



Alignment Health™

PRIOR AUTHORIZATION GUIDELINES

Alignment Healthcare Participating Providers are required to comply with Alignment's prior authorization policy for services that require prior authorization. These guidelines provide information about the services that require prior authorization, which services are automatically approved, and how to submit requests for authorization.

Failure to comply with Alignment's prior authorization policy or failure to obtain prior authorization from Alignment may result in Participating Providers' being financially responsible for such services, up to and including offsets from future payments to the Participating Providers. Medicare Advantage health plans must follow Centers for Medicare & Medicaid Services (CMS) regulations, and all services and procedures, regardless of place of service, must be covered by CMS or an additional benefit offered by the health plan. Please refer to Alignment Healthcare's Provider Operations Manual and/or the health plan's Evidence of Coverage for more information.

KEY CONTACTS

UTILIZATION MANAGEMENT

Phone: **844-310-2247**, 8 a.m.-5 p.m., Monday-Friday

AVA PROVIDER LOGIN

<https://www.alignmenthealthplan.com/providers>

PRE-SERVICE EMAIL

umdept@ahcusa.com

PRIOR AUTHORIZATION

Prior Authorization Phone (All Markets): **844-942-4226**, 8 a.m.-5 p.m., Monday-Friday

AUTOMATIC APPROVALS

The following services are automatically approved by the health plan with or without authorization:

- All IN-NETWORK specialist office visits, including initial and follow-up visits
 - There are no quantity limits or limits to level of services
 - If overutilization and/or abuse of high level of services are discovered, auto-approval for that provider will be revoked
- Simple radiology (X-rays, ultrasounds, select CTs, and MRIs) at IN-NETWORK facilities
- Any HEDIS-related measures (e.g., mammogram, colonoscopy) at IN-NETWORK facilities
- Preferred Part B drugs subject to step therapy

Note: PPO plan members have no network requirement but may be subjected to higher copays and/or co-insurance for using out-of-network providers.

Effective 1/1/2024

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INPATIENT ADMISSIONS & OBSERVATIONS

Prior authorization is not required for emergent inpatient or observation admissions. Hospitals are required to notify the health plan of an inpatient or observation stay once the member is stable and prior to admission. Out-of-network providers must obtain authorization for admission once the member is stable to avoid denial of payment based on post-stabilization policies. Notification can be in the form of faxed face sheets or phone calls to the health plan.

PREFERRED PROVIDER ORGANIZATION (PPO) PLANS

PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance by choosing to do so. All services, procedures, and medications listed on the prior authorization list still require clinical review for final determination.

SERVICES REQUIRING AUTHORIZATION

Participating Providers are required to submit requests for services through the AVA provider portal. Alignment’s Utilization Management staff, or Alignment’s designee, will review the request, and the request will either be approved or denied. Only a licensed physician can deny services. This will be communicated in writing to the requesting provider and to the member. **The categories that usually require additional Utilization Management review include but are not limited to:**

- Services with the following place-of-service codes:

9	Prison
21	Inpatient Hospital
22	On-Campus Outpatient Hospital
31	Skilled Nursing Facility
33	Custodial Care Facility
34	Hospice
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility

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SERVICES REQUIRING AUTHORIZATION (CONT.)

- Services from out-of-network providers, except for PPO plan members, who are not restricted to use in-network providers unless the services, procedures, or medications are listed on the prior authorization list
- All chemotherapy and high-cost drugs, including but not limited to monoclonal antibodies, immunotherapy, skin substitute, and any medications on the non-preferred drug list of the health plan's step therapy program
- Home health and related services, outpatient occupational therapy, physical therapy, and speech therapy will be pended for further review after the first 12 visits every 6 months
- Chiropractor services are only approved for confirmed diagnosis of subluxation
- Acupuncture services are only approved for confirmed chronic lower back pain
- Others: High-cost radiology (some MRIs and nuclear studies), high-cost durable medical equipment (DMEs)/prosthetics/orthotics, genetic/molecular testing, hospital-based procedures, high-cost implants/stimulators, cosmetic procedures, radiation oncology, transplants, experimental/investigational requests, any codes that are not covered by Medicare
- Any codes listed in the prior authorization list

PRIOR AUTHORIZATION LIST

The list represents medical services and Part B medications (i.e., medications that are delivered in the physician's office, clinic, outpatient, or home setting) that require authorization prior to being provided or administered. Services must be provided according to Medicare coverage guidelines and must be medically necessary, as established by the Centers for Medicare & Medicaid Services (CMS). Please contact the health plan or consult its Evidence of Coverage for confirmation of coverage.

[View list here.](#)

Services or medications provided without authorization may be subject to retrospective medical necessity review. Submitting all relevant clinical information at the time of the request will facilitate a more expeditious determination. If additional clinical information is required, a health plan representative or designee will request the specific information needed to complete the authorization process. Providers can refer to the Alignment Healthcare Provider Operations Manual for guidelines to submit an authorization request. Providers who participate in an independent practice association (IPA) may be subject to an IPA prior authorization list and should refer to their IPA for guidance.

Note: An approved authorization is not a guarantee of payment. Payment is based on benefits in effect at the time of service, member eligibility, and medical necessity. This list is subject to change at any time without notification.

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