

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 1**

POLICY TITLE: PRIOR-AUTHORIZATION OF SAME DAY SURGICAL PROCEDURES

POLICY STATEMENT: Elective Same Day Surgical Procedures must be communicated to the Case Managers for prior-authorization. Note: This is for out of plan practitioners and I-Plan members referred to MAC and Non-plan practitioners or facility.

PURPOSE: To insure that the Health Plans' resources are utilized to deliver care in the most appropriate setting and to determine benefits coverage for Health Plans enrollees.

PROCEDURE:

1. Information is received from referring practitioner office. The Case Managers receive notification of all Elective (Same Day Surgeries) at least 7 days prior to the procedure. Emergency SDS procedures do not require prior-authorization but should be called in within 48 hours of the procedure or as soon as physically possible.
2. Information received is as follows:
 - a. Name of caller
 - b. Date
 - c. Patient name
 - d. Admitting diagnosis
 - e. Surgical procedure and
 - f. Surgery date
 - g. Hospital name/Facility name
 - h. Attending practitioner
 - I. Clinical information pertinent to this case
3. Verification is made that the patient is an eligible Health Plans' enrollee. Investigation is conducted by the Case Managers to determine appropriateness of the use of out-of-plan providers. When this is substantiated by the original attending/referring practitioner, an authorization will be created in the computer system. If not, a denial will be communicated to the consulting practitioner, facility, and subscriber (according to Policy Number Two: Health Care Services Denial Policy).
4. If verification is made of member, practitioner, and facility eligibility, coverage is assessed according to limits within subscriber contracts.

Authorization for procedures will be communicated by telephone, fax, or written correspondence.

5. If subscriber contract does not indicate coverage for the impending procedure, the denial is documented in the computer system. If authorization has not been granted, notification of

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denial of MAHP coverage is provided according to Policy #2: Health Care Services Denial Policy.

6. The exception is the I-Plan, prior authorization and correspondence will be entered into the information system and sent to the member, practitioner, and or facility as stated above.
7. For I-Plan members, if the request for health care services comes from the practitioner, MAHP can send the request for additional information to the practitioner, however, MAHP must notify the member if it makes a decision to deny the services.
8. Prior authorization requests for I-Plan members may be sent to case managers for review from MAC prior authorization nurse to determine if criteria is being met. Prior authorizations are sent via the clinics eMAC (electronic medical record) or by forms available on the MAHP Internet and Intranet for non-MAC required authorizations.
9. See attached flow chart.

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Date

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Date

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