

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP7**

POLICY TITLE: REFERRAL AUTHORIZATION

POLICY STATEMENT:

Referrals made by Health Plans' participating practitioners (PCP and SCP) to non-participating practitioners/providers are authorized according to established Health Care Services Guidelines. These guidelines are reviewed and approved annually by the Chief Medical Officer, Utilization Management Committee, Quality Improvement Committee, and Clinic Board of Directors.

PURPOSE:

To insure the Health Plans' resources are utilized to deliver care in the most appropriate and cost-effective setting. Pre-certification decisions are now known as **pre-service decisions**. Retrospective decisions are now known as **post-service decisions**. **Concurrent review** decisions are any reviews for extension of a previously approved ongoing course of treatment over a period of time or a number of treatments. If the request isn't considered urgent care, then the decision must either meet pre-service or post-service timeframe, as applicable. All time frames start upon the receipt of the request. **Urgent care** is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

PROCEDURE:

1. Case Managers receive communication from the participating Health Plans' practitioner or practitioner's staff to request authorization of an out-of-plan referral.
2. The Case Managers request the following information:
 - a. Patient name
 - b. Birth date
 - c. Referring Practitioner name
 - d. Consulting Practitioner/facility name
 - e. Reason for the referral, including ICD-9 diagnosis code
 - f. Scope of referral - outpatient vs. inpatient, number of visits, testing, etc. (including procedure code if applicable and available)
 - g. Date of visit
3. The Case Managers review referral request and may approve immediately Routine Requests according to Health Care Services guidelines (see attached).
4. 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:

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- a. For **pre-service of non-urgent care decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 15 calendar days of the request.

For non-urgent pre-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 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 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.

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- 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.

5. Referral requests suggesting lack of Medical Necessity or those which are not considered "Routine Requests" must be reviewed by the Chief Medical Officer.
6. Standing Referral: A standing referral for a member to utilize a non-participating physician or provider may be issued if requested by the member and approved by the MAHP Chief Medical Officer. The Chief Medical Officer shall consider the following in making an authorization for a referral:
 - a. proposed treatment plan;
 - b. diagnosis;
 - c. travel distance to the non-participating physician or provider;
 - d. ability of In-Plan Physicians or Providers to provide proposed care;
 - e. frequency of needed care from non-participating physician or provider; and/or

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- f. continuity of care issues.
7. The Chief Medical Officer or physician designee will review the request for appropriateness, authorize the scope of the services, conditions of the referral, or make recommendations for alternate care. The Chief Medical Officer may wish to discuss the case with the attending practitioner, review appropriate medical records, or review current medical literature pertaining to the request. As necessary, a Board-Certified practitioner of a similar specialty as the attending practitioner may be asked to review the case and provide input. HC &HMO may have to send cases to an external review company such as IMEDECS or Medical Review Institute. See attachment A for IMEDECS case review process and attachment B for the Medical Review Institutes case review process. Blind the information if possible.
8. When applying the Health Care Services guidelines to a given individual, the following factors are considered:
 - a. age
 - b. comorbidities
 - c. complications
 - d. progress of treatment
 - e. psychosocial situation
 - f. home environment, when applicable
9. MAHP also considers characteristics of the local delivery system available for specific patients such as:
 - a. availability of skilled nursing facilities, home care etc. in the MAHP service area to support the patient after hospital discharge
 - b. coverage of benefits for skilled nursing facilities, home care etc. where needed
 - c. local hospitals' ability to provide all recommended services within the estimated length of stay.
10. The Case Managers will then provide immediate verbal notification of the decision to the requesting practitioner.
11. The information is entered into the computer system and letters are generated to the patient, physician (if applicable) and hospital/facility (if applicable) as noted in the guidelines in #4. See attached samples.
12. If the out-of-plan referral request is denied, the Health Care Services Denial Policy # 2 will be followed.
13. The Case Manager will coordinate exchange of pertinent medical information between Primary Care Physician (PCP) and the Specialty Care Physician (SCP) pre- and post-referral as indicated.

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14. For cases where clinical judgment for UM decision making is sufficiently specialized, the Chief Medical Officer may call upon available board certified specialty physicians from Utilization Management Committee, Quality Improvement Committee, and Pharmacy & Therapeutics Committee. It may be necessary to contact “experts” at the tertiary level, i.e. as deemed appropriate by the Chief Medical Officer.
15. A quarterly report of authorized and denied/redirected out-of-plan referrals will be presented to the Utilization Management Committee.
16. Documentation of referral requests will be kept on file for a minimum of three years in our information system.

NOTE: Per CMS; for enrollees residing in an emergency area, MAHP will waive prior authorization and out-of-network requirements. MAHP will help members access care and answer questions from out-of-network providers.

See attached flow charts.

- A. IMEDECS case review forms
- B. Medical Review Institute case review forms

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

Date

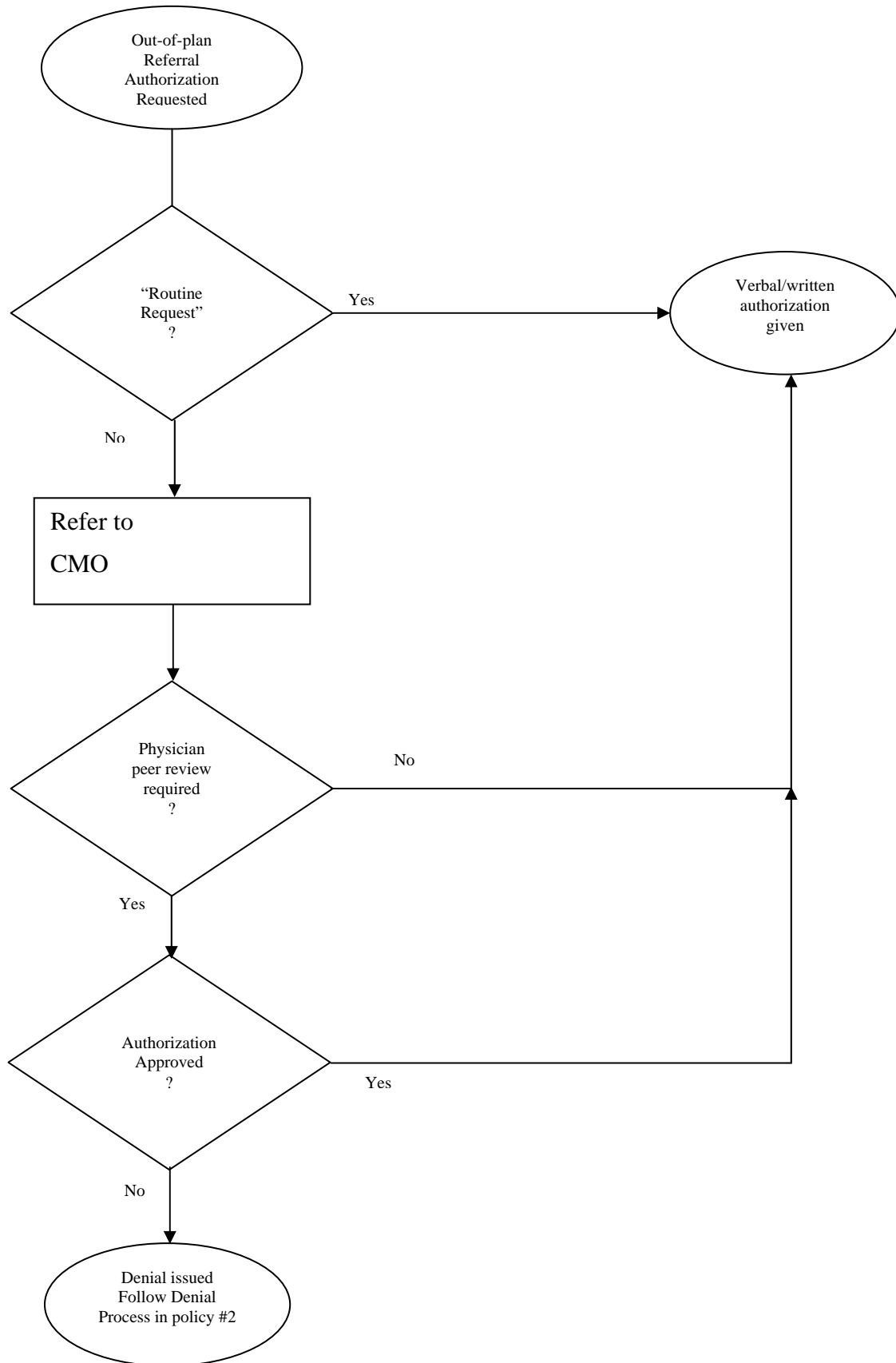
Mary Leary, R.N.
Director of Health Care Services/Quality Improvement

Date

Original: 07/89 Revised: 03/98 Revised: 03/02 Revised: 03/07 Revised: 01/12
 Revised: 02/90 Revised: 02/99 Revised: 11/02 Revised: 03/08
 Revised: 02/91 Revised: 04/99 Revised: 03/03 Revised: 03/09
 Revised: 03/92 Revised: 09/99 Revised: 01/04 Revised: 02/10
 Revised: 07/94 Revised: 02/00 Reviewed: 03/04 Revised: 07/10
 Revised: 01/95 Revised: 05/00 Revised: 03/05 Revised: 01/11
 Revised: 10/95 Revised: 05/01 Revised: 03/06 Revised: 07/11

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**Referral
Authorization
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SUGGESTED GUIDELINES FOR OUTPATIENT NUTRITION VISITS

In an effort to provide adequate time to instruct a patient regarding a modified diet and assure that the patient understands the information presented, the following guidelines should be used for authorizing visits for nutrition education.

Low Cholesterol Diet	2 visits
Low Cholesterol with other modifications	2 visits
Sodium Restricted Diet	2 visits
Sodium Restricted with other modifications	2 visits
Diabetic Diet	2 visits
Diabetic Diet with other modifications	3 visits
Gestational Diabetes	2 visits
Hypertriglyceridemia	1 visit
Hypertriglyceridemia with other modifications	2 visits
Eating Disorder (Anorexia Nervosa/Bulimia)	4 visits
High Fiber	1 visit
Low Residue	1 visit
Low Fat (Gallbladder)	1 visit

NOTE: Finley Diabetic Center usually sees someone 5 times over 6 months.

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**OUT-OF-PLAN REFERRALS –ROUTINE REQUESTS
HMO – OPEN ACCESS PRODUCTS**

The Case Managers may authorize immediately the following routinely requested referrals when the standard referral process has been met:

1. Out-of-plan referral requests from Medical Associates Clinic specialists to contracted providers of a similar specialty, i.e.:
 - a) High risk cardiology patients of MAC Cardiology and/or Cardiovascular Surgery Physicians for second opinion and/or procedures. (Referral requests to non-contracted providers must be approved by the Chief Medical Officer).
 - b) Dermatology patients from MAC Dermatology physicians for laser therapy and P.U.V.A. therapy.
 - c) General Surgery referral requests from the Medical Associates General Surgeons may be authorized when referred to contracted providers. (Referral requests to non-contracted providers require Chief Medical Officer approval).
 - d) Female infertility problems will be referred by the Medical Associates OB/GYN Department to contracted providers for services not offered here. Contract limits apply.
 - e) Hematology/Oncology patients may be referred by Medical Associates Oncologists to contracted providers for consultation and/or treatment.
 - f) Ophthalmology patients may be referred by Medical Associates Ophthalmologists when referred to contracted providers. This includes consultation and/or treatment.
 - g) Amniocentesis is available at Medical Associates OB/GYN Department; out of network Amniocentesis require a prior authorization.
 - h) Patient for breast reduction mammoplasties must meet established criteria in order to provide coverage. These surgeries may only be authorized, when medically indicated, such as in cases of documented neck pain, back pain, skin excoriation and conservative medical treatment have failed. Such conservative measures would include, but not be limited to, weight reduction, physical therapy, and instruction on body mechanics. See Health Care Services Policy #72 Criteria for the Coverage of Reduction Mammoplasty.
 - i) Patients for breast augmentation may only be authorized when medically indicated such as in follow up to breast cancer.
2. Non-Clinic Network Provider requests for out-of-plan referrals must be directed by a physician, ARNP's or PA's within the appropriate specialty being requested. When that specialty is not available at MA Clinic, referrals to non-contracted Providers may be authorized (exception Pediatrics).
3. Home Health referrals for Home Health services should be authorized for the specific treatment plan requested. Subsequent visits may be authorized as considered appropriate by the Case Managers, i.e.:
 - a) Maternal/Child home visits post-delivery.

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- b) Home health visits in follow-up to hospital discharge or to prevent hospitalization.
 - c) Other home skilled services such as physical therapy and laboratory procedures when the staff of Medical Associates cannot provide the services.
4. Radiation therapy at the Wendt Regional Cancer Center (no referral is necessary).
 5. Post-operative follow-ups to a previously approved surgical procedure within global period.
 6. Annual follow-ups for chronic conditions and surgeries that cannot be performed in Dubuque to contracted providers, i.e.: Cardiac Clinic, Hemophilia.
 7. Prosthetic eye care at Coralville Prosthetics in Iowa City, when benefit coverage exists.
 8. In-patient consultations by non-plan specialists where there is not a Health Plans specialist providing services to that area, i.e., Nephrology, Manchester, Boscobel, Darlington.
 9. Darlington area patients may be seen by non-plan satelliting specialists at the Darlington Hospital on an outpatient basis when referred by a participating Health Plans physician. This includes testing. Patients needing same day surgery may be authorized, if performed at the Darlington Hospital only. Dr. Sathoff performs inpatient surgeries strictly for straight HMO.
 10. TMJ patients needing evaluation over and above the service provided by Medical Associates physicians are to be referred to the TMJ clinics. Evaluation only will be approved depending on the plan contract. The Health Plans do NOT cover braces or splints. If surgery is medically necessary, and the result of cleft lip/cleft palate, the Health Plans do provide this coverage. (Contract limits apply). There is no coverage for accidental injury to teeth, implant, etc. WISE contract covers treatment of temporomandibular disorders if established criteria are met and approved by the Chief Medical Officer. (Please refer to contract language for specifics.). WISE also covers accidental injury to teeth, implant, etc.
 11. Student's out-of-area needing eye exams and are unable to schedule an appointment at Medical Associates Ophthalmology Department within 4 weeks will be approved to use non-Health Plans practitioners based on UCR rates and contract limits.
 12. Physical Therapy requires prior authorization when performed at provider hospitals, i.e. Mercy Medical Center, Finley, etc. or any location other than Medical Associates Clinic Departments.
 13. Terminally ill patient in need of palliative and supportive care may be referred to Hospice.
 14. Patients may be referred to contracted providers and/or local non-Health Plans providers as needed due to inadequate staffing at Medical Associates Clinic. If applicable, the copay for office visit applies, however the 80%/20% for out-of-plan referral does not apply to these

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situations. Please document in remarks in information system that copay applies. Chief Medical Officer is made aware of these cases.

15. Enrollees needing services of a dietician may be referred to participating hospital dietitians. Number of visits, unless specified by the Health Plans physician, is based upon guidelines for outpatient nutrition visits. (See attached copy of guidelines Clinic need prior approval).
16. Elective MRI's & CT's performed outside of the contracted providers of Medical Associates require prior-authorization.
17. Referrals for organ transplantation, when described as a covered benefit and the patient is utilizing a designated transplant facility. The Chief Medical Officer and Health Plans Management Staff will be made aware of all transplant cases.
18. Mental Health Services -
 - a) Due to Mental Health Parity, in area/in plan mental health or chemical dependency services do not require an authorization. This excludes Health Choice groups with exception of Medical Associates Clinic.
19. Dr. Dachman can provide surgical care upon referral.

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SUBFULLNAME
C-A1
C-A2
C-CTY, C-ST C-SP

Dear HMO Subscriber:

Attached please find the Referral Authorization Notification for M-FN M-LN.

Please refer to the attached forms for the limits of the services authorized, as well as reimbursement instructions.

Sincerely,

Chief Medical Officer

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Date

SUBFULLNAME
C-A1
C-A2
C-CTY, C-ST C-ZP

Dear Provider:

Attached please find the Referral Authorization Notification for your patient, M-FN M-LN.

Please refer to the attached forms for the limits of the services authorized, as well as reimbursement instructions.

Sincerely,

Chief Medical Officer

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REFERRALS REQUIRING CHIEF MEDICAL OFFICER'S REVIEW AND APPROVAL

The Chief Medical Officer must authorize the following requests:

1. Referral requests when practitioners are insisting upon utilizing non-contracted provider.
2. Chief Medical Officer will review inpatient cases weekly for appropriate length of stay, communicate with practitioners regarding questionable inpatient cases and facilitate discharge planning.
3. Chief Medical Officer will be informed prior to the Case Manager's redirecting of complex cases to Medical Associates Clinic practitioners.
4. Chief Medical Officer will be informed of non-compliant Health Plans' patients.
5. Chief Medical Officer will review all Medical Necessity requests to determine level of Health Plans' coverage.
6. Potential gastric bypass patients, who have previously received verification of necessity, are to be reviewed and approved by the Chief Medical Officer. Secondary panniculectomy will also be reviewed by the Chief Medical Officer.
7. Requests for out-of-plan specialty referrals by a practitioner of another specialty may be reviewed by a Medical Associates practitioner in the pertinent specialty to determine appropriateness. The Chief Medical Officer will be informed of these cases and authorize out of plan care as indicated.
8. Requests for out-of-plan referrals by non-clinic network practitioners may be reviewed by a Medical Associates practitioner in a pertinent specialty to determine appropriateness. The Chief Medical Officer will be informed of these cases and authorize out of plan care as indicated.
9. Requests for services in which the attending practitioner feels the case requires an immediate decision, such as when the service is imminent or ongoing.

Revised: 07/89	Revised: 07/97	Revised: 05/00	Revised: 03/08
Revised: 02/90	Revised: 03/98	Revised: 05/01	Revised: 02/09
Revised: 02/91	Revised: 02/99	Revised: 03/02	Revised: 02/10
Revised: 03/92	Revised: 04/99	Revised: 03/03	Reviewed: 07/10
Revised: 07/94	Revised: 08/99	Reviewed: 03/04	Reviewed: 01/11
Revised: 01/95	Revised: 09/99	Revised: 03/05	Reviewed: 01/12
Revised: 10/95	Revised: 02/00	Reviewed: 03/06	
Revised: 05/96	Revised: 03/00	Revised: 03/07	

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**OUT-OF-PLAN REFERRALS – ROUTINE REQUESTS
Community Plan**

The Case Managers may authorize immediately the following routinely requested referrals when the standard referral process has been met:

1. Out-of-plan referral requests from MAHP's PCPs to contracted providers, i.e.:
 - a. High risk cardiology patients for second opinion and/or procedures. (Referral requests to non-contracted providers must be approved by the Chief Medical Officer).
 - b. Dermatology patients for P.U.V.A. therapy.
 - c. General Surgery referral requests for services not available in-plan may be authorized when referred to contracted providers. (Referral requests to non-contracted providers require Chief Medical Officer approval).
 - d. Female infertility problems will be referred to contracted providers for services not offered here. Contract limits apply.
 - e. Hematology/Oncology patients may be referred to contracted providers for consultation and/or treatment.
 - f. Ophthalmology patients may be referred when referred to contracted providers. This includes consultation and/or treatment.
 - g. Amniocentesis to rule out pathology may be directed to contracted providers for services not available in-plan.
 - h. Patients for breast reduction mammoplasties must meet established criteria in order to provide coverage. These surgeries may only be authorized, when medically indicated, such as in cases of documented neck pain, back pain, skin excoriation and conservative medical treatment have failed. Such conservative measures would include, but not be limited to, weight reduction, physical therapy, instruction on body mechanics. Chief Medical Officer will review all requests for breast reduction mammoplasties. See Health Care Services Policy #72 Criteria for the Coverage of Reduction Mammoplasty.
 - i. Patients for breast augmentation may only be authorized when medically indicated such as in follow up to breast cancer.
2. Home Health referrals for Home Health services should be authorized for the specific treatment plan requested. Subsequent visits may be authorized as considered appropriate by the Case Managers, i.e.:
 - a. Maternal/Child home visits post-delivery.
 - b. Home health visits in follow-up to hospital discharge or to prevent hospitalization.
 - c. Other home skilled services such as physical therapy and laboratory procedures when the staff of Medical Associates cannot provide the services.
3. Radiation therapy at the Wendt Regional Cancer Center (No prior authorization is necessary).
4. Post-operative follow-ups to a previously approved surgical procedure within global period.

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5. Annual follow-ups for chronic conditions and surgeries that cannot be performed in Dubuque to contracted providers, i.e.: Cardiac Clinic, Hemophilia.
6. Prosthetic eye care at Coralville Prosthetics in Iowa City, when benefit coverage exists.
7. In-patient consultations by non-plan specialists where there is not a Health Plans specialist providing services to that area, i.e., Nephrology, Manchester, Boscobel, Darlington.
8. Patients with renal failure receiving hemodialysis (No authorization is needed).
9. Patients needing evaluation to diagnose TMJ over and above the service provided by participating physicians are to be referred to the TMJ clinics. Evaluation only will be approved depending on the plan contract. The Health Plans do NOT cover braces, splint, or dental evaluations or treatment for TMJ. (Contract limits apply).
10. Physical Therapy, speech therapy, occupational therapy require prior authorization.
11. Terminally ill patient in need of palliative and supportive care may be referred to Hospice.
12. Enrollees needing services of a dietician may be referred to participating hospital dietitians. Number of visits, unless specified by the Health Plans physician, is based upon guidelines for outpatient nutrition visits. (See attached copy of guidelines Clinic need prior approval).
13. Elective MRI's, MRA's, CT's & CTA's scans require prior authorization.
14. Referrals for organ transplantation, when described as a covered benefit and the patient is utilizing a designated transplant facility. The Chief Medical Officer and Health Plans' Management Staff will be made aware of all transplant cases.
15. Mental Health Services -No authorization is necessary for outpatient mental health or chemical dependency utilizing in plan providers due to the Mental Health Parity Act. Mental Health Admissions both in plan and out of plan require an authorization along with outpatient out of area. MAC Mental Health Department staff area available as a resource.

Original:	03/02	Reviewed:	03/05	Revised:	02/09	Revised:	01/11
Revised:	03/03	Reviewed:	03/07	Revised:	02/10		
Reviewed:	03/04	Reviewed:	03/08	Reviewed:	07/10		

Prior Authorizations-Medical Associated Health Plans

HEALTH CHOICES

Updated 1/1/12

Health Choices #41010 Medical Associates/ #41019 MA Copay

1. In-patient require notification
2. Non-formulary medications, Remicade and other high dollar meds – use eMAC task
3. Out of plan referrals
4. CT/MRI's being done outside of MAC
- 5.
6. DME over \$500 – use PA form from Intranet
7. OT and PT outside of MAC (Dubuque or Platteville) – treating facility responsible for Prior Auth
8. InterStim procedure requires prior authorization

Health Choices #41012 Mercy

1. In-patient require notification
2. Remicade and other high dollar meds – use eMAC task
3. Out of plan referrals
4. CT/MRI's being done outside of Mercy
5. PET scans – not needed if done at Mercy
6. DME over \$500 – use PA form from Intranet
7. No notification needed for CT scans/MRI when done at Mercy
8. OT and PT - treating facility responsible for Prior Auth – not needed if done at Mercy
9. InterStim procedure requires prior auth

Health Choices #41009 City of Dubuque (see note below), #41011 NICC, #41013 Multi Co (Namasco-non union Group HC0013MDN or MDE \$ Sisters of Charity Group 990046)

1. Prior authorization on all procedures/surgeries at TSSC or hospital; including colonoscopies
2. In-patients require notification
3. Remicade and other high dollar meds – use EMAC task
4. Out of plan referrals require Prior Auth
5. MRI's/CT scans, no auth required for City of Dbq for MRI's
6. PET scans
7. DME over \$500 – use PA form from Internet
8. OT and PT outs of MAC (Dubuque or Platteville) – treating facility responsible for Prior Auth
9. InterStim procedure requires prior auth

Health Choices – any other groups, **contact MAHP** for contract specifications

1. No prior authorizations is needed for out patient (SDS) procedures/surgeries at TSSC or hospital
2. For other contract specifications call: 556-8070 (option 4)

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3. InterStim procedure requires prior auth

Health Choice City of Dubuque: ****DME over \$250 require prior authorization.**

Prior Authorizations-Medical Associates Health Plans

Updated 1/1/12

MA/HMO 41021

1. In-patients require notifications
2. Non-formulary medications, Remicade and other high dollar meds-use eMAC task
3. Out of plan referrals use eMAC task
4. CT's/MRI's being done outside of MAC (include long bone)
5. DME over \$500-use PA form from Internet
6. OT and PT outside of MAC (Dubuque or Platteville) – treating facility responsible for Prior Auth
7. Note: **Platteville** only-SWHC employees are allowed to have all available out patient services ordered by in plan providers performed at SWHC without prior authorization.
8. Diabetic Shoes require prior auth
9. InterStim procedure requires prior auth

HMO Community Plan 41028

1. In-patient require notification
2. Non-formulary medications, Remicade and other high dollar meds-use eMAC task
3. Out of plan referrals use eMAC task
4. CT's/MRI's being done outside of MAC (include long bone)
5. DME over \$500—use PA form from Intranet
6. OT and PT (except for MAC) – need Prior Auth
7. Diabetic shoes require prior auth
8. InterStim procedure requires prior auth

HMO Medicare 11400 (includes **Community Plan Medicare and Freedom Plan)**

1. In-patient require notification
2. Remicade and other high dollar meds – use eMAC task
3. Out of plan referrals use eMAC task
4. CT's/MRI's being done outside of MAC
5. OT and PT outside of MAC (Dubuque or Platteville) – treating facility responsible for Prior Auth
6. DME over \$500 – use PA form from Intranet
7. Diabetic shoes require prior auth
8. InterStim procedure requires prior auth

***Outpatient tests at Midwest Medical Center: PT, OT, Speech, **will need** Prior Authorization.

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***DME items less than \$500 that still requires prior auth are:

- + Pulse oximeters
- + VED (vacuum erection devices)
- + Seat lift mechanisms
- + CPM machines
- + Apnea Monitors
- + Diabetic shoes