

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

**POLICY TITLE:** PRIOR-AUTHORIZATION OF INPATIENT HOSPITAL ADMISSIONS

**POLICY STATEMENT:** All elective inpatient hospital admissions should be communicated to the Case Managers for prior-authorization.

**PURPOSE:** To insure that the Health Plans' resources are utilized to deliver care in the most appropriate setting based upon established criteria by determining the appropriateness of the inpatient admission.

**PROCEDURE:**

1. Information is received from Health Plans' practitioner office or facility, or Hospital Admissions Notification Form is received from clinical department. The Case Managers should receive notification of all elective admissions in advance. Emergency hospital inpatient admissions do not require prior-authorization but should be called or faxed within 48 hours of the admission, or as soon as physically possible.
2. Initial information received is as follows:
  - a. Name of caller
  - b. Date
  - c. Patient name
  - d. Admitting diagnosis and ICD-9 code (if available)
  - e. Surgical procedure (if applicable)
  - f. Admitting date
  - g. Surgery date (if applicable)
  - h. Hospital name and phone number
  - i. Attending Practitioner
  - j. Clinical information pertinent to case
3. If verification is made that the patient is an eligible Health Plans' enrollee, and that the attending practitioner and the facility are participating providers, the admission will be reviewed for appropriateness. Authorization for procedures performed by MAC practitioners is implied unless office is notified otherwise.

- MAC Departments will be notified of approval of procedures via eMAC task and/or telephone. Authorization number will be given via eMAC task or phone.

That notification will occur by eMAC or telephone within 24-48 hours of receipt of information. Authorization for procedures performed by non-Clinic practitioners will be communicated via telephone within 24-48 hours of receipt of information.

4. If the attending practitioner or the facility is not a Health Plans' participating provider, verification is made with the original referring Health Plans' practitioner. If this authorization was requested and verified by the Health Plans' practitioner, the admission will be reviewed for appropriateness.

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5. Appropriateness of the elective admission is determined based upon established criteria. These criteria, developed by Milliman Care Guidelines, LLC and reviewed by Health Plans' practitioners, is specific to the admitting diagnosis and/or intended surgical procedure. The criteria is reviewed and approved on an annual basis by the Utilization Management Committee.
6. Once member has been admitted, the Case Managers will work with the Social Worker and hospital Case Managers to determine anticipated home care needs of the patient after discharge, so that arrangements can be coordinated by the Case Managers during the time prior to discharge.. If necessary, this may include a home care assessment, coordinated by the Case Managers. See Policy #17: Case Management and Discharge Planning.
7. Approval notifications may be given orally, electronic, or written. The notification for approvals will be communicated by the Health Care Services Staff to the Health Plans' subscriber, and attending practitioner in the following manner:
  - a. Within 15 calendar days of the pre-service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific information needed within 15 calendar days of the pre-service request. The written or electronic notice must describe the required information specifically. It must also specify the time period given to the member or to the member's authorized representative to provide the information. The member or the member's authorized representative must be given 45 days to provide the information. The decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension period, within which time a decision must be made by MAHP, begins on the date on which the member's response is received (without regard to whether all of the requested information is provided) or the end of the specified time period given to the member or the member's authorized representative to supply the information, whichever is earlier.

The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

- b. For **pre-service of urgent care decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 72 hours of the request. For urgent pre-service decisions, if the organization is unable to make a decision due to lack of necessary information, it may extend the decision time frame once

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for up to 48 hours. The member or the member's authorized representative must be notified within 24 hours of the specific information needed.

- c. For **urgent concurrent review decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 24 hours of the request (unless falls on a weekend).
- d. For **post-service (retrospective review) decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 30 calendar days of the request.

For non-urgent post-service decisions, if the organization is unable to make a decision due to matters beyond the control of the organization, it may extend the decision time frame up to 15 calendar days. Within 30 calendar days of the post service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific information needed within 30 calendar days of the post service request. The written or electronic notice must describe the required information specifically. It must also specify the time period given to the member or the member's authorized representative to provide the information. The member or the member's authorized representative must be given at least 45 days to provide the information.

The decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension, within which a decision must be made by MAHP, begins on the date on which the member's response is received by MAHP

(without regard to whether all of the requested information is provided) or the end of the specified time period given to the member or the member's authorized representative to supply the information, whichever is earlier.

The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

- 8. If authorization has not been granted, (See Policy Number #60: Criteria Utilized in Determination of Medical Necessity) notification of denial of MAHP coverage is provided according to Policy Number Two: Health Care Services Denial Policy. This denial is also documented in the computer system.

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9. For Commercial inpatient admissions an estimated length of stay is assigned and this length stay will be used interdepartmentally as a management tool. If there is no code listed for the particular admission diagnosis, this is documented in Amisys.
  
10. Repeated non-compliance of the Health Plans' practitioner to the prior-authorization procedure may result in corrective action by the Chief Medical Officer.
  
11. 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.
  
12. See attached flow chart.

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Judy Riniker, R.N.  
Manager of Health Care Services/Quality Improvement

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Date

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Mary Leary, R.N.  
Director of Health Care Services/Quality Improvement

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Date

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Pre-Authorization  
Of Inpatient  
Hospital Admissions  
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