

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 80**

POLICY TITLE: PRE-CERTIFICATION

POLICY STATEMENT:

Requests made by Health Plans' participating practitioners for services requiring authorization 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. Pre-certification may be initiated or removed as deemed necessary by MAHP.

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.

PURPOSE: To insure the Health Plans' resources are utilized to deliver care in the most appropriate and cost-effective setting.

PROCEDURE:

1. Case Managers receive communication from the participating Health Plans' practitioner or practitioner's staff to request authorization for identified services.
2. The Case Managers request the following information:
 - a. Patient name
 - b. Birth date
 - c. Treating Practitioner name
 - d. Consulting Practitioner/facility name
 - e. Reason for the request, 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 the request and may approve immediately Routine Requests according to Health Care Services guidelines. 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. (See Administrative Policies # 10's)

- 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.
4. Pre-service requests suggesting lack of Medical Necessity or those that are not considered "Routine Requests" must be reviewed by the Chief Medical Officer. A decision will be made according to the applicable time frames as noted previously in policy.

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5. The Chief Medical Officer shall consider the following in making a pre-certification for a service:
 - 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; and/or
 - f. continuity of care issues.

6. The Chief Medical Officer or designee will review the request for appropriateness, authorize the scope of the services, conditions of the prior authorization, 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. The Chief Medical Officer has the ultimate authority to deny/approve requests for services.

7. 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

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
 - d. length of stay.

8. The Case Managers will then provide immediate verbal notification of the decision to the requesting practitioner.

9. The information is entered into the computer system and letters are generated to the patient and physician within established timeframes.

10. If the pre-certification request is denied, the Health Care Services Policy #2 Denial will be followed.

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11. The Case Manager will coordinate exchange of pertinent medical information between PCP and SCP pre- and post-service as indicated.

12. MAHP has the following pre-certification programs:

- Physical Therapy performed outside of Medical Associates Clinic PT Departments – West Campus and Platteville locations. Interqual Outpatient Rehabilitation & Chiropractic Criteria and Medicare are the criteria utilized in reviewing requests for PT services.
- Chiropractic services requested for MAHP members who do not have open access coverage for chiropractic care and Medicare member’s seeing identified chiropractors will require pre-certification according to the Interqual Outpatient Rehabilitation & Chiropractic Criteria. Expectation is that the member has exhausted internal resources before being referred for chiropractic care. Requests for chiropractic care outside of Interqual guidelines and/or extensions beyond the suggested number of visits will be reviewed by physician reviewer.
- MRI’s & CT’s performed outside of Medical Associates Clinic require pre-certification. The preferred MRI & CT unit is at Medical Associates Clinic and members are to be directed to the Medical Associates Campus for the MRI & CT’s to be performed whenever possible. MRI’s & CT’s performed outside of Medical Associates Clinic must have an authorization entered in the information system and must meet one of the following to be approved:
 - emergency/urgent situation
 - when timely MRI or CT are not available at an in-plan facility
 - member’s need – inability to travel due to illness, injury, physical disability etc.
 - unable to obtain procedure at in-plan facility i.e.stereotactic MRI, CTA.

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Date

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Date

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