
TITLE: Preauthorization of Medical Services

POLICY: First Coast Advantage will manage utilization in an organized, consistent manner to ensure that services provided to the members are medically necessary, as well as being cost effective, provided in the most effective and appropriate setting. All initial determinations of medical necessity will be based on National and State Established criteria.

PROCEDURE:

A. General Information:

1. Requests for services are accepted by fax, phone or letter. Staff identifies themselves by their first name, title and company name when answering the phone.
 - a. Fax communications are removed from the fax machine no later than every 30 minutes to screen for urgent requests.
 - b. Members, designated facility personnel, the attending physician and other ordering providers are notified of any specific utilization management requirements.
 - c. Ongoing communication is conducted in relation to utilization management during providers' reasonable and normal business hours, unless otherwise mutually agreed.
 - d. All HIPAA Guidelines, as outlined in policy for health information, for PHI obtained during the preauthorization review process will be followed. The information obtained will be used solely for the purposes of preauthorization, quality management and for identifying members that might benefit from case management.
 - e. Only the Medical Director can deny a service.
 - f. All emergency room visits are approved.
 - g. Admissions through the emergency room are approved and followed by an Inpatient Case Manager for continued stay approval.
 - h. Not all services on the Preauthorization list require medical necessity review. In these cases Preauthorization acts as a mechanism for tracking over/under-utilization and/or verifying eligibility and benefit coverage.
 - i. The Preauthorization Department has a copy of the established criteria to utilize for decision-making. The copy is available in the Preauthorization Department and available to providers upon request.
 - j. All staff involved in authorization of services will be in serviced on criteria and on updates as they are implemented.
 - k. The Medical Director approves all scripts or algorithms used for preauthorization screening.



- l. Review staff is available by a toll free or collect call telephone line from 8:00 AM to 5:00 PM Monday through Friday with the exception of holidays. Access is available in each time zone where First Coast Advantage conducts at least 95% of its review activities.
- m. Preauthorize nurses refer cases that meet the criteria for case or disease management to the appropriate department.
- n. Toll free numbers or voice mail is available to members and providers after hours. On nights, weekends and Holidays Revised 09/01/2006: messages left by providers and members on the toll free line are addressed the next business day.
- o. Hospital admissions called in after hours, weekends and Holidays are honored pending review for appropriateness for admission.
- p. The Preauthorization Department will be responsible for sending members, upon their request, the medical records and supporting information used to make the determination free of charge (HIPAA guidelines will be followed).
- q. Revised 09/01/2006: Authorization numbers for approvals are provided to participating and non-participating providers telephonically or in writing.

B. Process for Routine Service Requests

1. The preauthorization nurse will:
 - a. Stamp in all referral requests via fax and letter with the date and time the request is received in the department.
 - b. Document all phone requests on an Authorization Referral Form and stamp the request with the date and time the call was received and the name of the person calling the referral.
 - c. Utilize appropriate criteria and plan benefits for decision-making and approved the requests when the criteria and/ or the plan benefits are met.
 - d. Approve request that do not have established criteria when sufficient medical information is provided to support medical necessity; otherwise, the case will be referred to the Medical Director.
 - e. Request information not provided with initial service request via phone or fax within 24 hours of receipt of request.
 - f. Make two attempts 24 hours apart to obtain the Medical information to make an informed determination.
 - g. Document the attempts to obtain information on the Referral Communication Form with the date, time information requested, and contact person. Document the date information was requested and the date information received in the designated area on Authorization Review Form.

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- h. Present requests without appropriate supporting documentation to the Medical Director for review and intervention as needed.
 - i. Revised 09/01/2006: Process all routine elective services or admissions within five (5) calendar days or as soon as the member's health condition dictates. Authorization requests must be processed within fourteen (14) calendar days.
 - j. Request that require Medical Review will be presented to the Medical Director no later than the morning of the 5th (fifth) day to allow for appropriate review and intervention as needed. The Medical Director will contact the referring physician when necessary.
 - k. Notify the provider within 24 hours of request when the specific information needed to process the request has been provided. Information needed to process the request is the patient identifier, Health Plan name, services needed and Revised 09/01/2006: provider.
 - l. Revised 06/10/08: When a request is approved by the Medical Director, the referring physician will be notified of the decision by phone or fax. The referring provider notifies the member, provider and facility rendering service.
 - m. When a request is denied by the Medical Director, the requesting physician is notified via phone of the denial and the right to initiate an expedited appeal or standard appeal. The PCP, referring physician and member are notified in writing of the denial, appeals and expedited appeals process. The physician who made the denial decision is available within one business day by telephone or in person to discuss the determination with the provider. Revised 09/01/2006: When the condition in question is beyond the scope of the Medical Director's Board Certification, he confers with physicians having clinical expertise in treating the condition or disease.
 - n. Revised 06/10/08 Prior to a non-participating provider's request being approved, the preauthorization nurse or designee will ensure that they are a Medicaid provider and advise that they must accept Medicaid reimbursement rates. Preauthorization staff needs to ensure that documentation accompanying the referral request identifies the reason for the non-participating provider.
 - o. All referrals to the Medical Director, approvals or denials will be documented in the authorization screen in the computer system.

C. Process for Expedited (Urgent) Service Request:

1. Definition of Expedited (Urgent): Medical care or treatment needed when the timeframe for non-urgent care determination could;
 - a. Seriously jeopardize the life or health of the member
 - b. Ability of the member to regain maximum function
 - c. In the opinion of the requesting provider with knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment recommended.

2. The Preauthorization Nurse will:
 - a. Accept urgent referrals Revised 09/01/2006: from providers representing claimants for urgent cases. These providers are to be considered authorized representatives and do not require any type of formal authorization document.
 - b. Process the requests for preauthorization of urgent services within 24 hours when adequate information is provided. If information or additional information is provided within 48 hours of the original request, the request will be reprocessed and a decision will be made within one calendar day.
 - c. Requests for urgent extension of an already approved course of treatment (concurrent) will be made within 24 hours of request.

3. Concurrent Non-urgent Request:
 - a. Concurrent non-urgent requests are processed within four calendar days.
 - b. Utilize the same process as routine request.

D. Process for Retrospective Requests:

1. The appeals process is the mechanism in place for retro-authorizations. If a request for retro-authorization is sent to the preauthorization department and the following is included, the request will be processed as a routine request.
 - a. Member name
 - b. Medical condition or symptom
 - c. Treatment, service or product

Attachments:

Referral Pre-authorization Form
Authorization Review Form
Communication Form



Case Manager / Attending / Communication Form

Date: _____

Time: _____

Physician _____

Patient Full Name	Unit Number	Physician
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() Severity of Illness – Intensity of Service criteria for admission and / or length of stay not met

- () Please consider discharge of a lower level of care
 - () Routine home to follow-up with MD as outpatient
 - () Short-term rehab (HRS 3008 Attached)
 - () ALF (HRS 1823 Attached)
 - () HHC for:

Please Page _____ at pager #: _____
to assist in arranging discharge needs and/or make arrangements for a physician to physician discussion with the First Coast Advantage Medical Director to discuss a treatment plan.

Thank you,

First Coast Advantage

THIS IS NOT A PERMANENT PART OF THE MEDICAL RECORD



Case Manager / Attending / Communication Form

DATE: _____

TIME: _____

Doctor: _____

Discharge planning should start at admission, please document discharge plan in progress noted.

First Coast Advantage Case Manager _____

is following this patient for any discharge needs. Current discharge plan:

Please write orders early so that Case Management has sufficient time to arrange for any indicated discharge needs!

Thank you,

First Coast Advantage, Case Manager

Beeper #: _____

Phone #: _____

THIS IS NOT A PERMANENT PART OF THE MEDICAL RECORD



AUTHORIZATION REVIEW

Date Received:		Nurse Reviewer:					
Name:		DOB:		Plan:			
PCP:		Auth #:		ID#:			
Type of Service:		<input type="checkbox"/> IP	<input type="checkbox"/> OP	Other:			
Added info requested D/T				Added info. Received D/T:			
***** Nurse Comments*****							
To MD for Review:		Date:		Time:			
MD Final Decision:		<input type="checkbox"/> Approve	<input type="checkbox"/> Deny	Date		Time	
MD Initial appropriate box, make comment as needed, sign and date.							
MD Decision Reason:		<input type="checkbox"/> NP	<input type="checkbox"/> NPA	<input type="checkbox"/> B	<input type="checkbox"/> LOI	<input type="checkbox"/> MN	
Medical Director Signature:		Date:		Time:			
Medical Director Communication to Physicians (s):							
Letter Sent by/date: _____ PCP ___ Specialist ___ Member ___ Facility _____							
Member Address:							
PCP called DT: _____ Time _____ Name: _____ Fax: _____ Contact _____							
Spec called DT _____ Time: _____ Name: _____ Fax: _____ Contact: _____							
Facility called DT _____ Time: _____ Name: _____ Fax: _____ Contact: _____							

NP = Non-Par
 NPA = No Prior Auth
 B= Not Covered Benefit
 LOI = Lack of Information
 MN = Medical Necessity



This authorization satisfies the pre-authorization requirement. It does not guarantee payment. E-mail to: pre.authorizations@jax.ufl.edu

PLEASE RETURN FAX TO 904- 244-9744

PRE-AUTHORIZATION FORM

Today's Date: _____ New Request: [] Updated Request: []
Patient Name: _____ SS #: _____ DOB : _____
Patient Home Phone: _____ Patient Work Phone: _____
Payor/Insurance (Primary): _____ ID #: []
Payor/Insurance (Secondary): _____ ID #: _____
Primary Care Physician: _____ Office Name: _____
Requesting Physician: _____ Office Name: _____
E-mail address for auth response: _____
Contact Phone: _____ Contact Fax: _____
ICD 9 Code(s) & Descriptions: _____
DOS: _____ If Pregnant, LMP: _____ EDC: _____
CPT/HCPC Code(s) & Description(s): _____

Place/Type of Service: Outpatient Office [] Outpatient Surgery [] 23 Hr Observation []
DME [] Inpatient Stay [] Diagnostic Procedure [] Home Health []

THIS SECTION TO BE COMPLETED BY THE PROVIDER OR CLINICAL STAFF

REFERRING TO: (Complete areas that apply-Attach medical information if available)

A. Specialty Physician/Service: _____ Provider ID #: _____
Specialist Fax: _____ Specialty: _____
B. Reason for Pre-Authorization: _____
C. Brief History; Include Prior Auth and Surgery: Clinicals attached: N [] Y [] # of pgs ____
How soon does patient need to be seen? Stat: [] Appt. First Available: [] Routine: []
Attending Physician Signature: _____ Physician ID #: _____

THIS SECTION IS FOR FCA PRE-AUTHORIZATION DEPT USE ONLY
DOS: _____ New: _____ Update: _____ # of Visits: _____ Total: _____
Auth # _____ Exp. Date: _____
Received Date & Time _____ Approved Date & Time _____ By: _____

For Billing information, please call Benefit Services: (866) 270-2468
Claims submissions: First Coast Advantage, P. O. Box 3620, Akron, OH 44309-3620