SHARP			
	SECTION #:		DOCUMENT #: UM138
	ORIGINAL ISSUE DATE 6/2019	CURRENT EFFECT DATE 2/2026	**Department Guideline**
	AFFECTED DEPARTMENT: Utilization Management		**ENTITY(S):** SRS
	TITLE: Prior Authorization List		

Purpose: To ensure requested a health care service, treatment plan, injectable drug or durable medical equipment is medically necessary. Prior authorization (PA) is a technique for minimizing costs, wherein benefits are only paid if the medical care has been pre-approved by the insurance company.

Goal: To have a process for determining items that services that require prior authorization, SRS will have a list of services that will require prior authorization.

RESPONSIBILITY::

Medical Director of Managed Care and Director of Utilization Management with the oversight of the Managed Care Business Committee.

Policy:

I. The following criteria will be considered for determining items and services that require prior authorization:
SRS UM will follow guidelines and criteria hierarchy as defined by the Health Plans, State and Federal regulations and requirements, as appropriate.

1. Medical necessity
   a. Determine whether the service is medically necessary based on evidence-based guidelines, clinical research, or professional standards of care.
   b. Validate the service aligns with the best outcomes for the patient.
2. Utilization patterns
   a. Review the frequency and variability of use of the service.
   b. Services with high variability in usage or potential overuse are more likely to require prior authorization.
   c. Evaluate whether the service has a history of being used inappropriately or excessively.
   d. Validate appropriate use to protect patient safety and reduce unnecessary healthcare costs.
3. Cost-effectiveness
   a. Analyze the cost implications of the service, especially if it involves high-cost drugs, procedures, or technologies.
4. Complexity or specialized nature of service
   a. Identify services that are complex, experimental, or require specialized training or facilities.
5. Quality and outcomes
   a. Assess whether prior authorization can help ensure the delivery of high-quality care and prevent avoidable complications or adverse outcomes.

   b. Validate that services provided are likely to yield measurable benefits.
6. Alternative treatments
   a. Consider whether less invasive, less costly, or equally effective alternatives are available and require that they are utilized first when clinically appropriate.
7. Regulatory standards
   a. Adhere to guidelines established by regulatory bodies.
   b. Align prior authorization practices with industry standards.
8. Data and analytics
   a. Use data, patient outcomes, and other analytics to identify trends or areas where prior authorization may help manage care more effectively.
9. Stakeholder input
   a. Incorporate feedback from health care providers, patients, and other stakeholders to ensure the policy is balanced and addresses real-world concerns.
10. Duration and review frequency
   a. Establish a periodic review process to decide whether to retain or remove prior authorization based on changes in clinical evidence, utilization patterns, or cost data

II. PROCEDURE:

1. SRS will create a Prior Authorization (PA) list that includes the following classifications of benefits;
   a. Inpatient (in-network, out-of-network)
   b. Outpatient (in-network, out-of-network)
   c. Outpatient Office visits (in-network, out-of-network)
   d. Outpatient Other Items and Services
   e. EmergencyCare
   f. Prescription Drugs

2. The PA list will be maintained by the UM Department with the direct oversight of the Medical Director of Managed Care with approval by the Managed Care Business Committee.

3. The PA list will be reviewed on an annual basis, but may have updates, as necessary.

4. Inclusion or removal from the list may be based on a review of the factors, type of services, location, Medical Staff request and quality/performance data.

5. The approval of the list will be obtained from the Managed Care Business Committee on an annual basis and as needed.

6. Referrals will be evaluated and authorized by a person with a defined level of responsibility, for clinical and non-clinical, based on the necessary protocols and within the parameters of the requested service. (See DG 110 Appropriate Health Care Professional

7. The PA List will be submitted to the Health Plan, per individual HP requirement.

III. **ATTACHMENTS:** Prior Authorization List

IV. **REFERENCES:**
   a. DG 110 Appropriate Health Care Professional
   b. DG 133: Criteria Hierarchy
   c. UM Plan

V. **APPROVALS:**
   a. Medical Director of Managed Care: 6/2019, 2/2026
   b. Director of UM: 6/2019, 1/2026
   c. Managed Care Committee: 6/2019, 2/2026

VI. **REVIEW/REVISED:** 1/2026

SRS Prior Authorization List

Ambulance Transport non-emergent, non-capped
Botox at SRS
Bariatric procedures
Blepharoplasty
Conization: Cold Cone Procedure at SRS
Continuity of Care
Continuous Glucose Monitoring
Cortisone Knee Injections at SRS
Dialysis (non-ESRF purposes only)
Dental
DME (non-cap prior auth needed)/Orthotics
Dermatology UV light therapy/Photodynamic therapy
General Surgery
Hearing Aids/Cochlear implants
Hospice (commercial only for OON/non-Sharp)
Home Safety Evaluations
Home Health
Injectables
Infusions/OPP
Infertility
Inpatient Acute Rehab
Inpatient Admissions Elective admissions within Sharp and Radys
Inpatient Acute Medical Chemical Dependency, BSC only
OOA Directed Care Consult, Treatment, Services, and Admissions, if PMG risk.
OON Admissions elective only
OON Labs, testing, Imaging, procedures, and therapy
OON Specialist Consult and Follow Up
OT and Speech Extensions
Otolaryngology procedures
Post-Acute (SNF) Admission
Sharp Facilities Treatments and Therapies (i.e.: SHIS, Cardiac Rehab, Pain management, genetic counseling, Chemotherapy, pulmonary rehab, CREP, etc.)
Pain Pump Referral and Maintenance
Vestibular Rehabilitation at SRS, Extensions only

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