Authorization Reference – Changes Effective November 1, 2022*

- Applies ONLY to the L.A. Care Direct Network

iExchange Termination

1. **What is iExchange?**
   L.A. Care partnered with OptumHealth and Medecision from June 1, 2020 to December 31, 2022 to offer Direct Network providers an electronic option (a.k.a. iExchange) to request authorizations and to check on the status of authorizations.

2. **Why is iExchange access changing?**
   L.A. Care's contractual agreement with OptumHealth ends on December 31, 2022 which also ends the use of iExchange/Medecision.

3. **When and how will the termination happen?**
   The following key activities and dates are part of the transition and termination process.
   - After September 9, 2022 no new providers will be registered for or provided new access to iExchange
   - After October 31, 2022 no new authorization requests can be submitted via Exchange
   - The iExchange platform will still be available for checking status until December 31, 2022

4. **How can a provider get a copy of an historical authorization after October 31, 2022?**
   - Registered providers can access authorizations in iExchange until December 31, 2022
   - Providers can also contact L.A. Care at (844) 361-7272

5. **Will L.A. Care offer an alternate electronic submission/tracking option?**

* Subject to regulatory approval.

There will not be an alternate submission and tracking option at the time of the iExchange termination. L.A. Care will provide a similar platform in the future which is currently in development.

6. **Are there changes to L.A. Care's other electronic platforms?**
   No, the changes to iExchange have no effect on other systems. Providers can continue to use the www.lacare.org site for the following frequently used options:
   - Find In-Network providers with Online Provider Directory "Find a Doctor" look up
   - Get authorization information and forms at www.lacare.org/priorauth
   - Access the L.A. Care Provider Portal via https://www.lacare.org/providers/provider-central/la-care-provider-central. Use the portal to:
     - Check member eligibility
     - Check claim status
     - Member reporting

7. **How can providers submit authorization requests without iExchange?**
   - All requests (pre-service/prior, admissions, concurrent review, retrospective) must be submitted by fax or phone.
   - Please use the **newly updated** Request Form which will post in late October 2022 at www.lacare.org/priorauth
   - Hospitals and Skilled Nursing Facilities should send facesheets, clinicals and discharge orders as follows for fastest processing
     - Facesheets and admissions clinical info 877-314-4957
     - Clinical review 213-438-5063
     - Discharge orders 213-438-5066
   - Note that the fax numbers previously listed on Direct Network materials are still valid (213-438-5680 for prior/retro auth; 213-438-2203 for hospitals and skilled nursing). These fax numbers will be rerouted directly to LA Care UM team work queues. **Do not send the same request to multiple fax numbers** as it will create duplicates and slow processing.

8. **What is NOT changing?**
   - Validity of authorizations issued prior to November 1* with end dates after November 1, 2022.* Note: Providers are still obligated to confirm member's eligibility status for the dates of service.
   - Phone and fax numbers for L.A. Care Customer Service, Provider Account Management.
   - Prior authorization requirements or turnaround times.
   - Primary Care Physician (PCP) assignments or membership within the Direct Network.
   - Participating network of specialty, hospital and ancillary providers.

- L.A. Care policies for UM, CM and Claims.
- UM and CM process for members assigned to other networks

9. **What if I still have questions?**
   Contact your L.A. Care Direct Network Account Manager with any questions (844) 361-7272 or via DirectNetwork@lacare.org

Important Tips for Submitting an Authorization Request
Additional authorization process details are found in our Resource Guides and Manuals
https://www.lacare.org/providers/provider-resources/forms-manuals

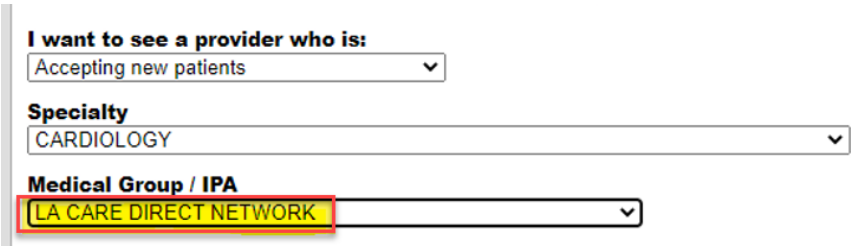
1. **How do I know if a member is in the L.A. Care Direct Network?**
   - **a.** L.A. Care has delegated UM functions to numerous medical groups and IPAs (aka PPG) who are responsible for authorizing care for members in their group's network. Always verify member eligibility with L.A. Care and member's network affiliation *prior to* submitting an authorization request. Submitting requests to the appropriate party is essential for quickest determination and avoids preventable delays in processing.
   - **b.** The most accurate information is available by phone 866-LACARE6 and select option 1 or via the L.A. Care Provider Portal https://www.lacare.org/providers/provider-central/la-care-provider-central (example below). We do not recommend using Medi-Cal eligibility system/AEVS because it does not provide information on the member's network (PPG) assignment.

2. **What requires an authorization? (General categories)**
    a. Outpatient procedures
    b. Hospital surgeries/procedures
    c. Hospital admission
    d. Skilled Nursing (facility and home)
    e. Long Term Care
    f. Community-based Adult Services (CBAS)
    g. Durable medical equipment
    h. Home health services
    i. Hospice services
    j. Outpatient rehab services

3. **What does not require prior authorization?**
    a. In-network only
        i. Primary Care Visits
        ii. Preventative Services
        iii. Routine lab studies
        iv. Total OB care
        v. Musculoskeletal x-rays
        vi. Pacemaker function surveillance
        vii. Initial treatment of fractures
        viii. Specialist office visits
    b. In-network or out-of-network
        i. Emergency or urgent care
        ii. Dialysis
        iii. Sensitive Services

4. **How do I know whether a specific service or procedure requires authorization?**
    Use our code-specific look-up tool
    https://www.lacare.org/providers/provider-resources/prior-authorization-search

5. **How is a referral for a member in L. A. Care's Direct Network made to an out-of-network (OON) specialist?**
   L.A. Care is obligated to use in-network providers when appropriate for the member's medically necessary care. For Medi-Cal members in LA Care's Direct Network no authorization is required for specialist consults and office visits, so they may be referred directly to the in-network specialist. Please use the "Find a Doctor" online provider directory at www.lacare.org to find a participating provider in the member's network.



If you are unable to find an in-network Provider and would like to proceed with an OON Provider, it will require prior authorization.

When L.A. Care receives a request for OON services, we confirm the requested codes are medically necessary using established criteria. If medically necessary according to criteria, L.A. Care will attempt to redirect out-of-network requests to an in-network provider. If an appropriate OON provider is not identified for a medically necessary service, we will attempt to secure a Letter of Agreement (LOA) with the OON provider. If the provider and L.A. Care do not come to mutually agreeable terms in the LOA, L.A. Care may authorize the service to a different accepting specialist.

If you have questions regarding authorizations, you can call (844) 361-7272.

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