

TREATMENT PRE-AUTHORIZATION POLICY

Policy No:
Effective Date:

Approved by:

I. POLICY

All chemotherapy and radiation services must be authorized before any services can be performed.

II. SCOPE

This policy applies to all outpatient sites performing chemotherapy and radiation services. Authorization may be in the form of approval from the payer or it may simply entail a medical necessity validation per payer guidelines.

III. PROCEDURE

Following are a list of required information necessary to determine medical necessity or obtaining prior authorization:

1. The ordering physician's name.
2. The hospital or group name as assigned by the insurance carrier.
3. The patient's insurance carrier name.
4. The insurance carrier fax number.
5. The patient's insurance ID.
6. The patient's date of birth.
7. The patient's name.
8. The patient's Social Security number.
9. The verbiage for the patient's diagnosis, both primary and secondary if applicable.
10. The corresponding ICD-9 code (if requested).
11. The CPT codes for lab tests and enter how often they must be done per the physician order (if requested).
12. The HCPCS code, drug name, dose, routes, and frequency for all premeds.
13. The HCPCS code, drug names, dosages, routes, and frequency for any and all hydration medications ordered (if required).
14. The HCPCS code, drug name, dosages, routes, and frequency for any and all chemotherapy medications ordered.
15. The treatment start date and regimen cycle.

FINANCIAL ADVOCACY NETWORK

It is important to document the interactions with payers very clearly in all documentation to include names, dates, and any referral or authorization numbers given. It is up to each facility to determine who will perform the prior authorization/medical necessity verification but whomever has the responsibility must be consistent in their processes. It is recommended to use all online and written transmissions when possible as there are varying routes per payer to accomplish this task.

It is further recommended to review the payer websites and CMS data for the most up to date information with each new care plan as payers change their requirements on a regular basis.

Allow 24 to 36 hours for a response from the insurance carrier. If you have not received a response within that time frame, follow-up must be done via phone or fax. Once the authorization has been obtained, the financial specialist will notify the appropriate parties for scheduling purposes.