

# **MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**

## **POLICY TITLE: AUTHORIZATION AND REFERRAL MANAGEMENT**

### **POLICY STATEMENT:**

Requests for services requiring authorization are reviewed according to member contract or plan documents and established MAHP HCS Guidelines. These guidelines are viewed and approved annually by the CMO, UMC, QIC, and Clinic Board of Directors. Authorizations may be initiated or removed as deemed necessary by MAHP based on industry standards and utilization patterns.

### **PURPOSE:**

To ensure MAHP's resources are utilized to deliver quality care to members in the most appropriate and cost-effective setting. MAHP will arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical need. Services and subsequent payment are based on the member's benefit plan document.

### **DEFINITIONS:**

1. Pre-service decisions: a request for services that requires approval by MAHP, in whole or in part, before the service can be rendered; a service that must be approved in advance before it is rendered.
2. Post-service decisions (retrospective decisions): a service or claim which has already been rendered. Occurs when notification is after the fact of care/service/delivery. The need for "retro-review" is most often created by late or non-notification.
3. Concurrent review decisions: a review conducted during a course of treatment for medical/surgical, mental health and/or substance use disorder. Included, but not limited to concurrent review is the anticipation and planning for post hospital needs, arrangement for post hospital or acute treatment follow-up and support, ongoing review for required disciplines.
4. Urgent pre-service decisions: Requires immediate action, although it may not be a life-threatening circumstance an urgent situation could seriously jeopardize the life or health of the covered member or the ability of the member to regain maximum function or in the opinion of a physician with knowledge of the claimant's condition would subject the member to severe pain. An urgent care condition is a situation that has the potential to become an emergency in the absence of treatment.
5. Emergent: Sudden or unexpected onset of severe symptoms which indicate an illness or injury for which treatment may not be delayed without risking the member's life or seriously impairing the member's health.

### **REFERRAL AND AUTHORIZATION SUBMISSION OPTIONS:**

Referral and authorization requests may be submitted to Health Care Services Case Management and/or Utilization Management Nurses via telephone, fax, or electronically from members,

## **MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**

attending practitioners and/or facilities. Requests can also be submitted through the Cerner Message Center, MAHP-HCS Pool.

### **REFERRAL REQUIREMENTS:**

Commercial HMO, Community Health Plan (CHP) and IPlan: Referral authorizations are required for any out of plan provider except for emergent care.

Medicare Smart and Community Health Plans: Referral authorizations are required for any out of plan provider except for emergent care.

Point of Service (POS): Members have the option of utilizing two levels of benefits, authorized or unauthorized. Members utilizing the authorized level of benefits are required to obtain a referral from their in-network specialty care provider. Members may choose to obtain services without a referral in or outside the MAHP network using their unauthorized benefits.

Medicare Freedom Plan: Members have the option of utilizing two levels of benefits, authorized or unauthorized. Members utilizing the authorized level of benefits are required to obtain a referral from their in-network specialty care provider. Members may choose to obtain services without a referral outside the MAHP network using their unauthorized benefits.

Health Choices: Refer to specific plan document for referral requirements.

### **REFERRAL MANAGEMENT:**

MAHP recommends that the referral request be obtained from an in-plan provider of the same specialty except on rare occasions. Only the initial consultative referral will be authorized except when there is a predicted need for more visits or when the member is involved in an ongoing process of care. In cases where a certain specialty is not available in-network, a primary care provider may make the referral request for authorization to MAHP.

Following the initial consultation, additional referrals from the referring provider are required in the following circumstances:

- a. If the specialist wishes to provide additional services not originally requested on the referral.
- b. If the specialist refers member to a second specialist
- c. If the specialty visits will exceed the number of visits initially authorized by MAHP
- d. If the specialty visits require an extension beyond the referral thru date.

A standing referral for a member to utilize a non-participating physician or provider may be issued if requested by an in plan and/or by request of a member with approval from the MAHP CMO. The CMO shall consider the following in making an authorization for a referral:

- a. Proposed treatment plan

## **MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**

- b. Diagnosis
- c. Ability of an in-plan provider to provide the requested services
- d. Frequency of needed care from the non-participating provider and/or
- e. Continuity of care issues

Second and third opinions are covered when MAHP criteria are met.

- a. Second opinions are covered according to the following:
  - The member has questions about the reasonableness or necessity of a recommended surgical procedure.
  - The member has questions about a diagnosis or plan of care for a condition that threatens loss of life, limb, or bodily function, or a serious chronic condition.
  - When a diagnosis is in doubt due to conflicting test results and the treating practitioner is unable to diagnose the condition, or the clinical indications are complex, unclear, or confusing.
  - When the current treatment plan is not improving the member's condition.
  - When the member has attempted to follow a plan of care and has serious concerns about the diagnosis or plan of care.
- b. Third opinions are covered if the recommendations of the first and second physician differ regarding the need for surgery or other major procedures/treatment.
- c. All second and third opinions, whenever possible, should be provided in-network and/or MAHP contracted provider and must be authorized by MAHP. (Unless member has out-of-network benefits) Out-of-network second/third opinions may be considered if there is no available or appropriate in-network/contracted provider and must be authorized by MAHP's Chief Medical Officer (CMO) or assigned physician reviewer.
- d. Second or third opinions may include:
  - A history and physical exam of the member
  - All diagnostic testing should be forwarded to the second or third opinion provider or brought along with member to consult.

Any additional diagnostic testing required for determining the need for surgery and/or treatment will require prior approval by the MAHP CMO or assigned physician reviewer.

**NOTE:** Referrals do not permit an out of plan specialist to refer members to another out of plan specialist for care. If this is necessary, patients must get a referral from their referring in plan provider to see another out of plan specialist. This referral is not a guarantee of payment. Payment is subject to eligibility on date of service, plan benefits, limitations and exclusions, pre-existing condition limitations, and patient liability under the plan. Referrals are time sensitive, so any date change requires notification to MAHP to update the referral.

### **PRIOR AUTHORIZATION:**

**Inpatient Services:** All elective inpatient hospital admissions should be communicated to MAHP for prior authorization. Emergency hospital inpatient admissions do not require prior authorization but should be called or faxed to MAHP within 48 hours of the admission, or as soon as the member is physically able to provide information for authorization.

## **MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**

Requests for Out-of-Area Urgent care require prior authorization. Emergent care will be processed according to the limitations of the member's contract or plan document, to the most appropriate tier or at an in-network level.

Health plan members with students and/or dependents residing or attending school outside of the MAHP service area may elect to participate in the "Care Package" program by completing the attached form. (See appendix B) Participation in the program is applicable to plans that elect to provide this service and in doing so allows members to obtain in plan benefits without requiring referral. If a member does not enroll their out-of-area dependent in the "Care Package" program, only urgent and emergent coverage will be provided

Observation Services do not require prior authorization when provided at an in-network facility. Authorization is required when services are being provided at an out-of-network facility and /or when required per member's plan contract or document. Services must be considered reasonable and necessary to assess an outpatient condition to determine the need for inpatient admission or discharge. Observation services should not be used for the convenience of the hospital, its physicians, patients or patient's families or while awaiting placement to another health facility.

All DME requests for items over \$2000 will be reviewed by the HCS Utilization Management Nurse or Case Manager for appropriateness per the member's contract/plan document and/or the Health Care Services policies and procedures. If approval is given, an authorization is entered into the system.

**Note:** If equipment cannot be supplied through the Health Plans' network DME providers, the Health Care Services Nurse will work with provider to make arrangements to obtain necessary equipment. If the requested services are determined medically necessary, an authorization is entered into the computer system to indicate coverage. The HCS Nurse will negotiate fees when necessary.

The replacement of equipment is considered medically necessary only when documentation shows that the current equipment/item is malfunctioning, cannot be refurbished and is no longer under warranty.

Additional precertification and prior authorization requirements can be found at <H:\Health Care Services Dept\Case Management\Precertification>. The complete list of prior authorization requirements can be viewed at <H:\Health Care Services Dept\Case Management\Precertification\PA Requirements\PriorAuthMAHP.HC Grid.xlsx>.

See appendix A, and B for additional precertification and prior authorization requirements.

Authorization, referral and denial decisions are made in a timely manner that accommodates the clinical urgency of the situation. Decisions are communicated to the requesting provider and facility verbally and in writing within standard time frames. See HCS Decision Timeframes and Determination Policy.

**MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES  
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**

A quarterly report of authorized and denied/redirected services and out of plan referrals will be presented to the Utilization Management Committee.

Documentation of referral requests will be kept on file for a minimum of three years in the MAHP information system.

Repeated non-compliance of the Health Plans' practitioner to the prior authorization and referral procedures may result in corrective action by the Chief Medical Officer.

**Appendix A:** MAHP Pre-Certification Guidelines for out of network requests

**Appendix B:** Copy of "Care Package" form

Original: 12/2015  
Revised: 07/2018  
Revised: 01/2022

Revised: 03/2017  
Revised: 08/2019  
Revised: 07/2022

Revised: 11/2017  
Revised: 11/2019

Revised: 04/2018  
Revised: 04/2020

# MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL

## Appendix A:

MAHP pre-certification guidelines for out of network requests include and may not be limited to the following:

- a. Routine care out-of-area is not a covered service. Routine care is defined as treatment for a condition which the patient has prior to leaving the service area. Medicare members: authorization will be granted for medical services when requested by treating in-network physician/provider for members with ongoing medical needs who will be out of service area. Examples include PT/INR for members on blood thinners, dialysis out of service area, physical therapy etc. An authorization for these services will be entered into the information system.
- a. Routine labs work regularly scheduled to occur is not covered while out of the service area unless medically necessary to maintain the member's health. An exception can be made, and an authorization entered the system.
- b. Eye exams for students will be authorized if the patient is having acute symptoms such as headaches or blurry vision. Routine eye exams will be authorized out-of-area if no appointment within the Health Plans' service area can be made for the patient within a four-week period. Payment will be made according to the contract limitations.
- c. Elective procedures such as, but not limited to repeat pap smears in follow-up to previous abnormal pap smears, colposcopies are not covered out-of-area. If it is felt to be more urgently needed, a copy of pap smear report will be obtained for review by the Chief Medical Officer.
- d. Treatment of sexually transmitted diseases for student's out-of-area will be approved for initial evaluation with a request for a treatment plan from the treating practitioner. Upon review of the treatment plan, subsequent follow-up visits will be authorized based upon the reasonableness of the treatment plan, with the understanding that the student will follow-up with a Health Plans' provider upon return to the service area.
- e. Follow-up care will be authorized as necessary when it is not reasonable for the patient to return to the service area and/or a considerable unsuccessful attempt has been made to obtain an appointment for the patient upon return to the service area. If an appointment can be arranged for the patient in the service area, but the patient refuses, the visit will not be authorized out-of-area.
- f. Allergy injections – College students will be directed to Student Health facilities. Authorizations will need to be entered for claims to pay. Adults needing allergy injections out of the services area will require an In-Plan Physician referral indicating medical necessity and time frame needing approval. An authorization will be entered when medically indicated.
- g. Vaccination Exception: Meningitis Vaccine is covered for college students at Student Health Departments. Hepatitis B Vaccine is covered for college students at Student Health Departments (if covered in contract). No referral is necessary. Schools are to submit bills to the Health Plans for reimbursement.
- h. Physical Therapy may be authorized out-of-area when in follow-up to treatment initiated by a participating practitioner and the treating provider requests authorization for the service. Physical Therapy will be authorized in follow-up to treatment initiated by non-participating practitioners out-of-area when the incident/illness/injury occurs while out of the Health Plans' service area.
- i. Requests for mental health/chemical dependency services by all enrollees will be directed to their designated mental health triage group i.e., HMO (open access) members are referred to Medical Associates HCS Department. HCS Policy Mental Health / Chemical Dependency Access Standards is utilized to determine coverage on non-participating providers. Information is entered into MAHP's computer system and treatment plans are requested as needed.
- j. Members receiving kidney dialysis and who have a short-term need (two weeks or less) out of the services area may request consideration of coverage for kidney dialysis while out of the service area. Requests should be provided by the treating Nephrologist with pertinent information such as, treating facility and length of stay. The Case Manager may authorize dialysis when appropriate.

# MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL

## Appendix B:



### Care Package PROGRAM

Do you have a dependent child living outside the Medical Associates Health Plans service area? Send them off knowing they're covered by enrolling them in our Care Package program!



With the Care Package program, dependent children who are enrolled in one of our health plans and live outside the designated service area will now receive out-of-area coverage at the in-network level of benefits.

#### How to Participate

Your dependent child may be able to participate in the Care Package program if he or she:

- is eligible for dependent child coverage as explained in your Subscriber Agreement and
- resides or attends school outside your plan's designated service area.

You may sign up your dependent child for the Care Package program by completing the form attached. If you do not enroll your out-of-area dependent child in the Care Package program, only Urgent and Emergent Coverage will be provided.

#### Using the Care Package program

- Always present your member ID card so providers can contact Medical Associates Health Plans to verify coverage.
- Just like your in-network benefit, certain services require prior authorization. Failure to obtain necessary prior authorization can result in a denial of benefits.

*Services received out-of-area may be subject to usual and customary charges. Additional charges may be avoided by utilizing providers that agree to participate with MAHP. Please go to [www.PHCS.com](http://www.PHCS.com) to view potential providers in your service area. If you need to fill a prescription that has been written by a physician outside of our service area, the pharmacy will need to call MAHP to get prior authorization. If you have any questions, please contact Member Services Department. Phone: 584-4885 or (toll free) at 866-821-1365. Email: [memberservices@mahealthcare.com](mailto:memberservices@mahealthcare.com). Fax: 563-584-4760.*

---

### CARE PACKAGE PROGRAM APPLICATION

You may sign up for the Care Package program by providing the following information:

Employer/Group Name: \_\_\_\_\_

Employee/Subscriber Name: \_\_\_\_\_

Dependent's Name: \_\_\_\_\_ Dependent's Date of Birth: \_\_\_\_\_

Dependent's Address: \_\_\_\_\_

Dependent's Member ID Number: \_\_\_\_\_ Effective (today's date): \_\_\_\_\_

Please submit this form to: Medical Associates Health Plans, Attn: Member Services, 1605 Associates Dr., Dubuque, IA 52002

# MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL



## Care Package PROGRAM

Do you have a dependent child living outside the Health Choices service area? Send them off knowing they're covered by enrolling them in our Care Package program!



With the Care Package program, dependent children who are enrolled in one of our health plans and live outside the designated service area will now receive out-of-area coverage at the in-network level of benefits.

### How to Participate

Your dependent child may be able to participate in the Care Package program if he or she:

- is eligible for dependent child coverage as explained in your Plan Document and
- resides or attends school outside your plan's designated service area.

You may sign up your dependent child for the Care Package program by completing the form attached. If you do not enroll your out-of-area dependent child in the Care Package program, you may have limited coverage or an increased cost share.

### Using the Care Package program

- Always present your participant ID card so providers can contact Health Choices to verify coverage.
- Just like your in-network benefit, certain services require prior authorization. Failure to obtain necessary prior authorization can result in a denial of benefits.

*Services received out-of-area may be subject to usual and customary charges. Additional charges may be avoided by utilizing providers that agree to participate with Health Choices. Please go to [www.PHCS.com](http://www.PHCS.com) to view potential providers in your service area. If you need to fill a prescription that has been written by a physician outside of our service area, the pharmacy will need to call Health Choices to get prior authorization. If you have any questions, please contact Health Choices **Phone:** 584-4783 or (toll free) at 866-390-3872. **Email:** [healthchoices@mahealthcare.com](mailto:healthchoices@mahealthcare.com). **Fax:** 563-584-4760.*

---

## CARE PACKAGE PROGRAM APPLICATION

You may sign up for the Care Package program by providing the following information:

Employer/Group Name: \_\_\_\_\_

Employee/Subscriber Name: \_\_\_\_\_

Dependent's Name: \_\_\_\_\_ Dependent's Date of Birth: \_\_\_\_\_

Dependent's Address: \_\_\_\_\_

Dependent's Participant ID Number: \_\_\_\_\_ Effective (today's date): \_\_\_\_\_

Please submit this form to: Health Choices, Attn: Member Services, 1605 Associates Dr., Dubuque, IA 52002