REFERRAL PROCESS

Physician Referrals within Plan Network

Physicians may refer members to any Specialty Care Physician (Specialist) or ancillary provider within the Fidelis Care network. Except as noted below, Fidelis Care communicates to members directing them to see their primary physician for their health care needs and that the physician will assist with a referral if they need to see a specialist. Fidelis Care does not require that a member return back to his/her primary physician for a referral to a different participating specialist if a participating specialist recommends that he/she be treated by another specialist. Fidelis Care does not require physicians to notify the plan when a member is referred to a participating specialist. To ensure coordination of care, Fidelis Care does recommend that a specialist notify the member’s primary physician when a referral to another specialist is made.

Fidelis Care does not cover care provided by non-participating providers, except for urgent/emergent care, without prior authorization by the Chief Medical Officer or designee. Please refer to Section 18 for more information.

Direct Access

Fidelis Care communicates to members that it isn’t necessary to see their primary physician before seeking care from a participating specialist provider. However, when a member does have a primary physician, it is recommended that the member consult with that physician before seeking the services of a specialist. For assistance in identifying a participating provider, members may contact Fidelis Care at 1-888-343-3547.

| Alcohol and Substance Abuse Services | No authorization is required for outpatient services. Except in an emergency, all inpatient services require prior authorization from Fidelis Care. Behavioral health providers should contact the Behavioral Health Case Managers to obtain prior authorization. For emergency situations, the provider should treat the patient and notify the Behavioral Health Case Managers as soon as practical, but, no later than forty-eight (48) hours or the next business day. |
| Behavioral Health Services | Most outpatient services do not require prior authorization. Providers should review the most current version of the Prior Authorization grid (Appendix I) to confirm whether or not a specific service requires authorization. Except in an emergency, all inpatient services require prior authorization. Behavioral health providers should contact the Behavioral Health Case Managers to obtain prior authorization. For emergency situations, the provider should treat the patient and notify the Behavioral Health Case Managers as soon as practical, but, no later than forty-eight (48) hours or the next business day. |
| Dental Services | Members may self refer to dental providers within the dental network of Fidelis Care. Please contact Fidelis Care at 1-888-FIDELIS (1-888-343-3547) for more information. Members can also contact Dent求Quest |
### General Information

Please refer to the authorization grid (Appendix I) to determine which services require prior authorization. Note that in order to determine medical necessity, clinical information is needed. Fidelis Care will make up to two (2) attempts to obtain necessary clinical information from a facility or provider. Once all of the clinical information needed to determine medical necessity is received, an authorization number will be assigned and the facility/provider will be notified.

Fidelis Care’s QHCM Department is staffed to provide authorization by telephone 8:30 AM to 5:00 PM Monday through Friday except on holidays. For non-urgent services, requests received after business hours (5:00 PM), will be processed the next business day. For urgent situations that cannot wait until the next business day, please call 1-888-FIDELIS (1-888-343-3547) for urgent access.

### Services Requiring Prior Authorization

- Fidelis Care requires prior authorization for services listed in Appendix (I)

- Effective 10/1/2017, outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, and outpatient radiation therapy services, for all products except Fidelis Care at Home (FCAH) and Fully Integrated Duals Advantage (FIDA), require prior authorization from eviCore healthcare. For a complete list of procedures that require prior authorization from eviCore healthcare, visit: [https://www.evicare.com/healthplan/fideliscare](https://www.evicare.com/healthplan/fideliscare).

### Pharmacy Services Requiring Prior Authorization

Members who have a metal-level plan have prescription drug coverage through Fidelis Care.
Section Eleven Referrals and Prior Authorization

- The Fidelis Care Formulary or Preferred Drug List is located on the website at: http://www.fideliscare.org/en-us/providers/pharmacieservices.aspx
  - Please note: Drugs listed on the formulary with a PA indicator require you to contact Fidelis Care to obtain a prior authorization.

Drugs administered in the doctor's office which are on the authorization grid Appendix (I) will require prior authorization by Fidelis Care.

Referrals to Non-Participating Providers
A participating Fidelis Care provider may not refer to a non-participating provider. If a participating provider believes a patient needs care that is not available from another participating provider, a physician should call the Fidelis Care prior authorization number at 1-888-FIDELIS (1-888-343-3547) to request approval for care. The Chief Medical Officer or designee will review the request.

The Primary Physician as a Specialist
A Fidelis Care physician who practices primary care and has training in a sub-specialty may be credentialed in that specialty and participate as a specialist in Fidelis Care's network. Such providers are called "Dual Providers."

Dual Providers, who wish to provide specialty services to their own Fidelis Care patient, must obtain an authorization from Fidelis Care's Quality Health Care Management (QHCM) Department at 1-888-FIDELIS (1-888-343-3547), prior to providing specialty services, unless the provider is credentialed as a Dual Provider with Fidelis Care. The Authorization Number and Taxonomy Code should be included on the bill for specialty services.

Referral to Specialty Care Centers
Should the member present with a life-threatening or degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time, a referral may be made to an accredited speciality care center with expertise in the condition. The decision to make such referrals is made by Fidelis Care's Chief Medical Officer or designee after consultation with the member's primary physician. In no event shall Fidelis Care be required to permit a member to elect to use a non-participating specialty care center, unless Fidelis Care does not have an appropriate specialty care center within the network.

Degenerative and Disabling is defined as any chronic or acute disease entity that, despite appropriate medical intervention, will destroy the body's integrity, leading to patient's dependence on others for activities of daily living (ADL) and eventually to death.

Life threatening is defined as a situation in which the patient's medical condition is such that any delay in treatment would result in the patient's death.

Considerations for Specialty Care Providers
The specialist plays an integral role in the delivery of quality services to our members. As recipients of referrals from the primary physician, it is important to keep in mind the following:

- Participating specialty care providers are expected to keep the primary physician informed of the member's clinical condition. If the member requires ongoing treatment, a report should be sent to the primary physician at the conclusion of the treatment.
- In the event that the member requires additional treatment (e.g. hospitalization, surgery, etc.), the specialist should keep the primary apprised.
- Should the member need the services of another participating specialist or ancillary provider, the specialist should contact the primary physician as soon as possible informing them of the referral to another specialist.
Section Eleven

Referrals and Prior Authorization

PRIOR AUTHORIZATION PROCESS

Purpose for Prior Authorization
- Give providers eligibility information based on Fidelis Care’s currently available data.
- Confirm that particular services are a covered benefit under Fidelis Care.
- Allow Fidelis Care to evaluate the medical necessity and appropriateness of the proposed treatment.
- Provide Fidelis Care an opportunity to suggest alternative treatments.
- Provide appropriate authorization to allow reimbursement to the provider for treatment.
- Enable the Case Management nursing staff to track the member’s care and coordinate services where necessary.

Process to Obtain Prior Authorization
Procedures requiring prior authorization by Fidelis Care are listed below. The prior authorization request must be generated by a Fidelis Care provider and authorized by Fidelis Care’s Quality Health Care Management (QHCM) Department. We recommend that a request be sent at least five (5) calendar days before the anticipated date of service.

The following information will be required to process a service for prior authorization:
- Member name/date of birth
- Member’s Fidelis Care ID number
- Ordering provider’s name, servicing provider’s name and hospital/ambulatory center name if indicated
- Diagnosis
- Current Procedural Terminology (CPT) codes of the procedure, surgery, or service being requested
- Anticipated date and time of procedure
- Necessary clinical information supporting need for procedure, surgery, or service. The Medical Director may request additional information.

Provider submission of service authorization requests can be accomplished as follows:
- Telephonically: 1-888-FIDELIS (1-888-343-3547)
- Fax: 1-800-860-8720 (Medical)
- Fax 1-718-896-1784 (Behavioral Health)
- Fax: 1-877-533-2405 (Pharmacy)
### Authorization Processing Timeframes

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Type of Communication</th>
<th>Receiver of Communication</th>
<th>Process Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Authorizations</strong></td>
<td>Telephone and in writing within 3 Business Days of receipt of necessary information.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>3 business days. Additional info must be requested within 3 business days. Provider has 45 calendar days to submit info. If info received within 45 days, decision must be made within 3 business days of receipt of this additional information. If all necessary information is NOT received, we must make a decision within 15 calendar days of the end of the 45 day period.</td>
</tr>
<tr>
<td><strong>Urgent Prior Authorization</strong></td>
<td>Telephone within 72 hours of receipt of request if we have all necessary info. Written notice follows within 1 calendar day of decision.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>Within 72 hours. Additional info must be requested within 24 hours. Provider has 48 hours to submit the additional information. We must make a decision and provide notice within 48 hours of the earlier of our receipt of the information OR the end of the 48 hour period.</td>
</tr>
<tr>
<td><strong>Concurrent</strong></td>
<td>Telephone and in writing within 1 Business Day of receipt of all necessary information.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>1 business days. Additional info must be requested within 1 business day. Provider has 45 calendar days to submit info. If info received within 45 days, decision must be made within 1 business day of receipt of this additional information. If all necessary information is NOT received, we must make a decision within 15 calendar days of the end of the 45 day period.</td>
</tr>
<tr>
<td><strong>Urgent Concurrent</strong></td>
<td>Telephone within 24 hours of receipt of request. Written notice provided within 1 business day if all necessary info was included and within 3 calendar days if all necessary info was not included.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>Within 24 hours, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment. If the request is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent prior authorization timeframes apply.</td>
</tr>
<tr>
<td><strong>Home Health Care Reviews - following an inpatient (IP) admission</strong></td>
<td>Telephone and in writing within one business day of receipt of necessary info. If the day following the request falls on a weekend or holiday, we will provide notice within 72 hours of receipt of necessary info.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>Following an IP admission, determination within 1 business day of receipt of necessary info (if the day following the requests falls on a weekend or holiday, we will make a determination and provide notice to You within 72 hours of receipt of necessary info). *We will not deny coverage while our decision is pending.</td>
</tr>
</tbody>
</table>

*We will not deny coverage while our decision is pending.*
### Section Eleven

#### Referrals and Prior Authorization

<table>
<thead>
<tr>
<th>Inpatient Substance Use Disorder Treatment</th>
<th>Telephone within 24 hours of receipt of request. Written notice provided within 1 business day.</th>
<th>Member or Designee and Practitioner/Provider</th>
<th>Within 24 hours, if the request for coverage is made at least 24 hours prior to discharge from the IP substance use disorder treatment. We will provide coverage for the IP substance use disorder treatment while our determination is pending.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective</td>
<td>In writing within 30 calendar days of receipt of request.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>Within 30 calendar days of receipt of the request. Additional information must be requested within 30 calendar days. Provider has 45 calendar days to submit info. We will make a decision and provide notice in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45 day period.</td>
</tr>
<tr>
<td>Reconsideration</td>
<td>In writing and by phone if adverse determination is upheld.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>Must occur within 1 Business Day of receipt of request for prior authorization, and concurrent determinations</td>
</tr>
</tbody>
</table>

*An expedited review must be conducted when Fidelis Care or the provider indicates that delay would seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum functions. Members have the right to request an expedited review. If Fidelis Care denies the member’s request for an expedited review, Fidelis Care will notify the member that the request will be handled under standard review timeframes.*

**Service Authorization Request Determination and Notification**

All cases are evaluated for the appropriate level of care and medical necessity based on the clinical findings and plan of care submitted to Fidelis Care. All cases are reviewed using nationally accepted guidelines (e.g. Milliman Care Guidelines, American Society of Addiction Medicine (ASAM), CMS National and Local Coverage Determinations) or guidelines developed by Fidelis Care. Any case not meeting guidelines will be reviewed by a Chief Medical Officer or designee.

All cases are evaluated for the appropriate level of care and medical necessity. *Medically Necessary* means health care and services which are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

Fidelis Care will provide the member (or their designee) and provider with verbal (telephonic) and written notification of the determination regarding the requested service, procedure or surgery.

- **Approved authorizations:** notification will include a description of the service and/or number of visits along with the date(s) of service/approval timeframe.
- **Adverse determinations:** If the Medical Director concludes, after review of all information submitted, that the service is not medically necessary or the level of care is not appropriate for the member's condition, a denial notice will be issued in accordance with the Subscriber Contract.
- **Denials also are issued when the clinical information submitted is insufficient to make a utilization determination.**
- **Reconsideration of adverse determination:** When an adverse determination is rendered without provider input, the provider has the right to reconsideration.
reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the member’s health care provider and the clinical peer reviewer making the initial determination.

- Exception: Retrospective reviews that result in an adverse determination are not eligible for reconsideration.

Fidelis Care must send a notice of determination on the date review timeframes expire. If Fidelis Care fails to make a determination within the time periods prescribed in this section, it shall be deemed to be an adverse determination subject to appeal.

A notice of adverse determination is in writing and includes:

a. The reasons for the determination, including the clinical rationale, if any;

b. Instructions on how to initiate internal appeals (standard and expedited appeals);

c. How to initiate an external appeal; and

d. Notice of the availability, upon request of the member or the member’s designee, of the clinical review criteria relied upon to make the determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by Fidelis Care, in order to render an appeal decision.

e. Description of Action to be taken.

f. Statement that Fidelis Care will not retaliate or take discriminatory action if appeal is filed.

f. Process and timeframe for filing/reviewing appeals, including member’s right to request an expedited review.

h. Member’s right to contact DOH, with 1-800 number, regarding their concern.

i. Fair Hearing notice including aid to continue rights.

j. Statement that notice is available in other languages and formats for special needs and how to access these formats.

**Reversal of Prior Authorized Treatment**

Fidelis Care may reverse a prior authorized treatment, service, or procedure on retrospective review pursuant to section 4905(5) of PHL when:

a) relevant medical information presented to Fidelis Care or utilization review agent upon retrospective review is materially different from the information that was presented during the prior authorization review; and

b) the information existed at the time of the prior authorization review but was withheld or not made available; and

c) Fidelis Care or UR agent was not aware of the existence of the information at the time of the prior authorization review; and had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

**Financial Incentives**

Fidelis Care is committed to providing members with the best and most appropriate care possible. Utilization management decisions are based only on the appropriateness of care and existence of coverage. At no time does Fidelis Care directly or indirectly reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives offered or compensation rewarded to individuals, as UM decision makers, to encourage underutilization of services.

**Provider Request for Clinical Criteria**

Providers may request a copy of the clinical criteria used to render a utilization management decision, free of charge.

Providers are notified of their right to obtain clinical criteria via:
Section Eleven  Referrals and Prior Authorization

a. Utilization Management notifications (adverse determinations) include an appeal rights attachment.
b. The provider portal or provider bulletin.

Requests can be submitted by calling 1-888-FIDELIS (1-888-343-3547) and speaking with a Call Center representative.

The applicable clinical criteria will be mailed to the requesting provider within 15 business days.