

Authorization for Services

The Family Practice residents and Health Services Agency based physicians are the primary care physicians for individuals covered by the Indigent Health Care Program. Most services rendered to an eligible Indigent Health Care Program beneficiary at any of the Health Services Agency Service sites do not require prior authorization. Neither emergency department services nor emergency admissions at Doctors Medical Center require prior authorization.

All services and supplies provided *outside* the Health Services Agency complex and its clinics require prior authorization. Exceptions will be made to this policy only for emergency services ordered by a DMC Emergency Room physician or HSA Clinic Based Physician. In these cases, the utilization management physician will do retrospective review.

Post-surgical follow-up for *emergency* office visits to physicians *on call for the patient's surgeon* will be exempt from prior authorization requirements if proof of an emergency condition is submitted with the provider's claim.

1. Inpatient Authorization

- The Indigent Health Care Program (IHCP) requires prior authorization for all elective hospital admissions and elective (non-emergency) surgeries, including those to be performed at Doctors Medical Center.

2. Treatment Authorization Request (TAR) Process

Treatment Authorization Requests (TARs) for community medical, surgical, or hospital services must be submitted to the HSA Utilization Management Department. This includes requests for diagnostic services. *Only dental TARs shall be submitted directly to the Indigent Health Care Program.*

In all cases, the Indigent Health Care Program reserves the right to designate the provider of services. Some service providers are selected on the basis of existing contracts. In other cases, the Indigent Health Care Program's Utilization Management physician will designate the provider of services.

a. Medical Care

When requesting services or supplies to be provided outside the Health Services Agency, the requesting physician fills out a **Treatment Authorization Request (TAR) form** and routes it to the HSA Utilization Management Department. Most TARs are reviewed within a week of their arrival at the Utilization Management Department Office.

Program regulations require that all TAR denials, and any denials of inpatient days, be automatically appealed in behalf of the provider and patient and, accordingly, are added to the agenda of the next monthly meeting of the Physician Utilization Review Committee (PURC) for further physician review.

Authorizations are only valid for the stipulated dates of service. Services rendered prior to a TAR

being approved will be denied. Extensions for prior authorized services must be requested before rendering services. **Prior authorization does not necessarily guarantee payment; if the client is not IHCP eligible on the date of service payment will be denied.**

b. Dental Care

All dental services provided in the Indigent Health Care Program must be prior authorized. **For dental referral, patients must be seen by a Health Services Agency (HSA) physician who will determine whether dental care is indicated.** If dental care is indicated, the HSA physician shall complete a Treatment Authorization Request (TAR) and submit it directly to the Indigent Health Care Program (IHCP) for approval. The TAR includes authorization for evaluation, treatment times one (1), to resolve any emergency symptoms or conditions (pain, abscess, etc.).

If more treatment is necessary than what is outlined on the initial TAR, a treatment plan is required to be submitted by the dentist to IHCP for review. Dental Treatment Plans may be submitted on any standard ADA approved or Denti-Cal claim form and must include detail sufficient to support the requested treatment. Procedures should be listed using three (3) digit CDS codes. Denti-Cal guidelines will be used in conjunction with the IHCP Dental Scope of Benefits in determining authorization.

3. Retro-Authorization

Authorizations are not provided retroactively. It is the provider's responsibility to assure all Treatment Authorizations are requested and approved prior to rendering services. Providers are advised to verify authorizations and patient eligibility prior to scheduling appointments.

Extensions may be granted on expired authorizations provided the patient is still eligible for IHCP and there is reasonable documentation regarding why services could not be performed during the prior approved authorization time frame. **Extensions must be authorized prior to rendering services.**

4. Appeals Process

The IHCP program automatically appeals any medical reviewer denials on behalf of the patient and provider. Appeals related to services denied on the basis of medical judgment are routed, under law, to the Physician Utilization Review Committee (PURC).

In addition, any denial upheld by the committee may also be appealed. The appellant must submit new and pertinent medical information not previously reviewed by PURC to be considered on second appeal. A second denial by PURC is final and, under a court decision (*Cruz vs Stanislaus*), may not be appealed in any court of law.