Facility Site Selection (FSS)

Home State Health

PROVIDER TRAINING

Goals of FSS Training

GOALS:

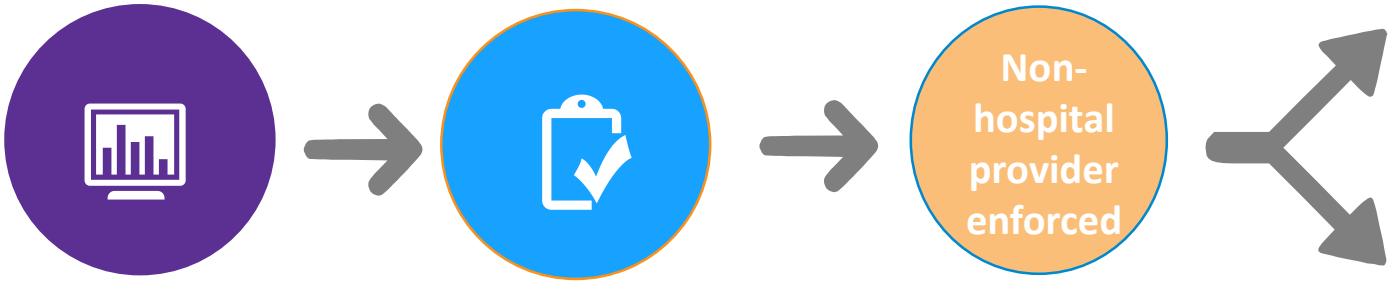
- Provide education with the ordering and rendering providers on new Facility Site Selection program and imaging site options.
- Review services excluded from the Facility Site Selection based on the clinical needs of the member as well as administrative rationale.
- Review the provider selection requirement which is enforced with claims payment.

FSS Program for Home State Health Changes 11/1/19

The modified Facility Site Selection (FSS) program supports the delivery of radiology assessments (CT and MR) in the appropriate outpatient (non-hospital) setting for Medicaid members

- Effective 11/1/19, the new FSS program for Home State is based on the concept that MR and CT services should be delivered in a non-hospital setting unless there are clinical exceptions that require a hospital.
- Auth requests for MR and CT will present free-standing facilities for selection based on distance from the member's zip code for both ordering and rendering providers who request the authorization. In-office providers will still be available as they are today.
- If the claim for an authorization that requires a non-hospital Place of Service is submitted with a hospital Place of Service (POS) code (e.g. 22 or 19), the claim will be denied.

Provider Setting Required (PSR) Components



Provider Designation
Providers are categorized by Place of Service code and other data

Facility Selection
Selection list presents free-standing providers within the geo-access area by distance from member

Front End/Auth Request Enforcement: assign a non-hospital facility if ordering doesn't select one and there are no clinical reasons that require a hospital setting.

Back End/Claims Enforcement: Deny claims that have a hospital Place of Service (POS) code for eligible auths (when non hospital POS was authorized)

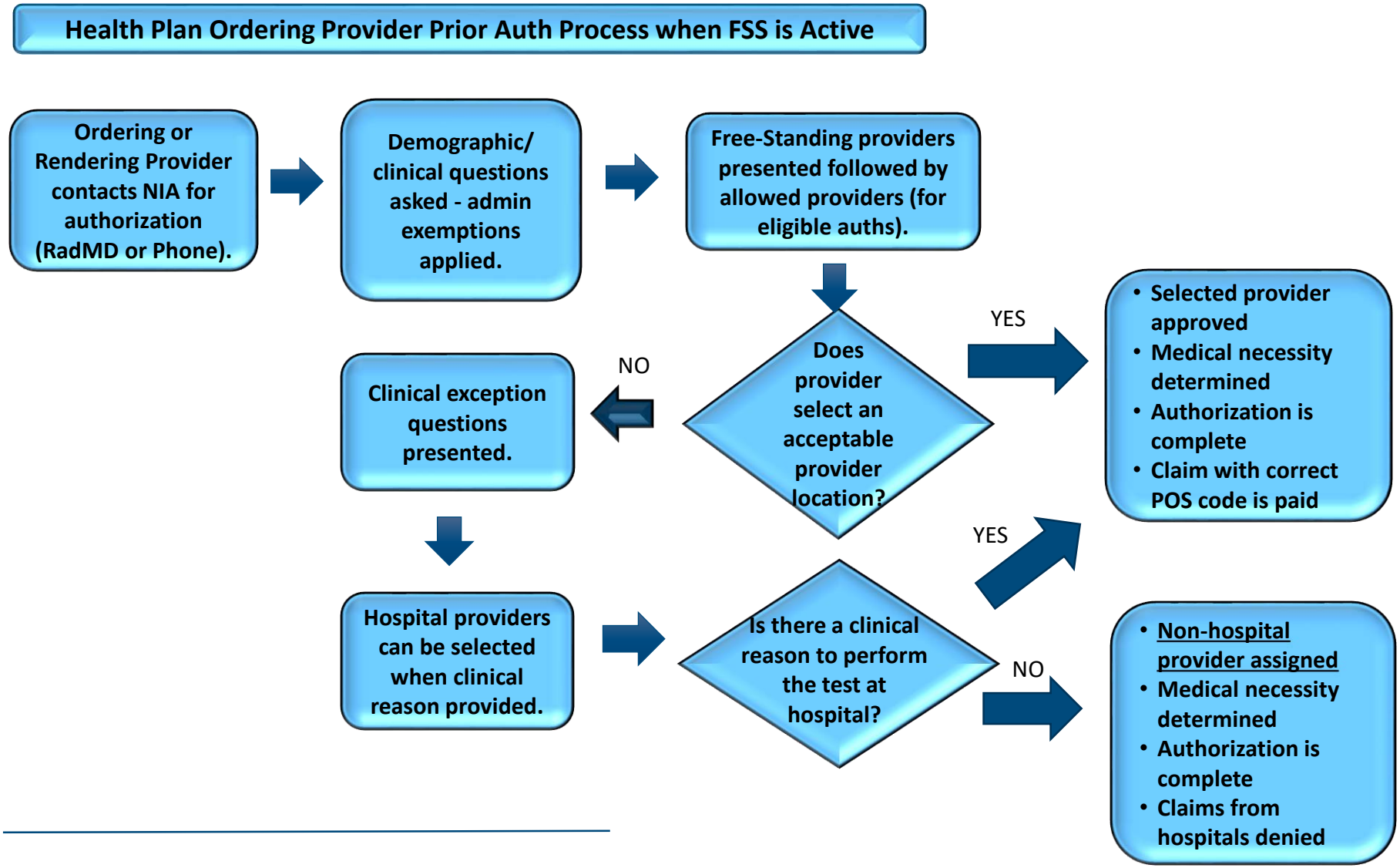
This **FSS program** is a provider selection program that enforces the use of non-hospital providers (free-standing facilities or in-office providers) unless there is a clinical reason to use a hospital setting

Provider Selection List

Goal	Description	Definition
Non Hospital (Free Standing)	Non-hospital (Free-Standing) providers are presented in order of distance from member (combines NIA FS and Client FS)	Non-hospital providers that perform MR/CT are presented, including NIA free-standing facilities and Health Plan free-standing facilities based on distance from the member's zip code.
Allowed Providers (In office)	Client In-Office Providers are available using separate in-office process	Home State will continue using the same process used today for selecting in-office providers separately.
Clinical Exception Reasons are presented to determine if a hospital provider is acceptable for the specific authorization request		
Hospitals	Client Hospitals	In-network hospitals in the health plan network, based on setting type from claims data and other data, are available when clinically appropriate (a clinical exception was documented).
	OON	Out of Network

Geo-access standards are configured in system such that an auth is exempt from FSS if no free-standing providers are available within the defined access standards for the specific member and to determine which providers to present in the list for selection. The order of presentation is by distance from center of member zip code area for each auth request.

Provider Selection Process for "Provider Setting Required"



Eligible Auth Requests

- As with Home State's current FSS program, some authorization requests may be exempted from FSS due to system-applied **administrative reasons**
- Clinical questions are utilized to identify scenarios for which a hospital setting may be clinically appropriate. The list of **clinical reasons** that result in an exception to the use of non-hospital providers may be slightly different from the current FSS program.
- Authorization request cases will have indicators applied to show if the authorization is eligible for FSS enforcement or not; enforcement includes evaluation of Place of Service (POS) code on the claim
- See following slides for details

Procedure and Administrative Exemptions from FSS
Implemented by System

Procedure Exemptions	*Applied to auth requests for members in an included plan[1]*
Auth Type Exemption	*Requests that are not Radiology Benefits Mgmt are excluded.*
Exam Category	*Exam types other than MR, CT are excluded.*
CPT4 code	*Selected CPT code groups are excluded (Breast MRI, MRS).*
Administrative Exemptions[2]	*Applied to auth requests for members in included plans for included procedures (MR/CT).*
Retro	*Requested procedure already performed.*
Patient Age Exemption	*Age cut-off is defined by client: Home State currently exempts members <10 (9 or younger).*
Geographic Reason	*The member's zip code is in a geographic area that does not have a free-standing provider available; Home state mileage areas are 25 miles for Urban/Suburban/Rural.*

1. Members whose plan cannot be determined at intake will be exempt from FSS and reported as not in an included plan.
2. Requests that are initiated by the rendering provider are NOT EXEMPT from FSS in the Home State program; these requests will have the same provider selection requirements as those initiated by ordering physicians.

Clinical Exceptions from requiring a Non-Hospital Provider *Selected by Requestor*

Script: "You have not selected an approved provider for this service. Please indicate if any of the following clinical reasons for using a hospital setting apply to this patient. By selecting one of these clinical exceptions, the ordering provider is attesting that this clinical scenario is documented in the patient's medical record, which will be available for audit upon request."

1.	This procedure is a follow-up to a previous exam performed at the requested facility within the past 8 weeks. (date validation process).
2.	Patient has an allergy to contrast media.
3.	Patient has been actively treated for the related condition at the requested facility within the past 12 weeks and requires continuity of care. (date validation process).
4.	Patient is scheduled for surgery within the next four weeks. (date validation process).
5.	Patient requires sedation.
6.	Patient's weight requires special equipment.
7.	Other medical reasons requiring the patient to have the services performed at the requested facility. Approval to be determined at the discretion of the member's plan. *(required text field).*
8.	None.

- *For the Home State **PSR** (Provider Setting Required) the selection of 1 – 7 will allow the selection of most clinically preferred setting. The selection of 8 – None will show script that states that since there are no clinical reasons that require a hospital provider, a non-hospital provider is required. Requester can go back to selection list or accept an assigned provider.*
- *When selecting "Other" the requesting provider must clearly state the clinical reason that a hospital is required. The text provided will be monitored and some patient charts may be audited to ensure accuracy of the reason provided. For Home State, a patient's need for a facility near public transportation is allowed in the "other" category.*

Home State's Transportation Benefit

- Home State Health Plan wants providers to know that their Medicaid members have support with transportation to ensure they are able to get to the services they need.
- Providers can call Home State Health at 855-694-4663 and select option 2 "Member Services" for help with transportation for the member.
- If there are any barriers to transportation providers can also call 855-694-4663, ext 6075125.

When Home State is the SECONDARY Payer

- When Home State is the Secondary Payer, a prior auth from NIA may or may not be required depending on the circumstances.
- If a prior authorization approval is obtained through the primary insurance, additional prior auth through NIA is not needed when Home State is a secondary payer.
- If the primary insurance rejects the auth request for any reason (e.g. not a covered benefit) or renders a denial determination, a prior authorization will be required through NIA.
- The ordering provider will need to determine if an authorization from NIA is required since NIA staff members will not know the status of the authorization with the primary insurance.

Questions

Q & A WITH PARTICIPANTS

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