Prior authorization FAQs

Q: Are there any exceptions allowed for prior authorization?

A: Several exceptions could apply. **CSD-UM-35 Retroactive Authorization Requests Policy** outlines exceptions for prior authorizations. Read the full policy.

Retroactive authorization requests will be accepted from contracted providers and facilities if:

a. The member indicated at the time of service that they were self-pay or no coverage was in place.
b. A natural disaster, for example, a pandemic, prevented the provider or facility from securing prior authorization or providing hospital admission notification.
c. Provider presents compelling evidence of an attempt to obtain prior authorization in advance of the service. The evidence shall support that the provider followed SHP policy and that the required information was entered correctly by the provider's office into the appropriate system.
d. Member enrollment was entered retroactively in Facets and was not available at the time of service for the provider to obtain prior authorization from Samaritan Health Plans.
e. Requested within seven calendar days of the dispense date for durable medical equipment items provided at an office visit.
f. The request is for detoxification related to substance use, an initial outpatient mental health evaluation, day treatment, psychiatric residential treatment, substance use disorder or subacute care.
g. Requested within 30 calendar days for durable medical equipment items that require a Certificate of Medical Necessity.

The time frame for acceptance of Retroactive Requests for Authorization:

a. Samaritan Advantage Health Plans, Samaritan Choice Plans and Employer Group Plans:
    1. Physical and behavioral health retroactive requests will only be considered within 30 calendar days from the date the service was rendered.
b. InterCommunity Health Network Coordinated Care Organization:
    2. Physical and behavioral health retroactive requests will be considered up to 90 calendar days from the date the service was rendered. Any requests for authorization after 90 days from the date of service require documentation from the provider demonstrating the specific reason why authorization could not have been obtained within 90 days of the date of service.

Q: What if the service is emergent?

A: Emergency services do not require prior approval from the plan.

Q: What if a prior authorization is needed quickly but doesn't meet the requirements for an expedited request?

A: Make sure the request has the scheduled date for service clearly noted. This will assist in getting a timely response.

Q: What if there is a prior authorization in place, but it doesn't match the service provided?

A: Code ranges are in place to assist with processing the claim. If the code is in the same code group as the one listed in the authorization; no changes are needed. Samaritan Health Plans' Claims staff work closely with the Care Coordination staff to match services billed to prior authorizations.