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Provider update

Urgent authorization requests

Urgent care requests
An urgent care request is any service that if not quickly decided could seriously jeopardize the member's life or health or the member's ability to regain maximum function. A claim is also an urgent care request if in the opinion of a physician with knowledge of the member's medical condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Utilization management will provide an initial decision for urgent pre-service requests within three calendar days of receipt. Decisions regarding urgent concurrent requests will be made within one calendar day of receipt.

Determinations are made by an appropriate practitioner, which may be the health plan medical director; a board-certified consultant; or licensed medical, behavioral health, pharmaceutical, dental, chiropractic or vision practitioner (as appropriate). Clinical guidelines are available on the medical policies website at https://medicalpolicies.amerigroup.com/search or the Amerigroup Community Care provider website under *Quick Tools*.

Criteria and guidelines:

- MCG Care Guidelines criteria is used only for medical necessity review for medical acute inpatient concurrent review, acute inpatient site of service appropriateness and behavioral health.
- McKesson InterQual® is used for post-acute inpatient services and home health.
- American Society of Addiction Medicine criteria is used for all levels of care related to substance use disorder.
- Amerigroup Medical Policies are used for outpatient rehabilitation.

Providers can request a hard copy of the clinical criteria relied upon to make the determination. Additionally, the requesting provider will have the opportunity to request a peer-to-peer with an appropriate health plan medical director (or appropriate practitioner) if requested within 24 hours of the decision.

Expedited appeals
An expedited appeal is a request to change an adverse determination for urgent care where taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or the ability to attain, maintain or regain maximum function.

Expedited appeals are resolved as soon as possible in accordance with the medical exigencies of the case, which under no circumstances shall exceed 72 hours in the case of appeal of determinations regarding urgent or emergent care, an admission, availability of care, continued stay, or health care services for which the member received emergency services but has not been discharged from a facility.

A physician with appropriate clinical experience in treating the member's condition or disease and/or a physician peer reviewer who was not involved in the initial determination and is not a subordinate of the original reviewer shall make the final determination in all adverse determinations.

Decisions for nonurgent pre-service requests are provided within 14 calendar days of receipt.

Please refer to your provider manual for additional information regarding authorization requests and the medical appeals process or contact Provider Services at 1-800-454-3730.