Regal - Lakeside – GCMG – ADOC Medical Group
Provider Tip Sheet PA-1:
What Services require Authorizations…
& which do not!

Authorizations are a key part of the Utilization Management Process for managed care healthcare members and their providers. It is essential for providers to know which services require authorization before the service is provided to the members while some other services do not require authorization. Per HPN (Heritage Provider Network) Provider Manual and Utilization Management Program, the list of the services requiring authorizations and which do not require authorization, are summarized as follows:

Services Requiring Authorization:

- Ambulatory Care
- Inpatient Services
- Skilled Nursing Facility Services
- Home Health Care
- Rehabilitative Services (such as physical, occupational and speech therapies)
- Physician-administered drugs
- Durable Medical Equipment and/or Supplies

Services Not Requiring Authorization:

- Emergency Services
- Family Planning
- Sensitive Services and confidential service treatment (including those related to Sexual Assault or Sexually Transmitted Disease)
- Preventive Services (including immunizations)
- Basic Pre-Natal Care
- HIV Testing/Counseling
- Direct Access to Women's Health
- Language Assistance Program/Interpretation Services
- Health Education
- Non-Facility Based Behavioral Health (including Mental Health Counseling, Drug and Alcohol Abuse Treatment)
- Medi-Cal Carve Out Programs such as Long -Term Services and Supports (LTSS), In-Home Supportive Services (IHSS), and Community-Based Adult Services (CBAS)
- Urgent Care Services
- Tobacco Cessation
- Biomarker Testing for Food and Drug Administration (FDA)-Approved Therapy for Advanced or Metastatic Cancer

For Retrospective Review Request for Rendered Services (Retrospective Review):

- For the service covered by Commercial Plan or Medicare Plan (Commercial or Medicare Line of Business):
    - Medical Group's Utilization Management Department /Prior Authorization Department do not accept retrospective review requests from contracted providers even if the services require prior authorization. The contracted providers may directly submit claims to the Medical Group's Claims Department for the rendered services for Commercial and Medicare members. If the contracted providers submit the retrospective review requests to the Medical Group's Utilization Management Department /Prior Authorization Department, the requests will be canceled, and a notice of cancellation will be sent to the provider including the instruction of submitting the claims for the rendered services directly to the Claims Department.
- For Service Covered by Medi-Cal (Medi-Cal Line of Business, or Applicable Integrated Plan benefits covered by Medi-Cal):
    - Medical Group's Utilization Management Department /Prior Authorization Department accepts and reviews retrospective requests for rendered services.

Frequently Asked Questions:

- Q: If member needs to visit Emergency Room (ER) or Urgent Care Center, do they need to obtain authorization before the visit?
  A: No, member does not need to obtain authorization prior to visiting ER or Urgent Care Center.

- Q: If I provided services that require authorization from medical group before I submit the referral request, shall I submit a retrospective review request to the medical group?
  A: This depends on what kind of health plan the service is covered by:
    - If the service is covered by Commercial or Medicare Plan Commercial or Medicare Line of Business), and you are a contracted provider with the medical group, you do not need to submit retrospective review request to the medical group for the services that you already rendered to the member. Instead, you may directly submit the claims for the rendered services to the Claims Department. If you are a non-contracted provider and rendered services that require prior authorization, you will need to submit the retrospective review request to the Medical Group Utilization Management Department /Prior Authorization department to review the medical necessity.
    - If the service is covered by Medi-Cal (Medi-Cal Line of Business, or Applicable Integrated Plan benefits covered by Medi-Cal), you will need to submit retrospective requests for the rendered services. The Medical Group's Utilization Management Department /Prior Authorization Department will accept and review the retrospective requests.

- Q: What happens if I submitted a referral request for the services that do not require authorization?
  A: Medical Group's Prior Authorization Department staff members will follow HPN prior authorization process to cancel the referral request for the services that do not require authorization. The requesting provider will be notified of the cancellation and the reason why it was cancelled.

  For any other questions, please contact Customer Services at (818) 357-5000 or (866) 654-3471, or your assigned Network Manager.