PROVIDER MANUAL 2024

Section Contents

Appendix

Chapter 1 CMS General Correct Coding Policy For National Correct Coding Initiative Policy Manual for Medicare Serivces

Chapter XI CMS Medicine Evaluation and Management Services

IPA Authorization Process Overview

Authorization Request Form (Sample Form for faxing)

Diagnostic Authorization Information

Procare Quickcap Web Provider Portal Authorization User Instructions

INTRODUCTION

Authorization requests may be submitted using the standard Treatment **Authorization Request Form** or using the Procare Quickcap Portal located on https://procaremso.quickcap.net/

The Web Authorization System (available through procaremso.quickcap.net) is available for Physician's offices to submit and view status of a referral request. An approval letter is also faxed (once the authorization is approved) to each office with authorization details including approval

IPA Authorization Department Information

Authorizations UM Department Phone (657) 206-8700 Fax: (888) 972-1931

Types of Referral/Authorizations

URGENT: Urgent means services that are required in order to prevent serious deterioration of a member's health that results from an unforeseen illness or injury. Urgent Authorization request will be process within 24 hours or up to 72 hours per CMS guidelines.

Urgent referrals are only to be submitted if the normal time frame for authorization will:

- Be detrimental to the patient's life or health; or
- Jeopardize patient's ability to regain maximum function; or
- Result in loss of life, limb or other major bodily function

NOTE: All referrals not meeting urgent criteria will be downgraded to a routine referral request and follow routine turn-around times.

Routine authorizations are for services that are not-urgent.

Retrospective authorizations are medical services provided without prior authorization. Retro authorizations must be submitted within two business days for review. If submitted after 48 hours, the next allowed date is up to 14 days but the following circumstances must occur:

- Unable to Know Situation-The provider and/or facility is unable to identify from which IPA to request an authorization. The patient is not able to tell the provider about their insurance coverage and/or the Medical Group or IPA she or he belongs to, or the provider verified different insurance coverage prior to rendering services.
- Not Enough Time Situations-The patient requires immediate medical services and the provider is unable to anticipate the need for a preauthorization immediately before or while performing a service.
- An enrollee is discharged from a inpatient facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

--

Urgent means services that are required in order to prevent serious deterioration of a member's health that results from an unforeseen illness or injury.

Generally, authorizations are required for all services except for PCP-capitated services, Ob/Gyn visits, and some exceptions made by the IPA such as Direct Referral Authorizations (attached) such as Preventative services and Initial Consult to Specialist performed at IPA contracted facilities.
See Direct Referral Form.

Frequently Asked Questions

What requires an authorization?

- PCP services beyond office visits such as Carve out services and additional visits that are more than one time per patient per month
- Follow-up visits for Specialist Services
- Specialist Procedure and test services
- Outpatient surgical services, Outpatient Dialysis services, ambulatory surgery, endoscopy, etc.
- Inpatient services (elective only)
- Physical Therapy, Occupational Therapy, Speech Therapy, Nutritional Services, Chemotherapy
- Adult Hep A and Hep B, Synagis, and other high cost drugs
- Bone Density for Diagnoses, CT Scans, Diagnostic Studies, MRIs, and Nuclear Medicine REQUIRE an authorization for all members at all facilities.
- Treadmill, Stress Echo, other Cardiology tests, and Holter Monitor, Apnea monitor, Sleep Testing
- HHC, DME, Orthotics
- Out of network or non-contracted providers or facilities
- High cost Lab services

The following do NOT require an authorization

- EKGs
- Cardiac Echo
- Routine Annual Lab and X-ray (Routine X-rays do not need an authorization through IPA designated Providers)
- Routine OB/Gyn Care, including well woman visits.
- Mammogram
- Colonoscopy
- Yearly Diabetes Retinal Screening
- Yearly Glaucoma Eye Exam Screening
- Yearly Foot Exam
- BMD Screening
- Initial Specialist Consult/Office visit

Please refer to the Appendix for the **Diagnostic Authorization Information** listing for additional info (i.e. All par OB/Gyns may perform up to two ultrasounds for

pregnancies without an auth. Any additional ultrasounds must be prior authorized).
Please call our UM Department for unlisted services.

Authorization Process Overview

You may submit referral authorizations using a standard Authorization Request Form or electronically through Procare Quickcap provider portal Contact Provider Services at (657) 206-3700 or email Daniel.H@procaremso.com to request login Provider portal access (contracted providers only) and/or additional copies of **Authorization Request Forms**.

The Authorizations Department fax number is (888) 972-1931.

Updating a request?
To update recently approved authorization requests, please fax PROCARE a written request with the referral number and the requested change. We will be happy to assist you. Please note that updates to already Approved Authorizations can only be modified within 48 hours of last Approval notice.

Once an Authorization Request is received, how long does authorization determination take?

Routine requests with complete supporting medical documents that justify the treatment request are completed within five business days from receipt of request. Although CMS allow up to 14 days to process Routine Authorizations.

Urgent requests with complete supporting documentations are completed within 48 hours from receipt of request. CMS allow up to 72 Hours.

How will we be notified of the determination?

A report will be faxed to the fax number we have on file for your office.

It is important to keep your fax machine on 24 hours a day, since we fax back daily notifications to you during and after typical business hours. Remember to check your incoming fax report before calling our office to inquire about status. You can also check our Web Authorization system on-line at **procaremso.quickcap.net**.

Notification letters of determination will be sent to the member, the requesting and requested provider, and the Primary care provider.

Prior Authorization Requests – Fax Number

If you send us Prior Authorization Request by fax, please send to (888) 972-1931. Sending to other fax numbers may delay your request.

Prior Authorizations – Reminders

DO:

- Check fax notification DAILY for status and authorization number. This is typically sent immediately after the determination is made. (Keep fax machine ON!)
- Fill in the diagnosis (code), procedure (code), procedure description, member name and ID on each request, and reason for treatment along with supporting medical documentation including recent Physical exam with treatment plan, tried RX therapies, labs/pathology results, diagnostics results, and other pertinent test results that support the treatment).
- Combine requests if the requested services are for the same provider at the same site. Please Note: Unbundled service requests are not allowed per CMS/NCCI edits.
- Respond to a request for additional information (medical records/notes) from our medical review staff as soon as possible so that a determination can be made.
- Include clinical information pertinent to the request.
- Include/enter the Facility when appropriate (i.e. hospital, ambulatory surgery center, SNF, etc.)
- Use the on-line Procare QUICKCAP web system to verify status of requests.
- Send two separate authorization/referral requests for office and hospital procedures

DO NOT:

- Send an additional New request to add a code. Contact us by phone or fax to modify an already approved authorization.
- Routinely send requests as URGENT OR EMERGENCY, the system will not accept the request if the services does not meet Urgent criteria. Urgent or emergency requests are based on medical conditions as outlined on the top of the request form. (paper form)
- Send multiple copies of the same request.
- Send a retro-authorization after 48 hours OR after a claim has been denied. No authorization will be given. This is considered an appeal.

- PCPs: Send a referral to an OB/GYN as prior authorization is not required.

Additional Important Information

- With the electronic Web Authorization request system, an Evaluation & Management code level has to be entered. Therefore, a level xxxx3 is automatically entered into the system. You may bill the appropriate level, and the Claims Department will pay the "level" according to the PROCARE guidelines. Please submit medical notes supporting the higher level with your claim if you are upcoding to a higher level.
- As a rule, requests for surgical supplies and trays, will not be prior authorized. These will be reviewed on a case-by-case basis by the Claims Department.
- Specialists should request follow-up visits and surgical procedures directly. If specialist has not seen member in last 3 months and is not under active treatment, member needs to redirect back to PCP for evaluation first.

Web Procare Quickcap Authorization System - Reminders

- Make sure the appropriate diagnosis codes and procedure codes are entered. The system will be cancelled for outdated codes or unlisted codes.
- Check the status of the requests daily in order to respond to request for information quickly.
- Providers who are not showing in the system are out-of-network providers. If you want to refer to an out-of-network provider, be sure to enter the reason for such a referral in the "notes" section of the authorization submission page in order to request an out-of-network provider

PCPS AND SPECIALIST AUTHORIZATIONS

The following describes basic information about authorizations for PCPs and Specialists.

Important: Authorizations are NOT required for a referral from a PCP to a contracted Ob/Gyn Specialist for Ob/Gyn visits. Be sure to inform your patients! This information is KEY in coordinating timely care for your patients.

Ob/Gyns: You do not need to ask for a referral authorization for an office visit related to Ob/Gyn care when a member self refers. Continue to submit referral authorizations for anything beyond office visits, including procedure(s) and delivery.

`

Specialists: When you receive a Direct Referral or Approval for Initial referral from a PCP, it is good for the initial consult only. YOUR Specialist office may request continued care and treatment authorizations for the member. To prevent further delay, please state reason(s) for the treatment request and attached complete supporting medical documentations including Initial visit Physical exam and treatment plan if new patient, or if established patients, most recent History and Physical with treatment plans, Conservative medications list tried but failed, recent lab results, diagnostic results, relevant tests results, and other relevant notes that support the treatment request. It is not necessary for the PCP to request follow-up visits, unless member does not have a recent history with specialist (not under active treatment in the last three months). In these cases, PCP should evaluate member first to determine need for referral to specialist.

Please Note: Some services combined may be subject to CMS NCCI edits where services are inclusive of each other. Unbundled services are not allowed per CMS. See Appendix for Chapter 1 General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services

USING THE PROCARE QUICKCAP WEB PORTAL TO SUBMIT AUTHORIZATIONS

There are a number of benefits and advantages to using a paperless process. Not only are your requests received instantly by the UM Department, you are able to:

- Check the status of any request any time.
- Check eligibility.
- Receive the referral/reference number immediately.
- Check history of a referral related to the member.

If you don't have a User ID, email the attached Provider Portal Login Request form to Daniel Hong at Daniel.h@procaremso.com or call Provider Services at 657-206-3700 to request a User ID, password and training.

Basic Instructions for Submitting Referral Authorizations Using the Web

For additional detailed instructions, please log on to **procaremso.quickcap.net** or refer to the provider portal document.

Launch a web browser of your choice (FireFox preferred) and go to procaremso.quickcap.net.

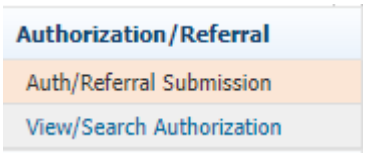
1. Click the PREMIER PATIENT CARE IPA under Select IPA.
2. Enter your assigned username and password (case-sensitive).

Reminder: Always type the password using case-sensitive keys.

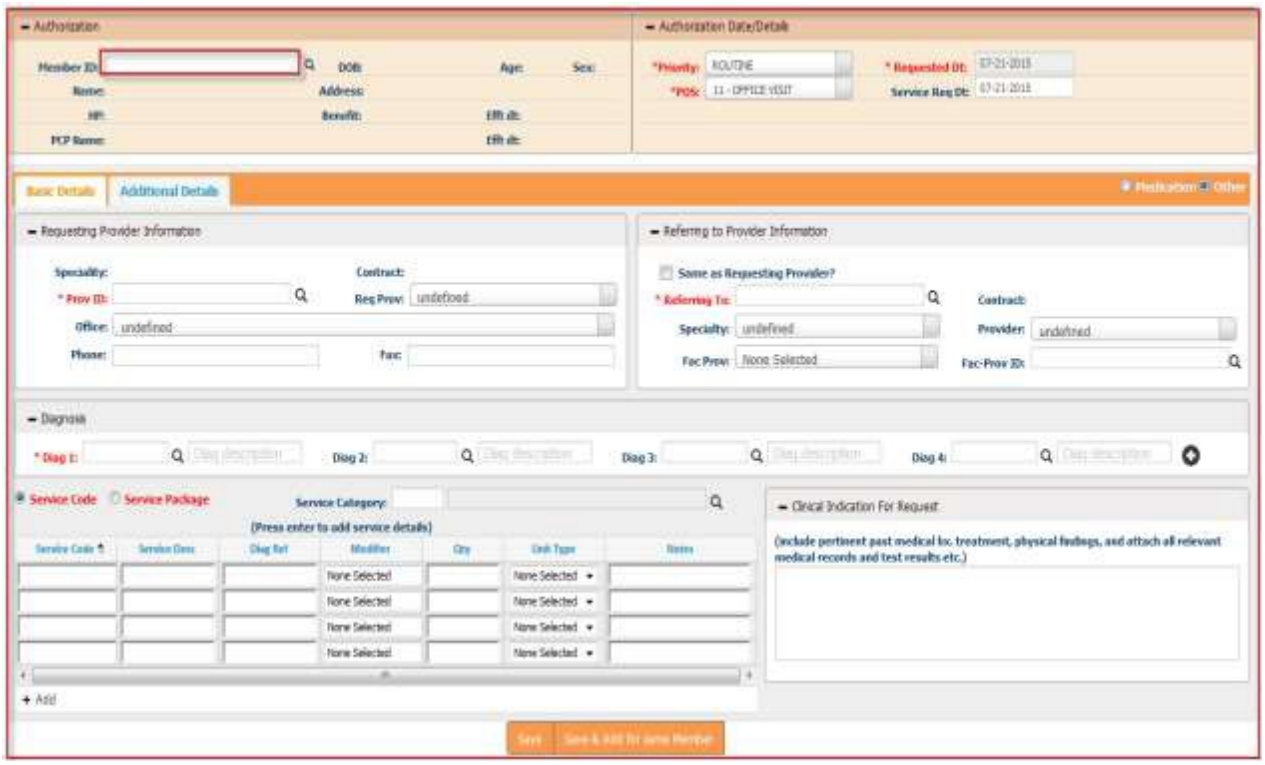
Click on the Authorization/Referral module and select "Auth/Referral Submission".

-

AUTHORIZATION PROCESS

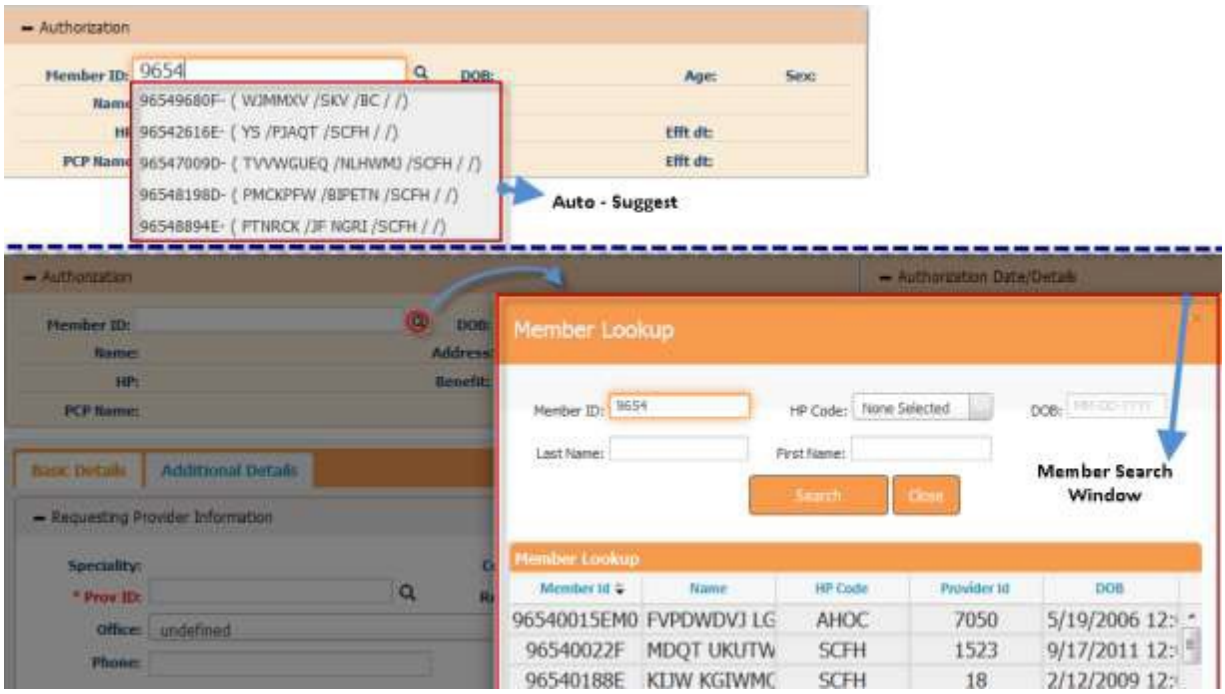


The screen will display as shown. On this screen, there are three subsections to add and submit an authorization.

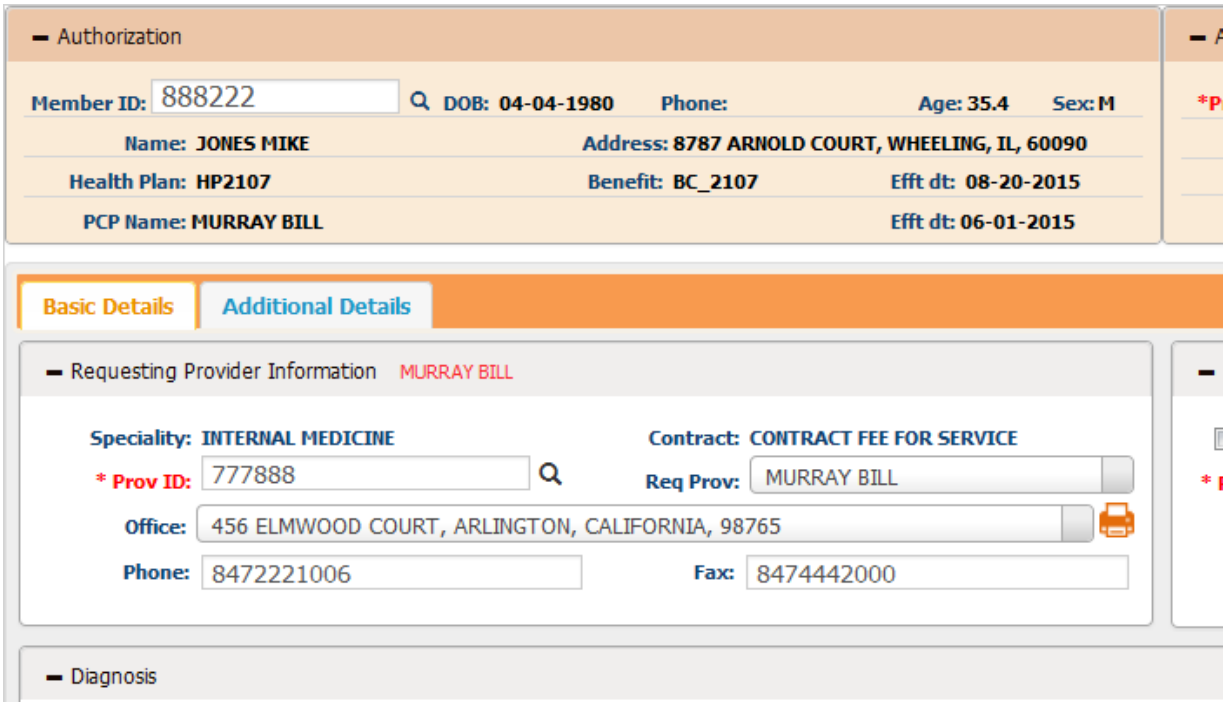


Step 3: The first section is the **Member Section.** Users can enter the member's information in one of two ways:

- Enter the **Member ID** for the specific member. The system will begin suggesting members once the user has entered part of an ID. Users can then select the correct ID to add the member's information to the screen.
- Users can click on the **Magnifying Glass** icon to search for the member. The -**Member Lookup** screen will open. From this screen, users can search using a combination of **Member ID, Health Plan**, **Name,** and **DOB** to find the record. Double click the correct record to add it to the authorization request.



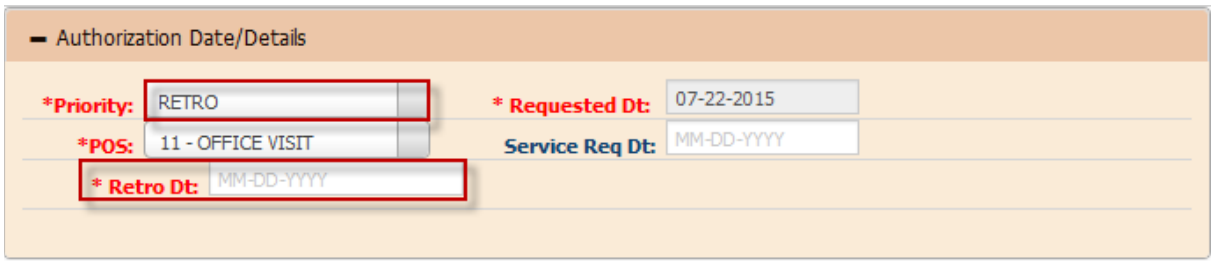
Step 4: The details for the selected member will be populated on the screen. The system will default the **Requesting Provider** information matching the organization and provider logged in.



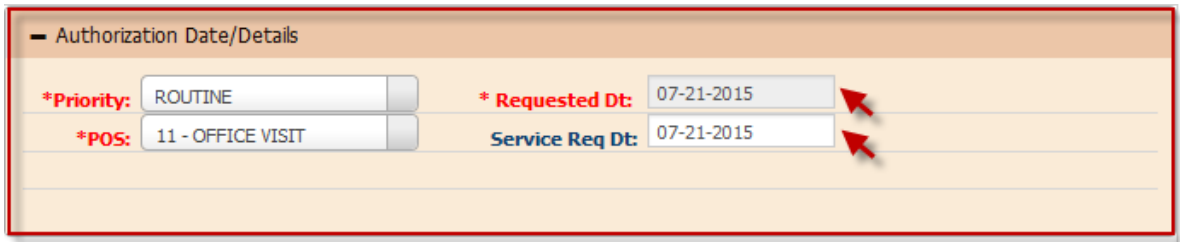
Step 5: The user can select the **Priority** and the **Place of Service** for the request.

- Within the **Priority** dropdown menu, two options which will trigger a popup screen to appear or additional options.
  - **Urgent**: If selected, the **Required Information for Urgent Requests** screen will open. Enter the necessary information and click the **Add** button to complete this step.

- **Retro**: If the services have already been provided, users should select **Retro.** A new field, **Retro Date,** will appear and require date entry.

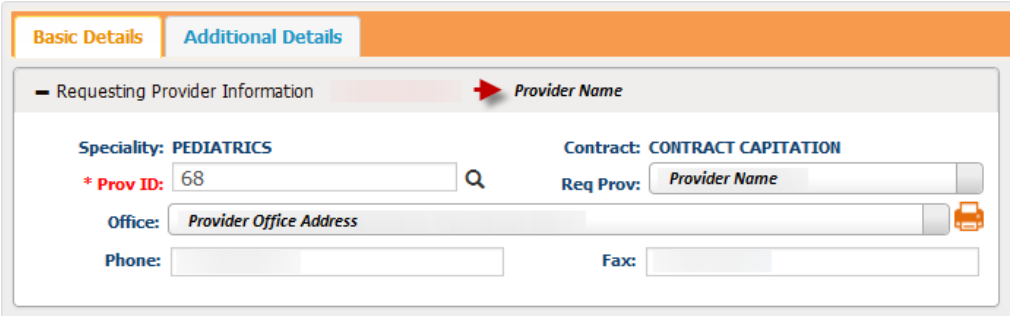


Step 6: The section to the right of the **Member Details** is the **Authorization Date/ Details**. The **Requested Date** is non-editable and will always default to the date of submission.

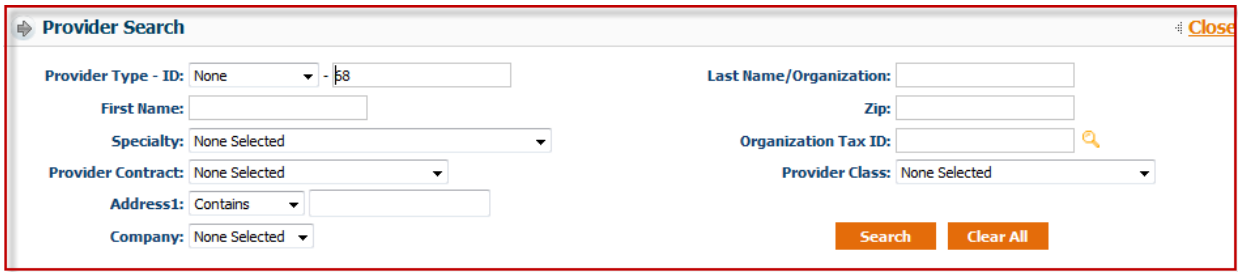


- The **Service Requested Date,** displayed in the **Service Req. Dt** field should be entered as the date that the service should be performed, scheduled for, or for the authorization to become effective. This date will be reviewed by Nivano Physicians internal staff and is subject to their discretion.

Step 7: The **Basic Details** tab displays the **Requesting Provider Information**. This screen includes **the Specialty, Contract Type, Provider ID**, **Requesting Provider Name**, and the contact information.



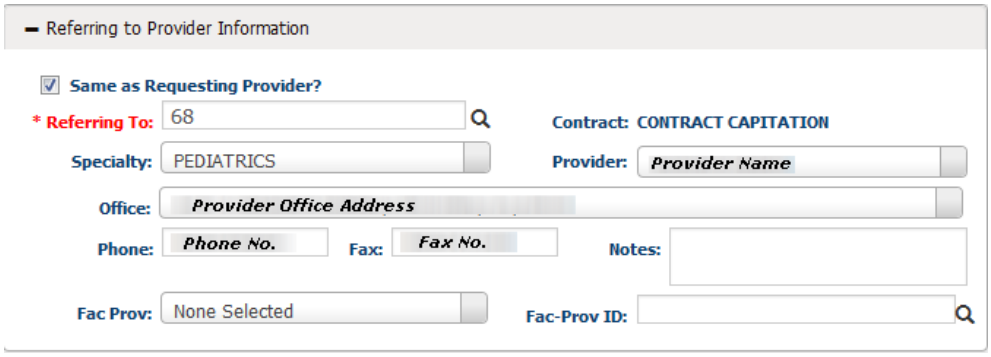
- Users can search for a requesting provider by clicking the **Magnifying Glass** icon on the right of the **Provider ID** field. The **Provider Search** screen will open as shown below. Search the provider by entering any of the available information. If you click on search without entering any parameter, all providers under your organization will show up.



- Click the **Provider ID** indicated in orange to populate the details of the requesting provider on the authorization request.
- If the provider has multiple offices, users can select the correct office from the dropdown menu.

Step 8: The next section, **Referring to Provider Information,** allows users to enter the information for the provider that member is being referred to.

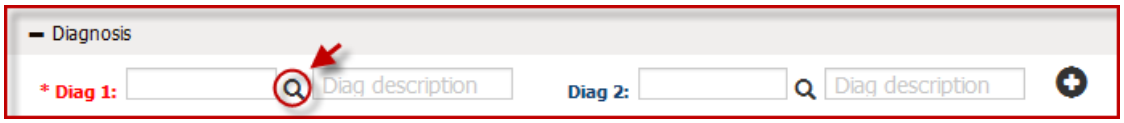
- For self-referrals, select the "Same as Requesting Provider" checkbox. This will auto-populate the information from the Requesting Provider screen.
- To search for a Referring To Provider, click the Magnifying Glass icon beside the Referring To field. The Provider Search screen will populate as shown in the above section. Users can search for the specific provider.
- Click the correct Provider ID to enter the details of the referring provider on the authorization request



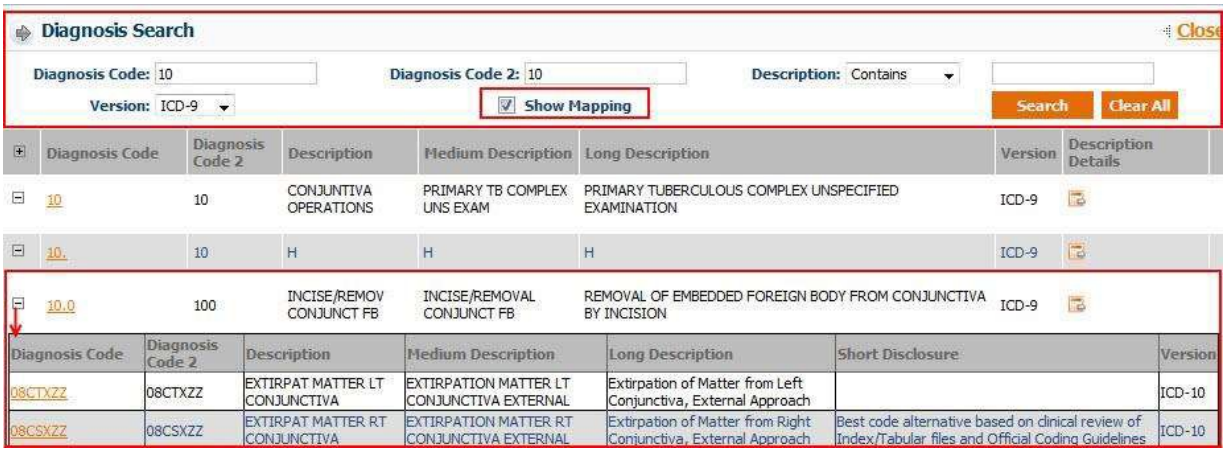
- Then, select the **Referring to Office** from the dropdown menu.

Step 9: This step is optional. Users can enter **Facility Provider Information** for the request, if needed.

Step 10: The next section, **Diagnosis**, is where users will enter all diagnosis details for a request.



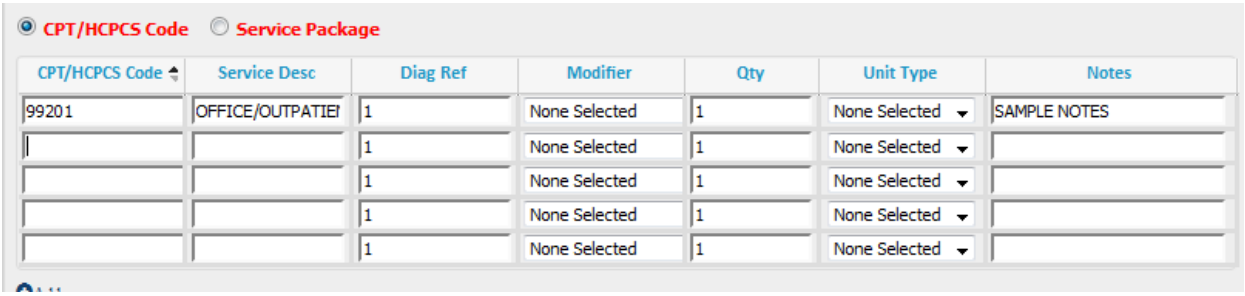
- Enter all ICD codes related to the request in the **Diagnosis Code** field.
  - If the user knows the ICD code, they can enter it into the field and press **tab** on their keyboard. The system will populate the description to the right in the **Diag. Description** field. The system will auto suggest codes if they are partially entered.
  - To search for the diagnosis code, click the **Magnifying Glass** icon by the **Diagnosis Code** field. The **Diagnosis Search** screen will populate, as shown below.

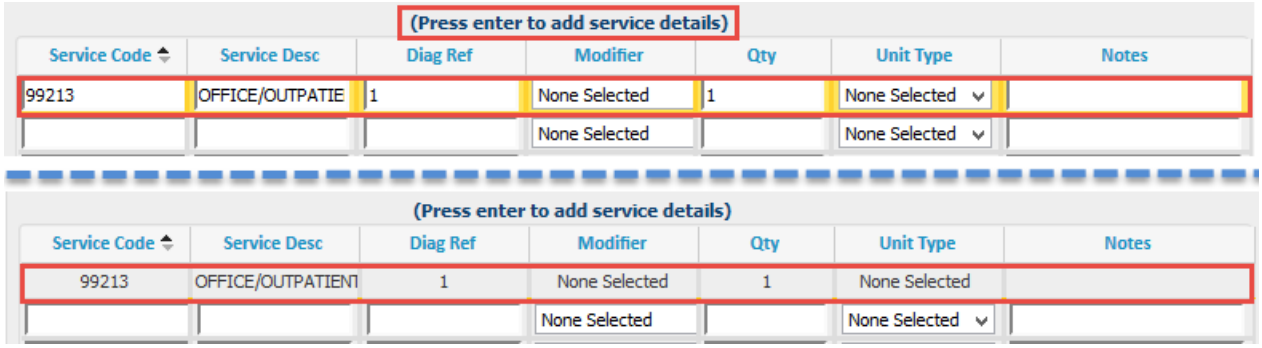


- From the **Diagnosis Search** screen:
  - Enter either the diagnosis code or description to search for the code.
  - Select the version of the code. ICD 9 codes will default. However, users can search for ICD 9, ICD 10, or for both codes.
  - Users can view the mapping between versions by selecting the **Show Mapping** checkbox.
  - Click the **Search** button.
  - Click the **+** icon to the left of each code to view the mapping.
  - Select the desired code by clicking on the correct **Diagnosis Code** shown in orange.

Note: Users can add 12 distinct diagnosis codes.

Step 11: The next section is used to enter the CPT/HCPCS codes for the requested services.

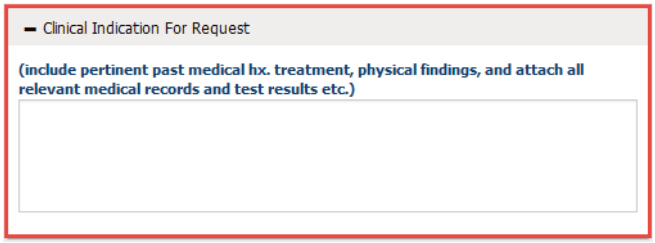




- The option for **CPT/HCPCS Code** defaults for entry; users can select **Service Package** if it is enabled. This will be described further below.
- To utilize the **CPT/HCPCS Code** option, users can enter the service code or search for the service code by clicking **F2** on the keyboard.
- If **Service Package** is selected, users can select the package from the dropdown menu. **Service Packages** may consist of multiple codes that are affiliated. This can be used to identify certain services such as Office Visits or Consultation visits.
- After the code is entered, the description will auto populate into the **Service Desc** field.
- Users can enter the **Diagnosis Reference**. The system will default automatically to 1, which indicates that the code is linked to the first ICD code from the **Diagnosis** section. Users can change the digit corresponding to which diagnosis code the service should reference.

- Users can enter a quantity for the service and select the unit type. If none is selected, it will default to **None** and for 1 for the **Quantity**.
- Users can add any modifiers if needed. Modifiers can be selected from the dropdown menu or manually enter the code.
- Press **tab** on the keyboard to go to the next CPT (service) line.

Step 12: The next section is **Clinical Indication for Request**. In this section, users can add the member's past medical history, physical findings, service notes being requested, or attach all relevant medical records and test results.



Step 13: The second information tab is **Additional Details.** Within this tab, three more sections will appear.

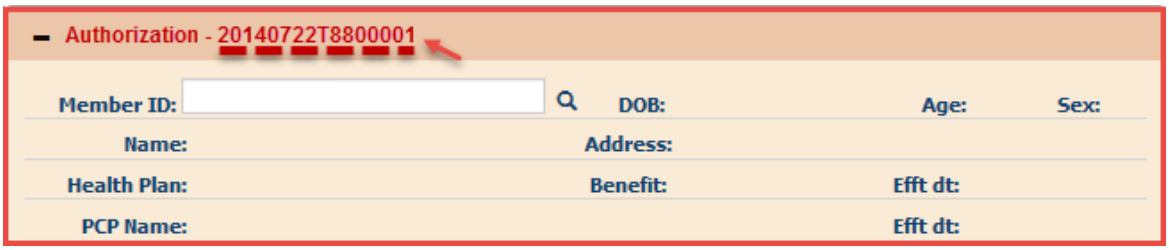
Step 14: The first section is **Documents**. Users can upload and attach documents to the referral request. Users are also able to fax documents to the organization. To upload documentation and submit it electronically with the referral request:

- Select the **Category** and **Priority** of the document.
- Click **Browse** to find the file from the computer directory
- Upload documents in the following formats: .doc, .docx, .xls, .xlsx, .pptx, .xps, .psd, .htm, .pdf, .tiff, .rtf, and text.
- Click the **Add Additional Documents** button to add multiple documents.
- Once users click **Save**, the document will send with the referral automatically.

Step 15: After verifying the data entered, users can save the request.

- To submit the referral request, click **Save**.
- To submit the referral request and add another request for the same member, click **Save and Add for Same Member**.

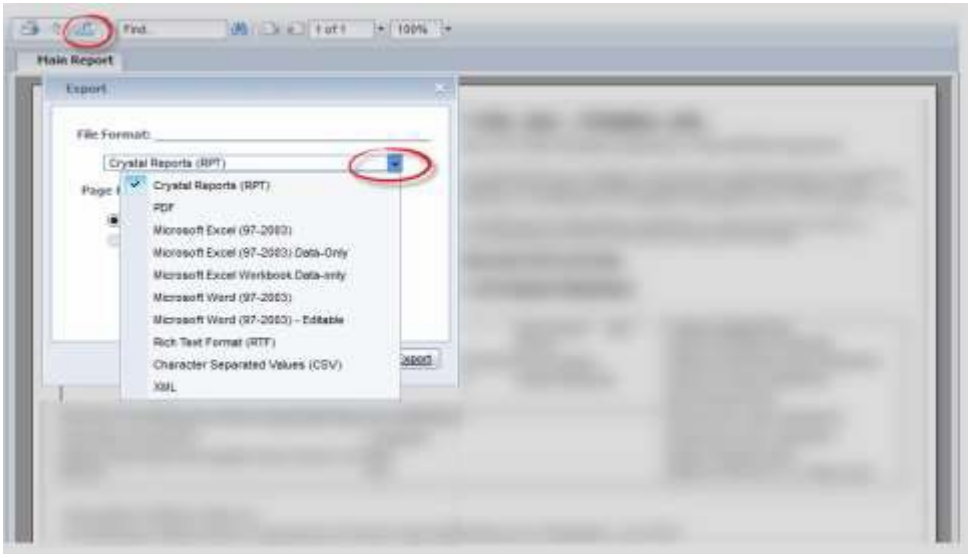
Note: When an authorization or referral request is submitted, users will receive a notification detailing the authorization request number with the status. Then on the **Authorization** screen, the recently submitted authorization number will be displayed automatically on the header portion.



Step 16: Users have the option to **Print Auth** on the lower section of the screen once it is saved. This feature allows users to print authorization requests. The popup window gives options to print and export the request.

- **Export Options:** There are several options that the reports can be exported to:
  - Crystal Reports (RPT)
  - PDF
  - Excel 97 – 2003
  - Excel 97 – 2003 Data Only
  - Excel Workbook Data Only
  - Word 97 – 2003
  - Word 97 – 2003 Editable
  - Rich Text Format (RTF)
  - Character Separated Values (CSV)

- XML



CHECKING THE STATUS OF AN AUTHORIZATION

To verify the status of an authorization, follow these steps:

Step 1: From the **Authorization/Referral** list, select **View/Search Authorization**.

Step 2: The **Authorization/Referral Status Search** screen will display as shown below:

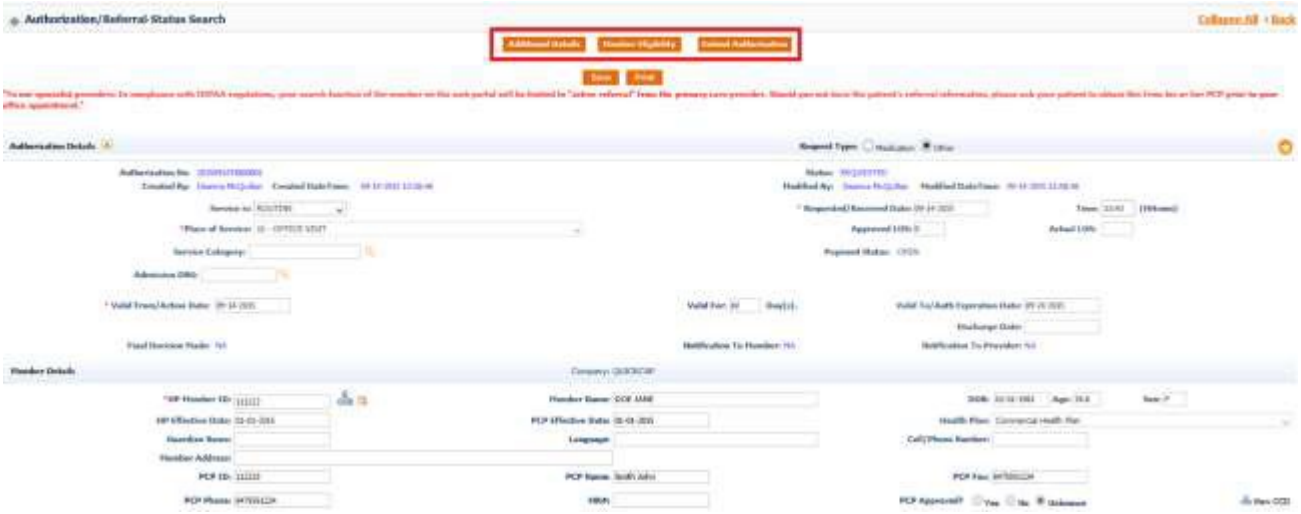
Step 3: The first section is where users search for authorizations. Enter search criteria in any of the available fields. The search results will display in the results section below.

Step 4: Click the (**+**) icon to view the services requested in the authorization. The service information will be visible.

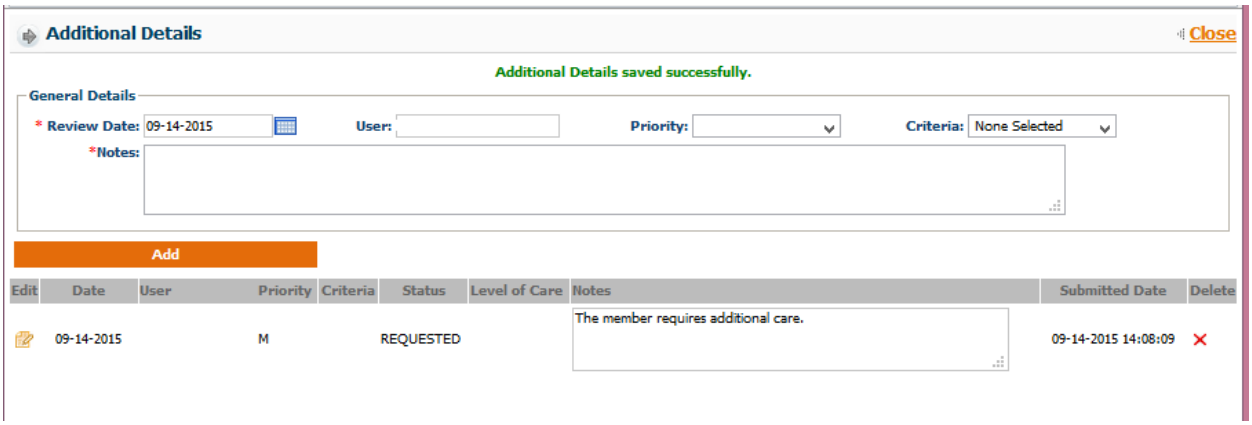
Step 5: The status of the authorization (requested, approved, denied) is displayed in the **Authorization No. Status** column.

Step 6: To view all of the information for a specific authorization, click on the row for the authorization. This will redirect users to the **Authorization/Referral Status Search** screen with all of the authorization details.

Note: This screen is only for viewing purposes. Only a few sections are enabled.

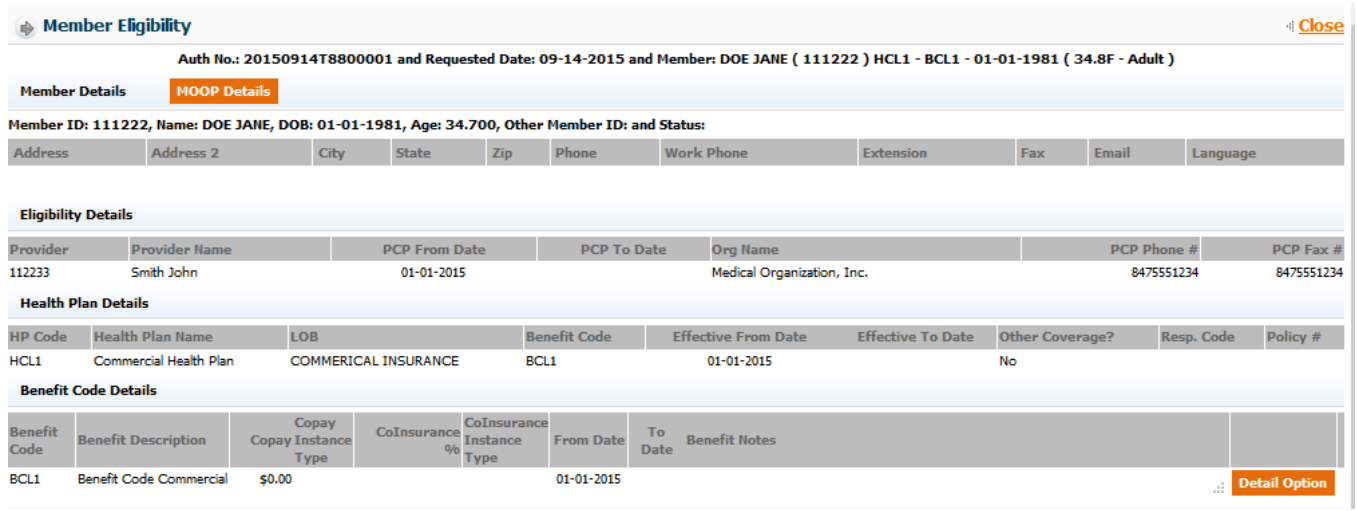


Step 7: To add additional details to the current authorization request, click the **Additional Details** button. The **Additional Details** screen will populate as shown below.

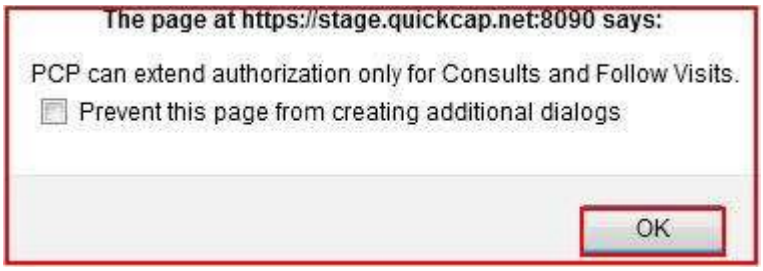


- In the **General Details** section, select the review date, priority of detail and criteria. Enter the information needed in the **Notes** field**.** Click the **Add** button to save the details.
- If you want to edit already added details, click the **Edit** icon.

Step 8: To view the member's eligibility details, click the **Member Eligibility** button. The **Member Eligibility** screen will populate as shown below.

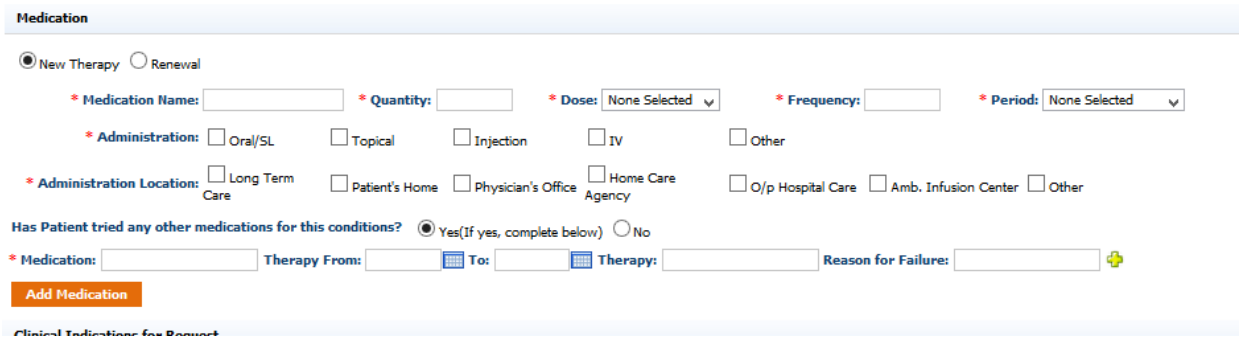


Step 9: If you want to extend the date of authorization, then click the **Extend Authorization** button. A message will pop up as follows.



- Click the **OK** button. This will redirect the user to the **Auth Expiration Date** field. Users can extend by either entering the new authorization expiration date or by entering the number of days in **Valid For** field.

Step 10: Users can add medication details and edit existing medication details from the **Medication** section.



Step 11: Users can send additional documentation related to the referral by adding the attachments in the **Documents** section.

Step 12: Click the **Save** button to save the updated request.

AUTHORIZATION PROCEDURES

Primary Care Physicians, Specialist Physician Offices and Ancillary Providers

Providers are responsible for verifying the eligibility of the member before services are delivered and the validity of an authorization before performing the services.

Submit Authorization Request using one of these methods:
Procare Quickcap Provider portal or by fax.
By FAX using the standard Authorization Request Form. Fax to (888) 972-1931.

Important! If any required information is missing, a request may be returned for clarification.

Emergency Services

Primary Care Physicians are requested to notify PROCARE immediately of all Emergency Department visits, including member visits to out-of-network facilities. ER services are periodically reviewed by PROCARE's UM department and/or the IPA's UM Committee. When ER services have been authorized by the PCP or other authorized representative of the IPA, but were later found through the UM review process not to meet medical necessity criteria, this information may be incorporated into targeted provider utilization history.

AUTHORIZATION PROCESS

Authorization Request Review

All authorization request reviews will be made according to standard time frames, provided appropriate information is submitted or available to make a determination. **Turn around times are**:

URGENT and Part B Injections:	within 72 hours (will attempt within 24 hours) System will showed Error if Urgent request does not meet Urgent Criteria
ROUTINE/NON-URGENT:	within 3-5 business days (up to 14 days if Medicare and pended for completed supporting documentations
RETRO REVIEWS (only if within 48 hours of rendered services):	within 7-14 days. Retro reviews that are passed 30 days must be sent as a claim and attached supporting medical notes to the claim.

Criteria for Determination by Hierarchy:

- Member's Eligibility with the Health Plan
- CMS National Coverage determination (NCD),
- Local Coverage Determination (LCD), Local Coverage Medical Policy Article,
- Medicare benefit Policy manual, Health Plan criteria (coverage summary, and Medical policy)
- Evidence based criteria such as Milliman Care Guidelines (MCG) latest version, and other evidence-based resources available including Academic and Specialty community based standards and practices

All denial determination for lack of medical necessity is made by the IPA's Medical Director or designated physician reviewer. If the requesting Provider disagrees with the Denial determination, he or she may request a Peer to Peer discussion with the IPA Medical Director or Appeal in writing to the Health Plan and attached further supporting medical supporting documentation.

*Physicians may request copies of criteria and/or guidelines by calling the UM Department at (855) 548-0911 or email support@procaremso.com.

Determination Notification (to Provider)

PROCARE will notify the referring provider, requested provider and the Primary Care Physician (if PCP is not the requesting provider) of all authorization decisions via fax (decisions are currently faxed in the mornings for requests made the previous day). Determination status is APPROVED, PENDED, CANCELLED or DENIED.

See also details on the Authorization Request Notification Report.

Member Notification

PROCARE notifies the member in writing for all decision determinations. This confirmation letter is sent to the member by mail within 48 hours of the decision determination.

Medical Director Availability

The IPA Medical Director is available to discuss any case with the physician/provider. Please call the UM department Monday through Friday between the hours of 9:00 AM and 5:00 PM at (657) 206-8700.

AUTHORIZATION REQUEST NOTIFICATION REPORT

The following illustrates the details in the approval letter that is faxed to your office on a daily basis with the activities related to authorization referrals.

Report sections include:

Your approved Authorization Requests
(referrals from you) and Referrals to you
For your information as a PCP (PCPs only)

SAMPLE

TO DAVID WILLIAMS, M.D., Fax #: (408)222-2222
1234 W. JACKSON AVENUE SAN JOSE, CA 95116
(408) 444-4444

Subject: AUTHORIZATION NOTIFICATION

This section displays the authorization requests that was approved from you to another Physician or Facility. It lists Date Received, AUTH #, Member #, Name/Sex/DOB, PCP/Comment, Referred By, ProcCode/Description, Qty, Processed, Expire, and Status.

Disclaimer: This report is subject to enhancement and is intended as a sample only.

CORRESPONDENCE

Approval Letters

The approval letter notifies the member regarding the specific request (for service for a specific provider/physician) has been approved. Non Discrimination language is also attached to the Denial letters

Denial Letters

The denial letter notifies the member regarding the specific request (for service for a specific provider/physician) has been denied in the member's preferred language. The letter also explains they have the right to appeal the decision by filing a grievance with their health plan. In addition, Health plan submission guidelines, including the number of days the member has to file an appeal is described. Non Discrimination language is also attached to the Denial letters.

The denial letter is sent to the member with copies to the requesting provider and PCP.

Cancel Letters

An Authorization request maybe cancelled because provider requests cancellation; it is a duplicate; health plan financial responsibility; or a "carved out" benefit. Given the complex nature of medical group contracts, there are many occasions when the requested services will be the financial responsibility of the health plans; in which case, the requests maybe cancelled and may need to be authorized directly by the health plan. One example is the member request for out of network second opinion. "Carved out" benefits are services that are covered by the health plans but administered by other entities or vendors other than the medical group. The best examples are Acupuncture services, vision, mental health, dental, and other Health Plan carved out services such as out of network or transplant cases that are not the responsibility of the IPA.

When authorization requests are being cancelled, the providers and the members will be notified with the exception of duplicate requests.

DENIAL PROCESS

The Utilization Management (UM) staff coordinates with other departments such as Quality Management and Claims, to ensure that accurate information is given to the members and providers when a denial for a service is processed.

It is Premier Patient Care IPA policy that:

All denial determinations are made by the IPA's Medical Director or Physician designee.
Utilization Management staff will send denial confirmation letters to PCPs, requesting providers and members.
All denials of service will be handled in a timely manner according to health plan guidelines, and will be documented and tracked.
All Peer to peer requests, and/or appeals will be handled in an efficient manner according to IPA/Health plan approved procedures.

Process

A denial letter is sent to member, PCP and requesting providers by the UM staff, and copied to the member's Health Plan. The requesting provider will be notified within one business day of the denial determination by fax.

Confirmation denial letters are sent within **2 business days** after the decision determination. In addition to the explanation for the denial, all letters will provide instructions for initiating an appeal in compliance with health plan and regulatory requirements.

Requests for service authorization commonly are denied for the following reasons:
The provider requested is not contracted with the IPA.
The service is not a covered benefit.
The service is not medically necessary/medically appropriate.
The member is not eligible.
The member's benefits for that service have been exhausted.
The services can be provided by the primary care physician.

AUTHORIZATION PROCESS

IF you have any questions or concern, please contact us at support@procaremso.com or 657-206-8700.