

**Complete Integrative Care**  
3156 State St., Medford, OR 97504  
1296 South Shasta Ave. Eagle Point, OR 97524  
(541) 773-9772  
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**Complete Care Health Centers**  
1296 South Shasta Ave. Eagle Point, OR 97524  
3132 State St., Medford, OR 97504  
(541) 830-4325  
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<b>Procedure Title:</b>	<b>Prior Authorization &amp; Scheduling Protocol for Procedures</b>
<b>Date:</b>	07/01/2025
<b>Version:</b>	1
<b>Department:</b>	Clinical Staff, Prior Authorization Team, Front Desk, Billing
<b>Approved By:</b>	<b>Brooke Gregory</b>

## Objective

To establish a clear and standardized workflow for verifying, obtaining, and documenting prior authorizations before scheduling any procedure that may require payer approval.

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## Scope

Applies to all clinical and administrative staff involved in the ordering, coordination, and scheduling of ALL procedures. The only exception would be for birth control procedures as these are federally mandated to be covered by all insurance carriers.

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## Procedure Steps

### Step 1: Procedure Care Plan Ordered by Provider

- Provider documents procedure care plan in the EMR and documents:
  - Diagnosis/ICD-10
  - Medical necessity
  - Relevant clinical notes
- Provider informs the MA that the procedure care plan (order) has been placed and may require authorization by sending a patient case.

### Step 2: Clinical Review by Medical Assistant (MA)

*Note: MA should NEVER schedule a procedure. Once the PA has been approved, denied, or marked as not required, the front office staff will be alerted. If the patient needs to be seen urgently, the Front Office staff will reach out to the lead MA coordinator or the provider's MA to arrange fitting the patient in.*

- MA gathers supporting documentation, including:
  - Chart notes for supporting documentation
    - Simply advising which date of service the procedure was ordered so the PA dept or billing can review and determine the appropriate CPT to request an authorization for.
    - MA sends the patient case to the prior authorization bucket for processing.



### Step 3: Authorization Review

- **PA Coordinator or Designated Staff** checks the patient's insurance using applicable payer portals to check whether a PA is required. If clarification is needed on which CPT and/or ICD-10 codes should be submitted with the auth request, PA should reach out to the billing department for further clarification.
  - If PA is **not required**, the scheduler is notified to proceed.
  - If PA is **required**, the following steps are taken:
    - Submit required clinical documentation
    - Log the submission date and expected turnaround time
    - Communicate status to the MA and front desk
    - Authorization number, start/end dates, and any payer-specific instructions are entered into the EMR.

*Note: Do not schedule the procedure until PA is confirmed or clearly marked as "not required."*

### Step 4: Scheduling the Procedure

- Once PA is approved or confirmed as not required:
  - **Front desk staff** contacts the patient to schedule the procedure.
    - **ALL PROCEDURE APPOINTMENTS MUST BE SCHEDULED AS A PROCEDURE. DO NOT SCHEDULE AS A FWUP OR AN OV.**
  - **MA** may assist if prep instructions or clinical input is required.

### Step 5: Communication & Follow-Up

- PA team monitors pending authorizations weekly.
- Denials are escalated to the billing team and/or provider for appeal if clinically appropriate.

### Step 6: Day-of-Service Checklist

- Confirm valid authorization is linked to the scheduled service and reflects correct CPT and diagnosis codes.
- Ensure any patient cost-share is communicated in advance.

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### Role Summary

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<b>Role</b>	<b>Responsibilities</b>
Provider	Orders procedure, documents medical necessity
MA	Gathers documentation, sends pt case for PA processing, supports PA team
PA Coordinator	Verifies PA requirements, submits & tracks authorization
Front Desk	Schedules only once PA cleared, confirms with patient
Billing (if applicable)	Supports with appeal process and CPT/ICD verification

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### **Compliance Notes**

- Procedures scheduled without valid authorization may result in claim denials, appointment reschedules, and patient dissatisfaction.