name is accurate, the member ID number is correct, and the date range is consistent with the member's treatment.)

You may also check the status of a prior authorization by calling HealthHelp's inbound call center at **1-888-717-9655.**

Q. How can my staff get additional training and support or learn more?

A. Additional information about the authorization process will be provided during scheduled webinars and system demos. Educational materials, webinars, and a list of all procedure codes requiring prior authorization through HealthHelp can be found at **upmchp.us/medicalpriorauth.** If you would like hard copies of these materials or have any additional questions, please contact your physician account executive or call Provider Services at **1-866-918-1595.**

Q. Are policies applicable to in-scope tests and procedures available for review?

A. Yes. You can review UPMC Health Plan's policies and procedures manual at **upmchp.us/policiesandprocedures.**

Q. How should requests be submitted until June 1, 2019, when the HealthHelp process goes live?

A. For procedures that currently require prior authorization, requests submitted by **May 31, 2019**, should be submitted through the existing authorization process. All authorization requests submitted on or after **June 1, 2019,** should be presented using the new HealthHelp process.

If authorization was obtained before **June 1, 2019,** a replacement authorization will not be required for the same service or procedure.

Q. Do prior authorizations expire?

A. Once submitted, the prior authorization is active for 60 days.

For current users of EpicCare with ACR Select:

Q. How will the HealthHelp program affect me as an EpicCare user?

A. If you currently submit prior authorization requests for radiology and cardiology procedures through EpicCare with ACR Select, you will continue to do so. You will continue to receive feedback regarding medical appropriateness from ACR Select, but it will not authorize the procedure. For prior authorization, you will need to enter the request into HealthHelp's system through Provider OnLine. Only if an authorization number has been generated by the HealthHelp system will the associated claim be paid.

The requirement to enter the information into HealthHelp and ACR Select is temporary and will be discontinued when HealthHelp's decision support tool is integrated into EpicCare.

Q. Will I need to get prior authorization for additional advanced radiology/imaging and cardiology codes that are within HealthHelp's scope?

A. Yes. More than 500 codes will be processed through HealthHelp, including some advanced radiology/imaging and cardiology procedures that are not currently subject to a prior authorization requirement.

If an advanced radiology/imaging or cardiology code is not processed through EpicCare with ACR Select but requires prior authorization, it must be entered in HealthHelp's portal. Please visit **upmchp.us/medicalpriorauth** for the list of codes that must be entered via ACR Select and/or HealthHelp.

Q. What is "the phased approach?"

A. This new process temporarily runs in tandem with your existing process for submitting prior authorizations. Codes currently submitted through ACR Select must continue to be submitted through ACR Select until HealthHelp is integrated into EpicCare. Requests for these codes (plus additional codes) must also be submitted through HealthHelp.

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