Policy & Procedure			
Subject:	Authorization for Out-of-Network Practitioners and Providers		
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POLICY

The use of Out-of-Network Practitioners or Providers requires Prior Authorization for Medical Necessity, unless services are for emergency services.

Prior Authorization for use of an Out-of-network Practitioner/Provider is not required for the following:

1. Emergency Services
2. 30-Hour Observations (notification is requested for Maternity Observation)
3. Family Planning Services
4. Dialysis from a dialysis center outside of the ACLA coverage area.
5. Post Stabilization Services
6. EPDST Screening Services
7. Women's Healthcare by in-network Providers (OB-GYN Services)
8. Continuation of covered services for a new member transitioning to the plan the first 30 (thirty) calendar days of continued services with no medical necessity review. An authorization may need to be entered to ensure proper payment.
9. Vision Services

The use of an Out-of-Network Practitioner or Provider is deemed to be Medically Necessary in the following situations:

1. Continuity of Care: Continuity of care for Members who are engaged in an ongoing course of treatment with an Out-of-Network Practitioner or Provider. (See ACLA Policy #UM.706L, *Continuity of Care*)
2. Services Unavailable from Participating Specialist/Provider: Medically Necessary out-of-network services if the requested services are not available within the ACLA network or if participating specialists/providers do not have the necessary expertise/training to provide the services. If coverage is approved, one evaluation visit and one follow-up visit are initially approved unless otherwise approved by the Medical Director or Physician Reviewer. Requests for services beyond the initial approval are reviewed for Medical Necessity.

3. Hospital-based Practitioners: Out-of-network hospital-based practitioners. Medically Necessary services from out-of-network hospital-based practitioners, including Hospitalists, provided in the inpatient setting are covered under the ACLA inpatient authorization. Residents and physicians-in-training are not credentialed by ACLA and therefore, no authorizations are issued to cover services from these providers. In these instances, authorizations are issued to the supervising physician in charge of (and billing for) the care.
4. All Out-of-Network Providers require prior authorization for covered services until such date as the Practitioner becomes credentialed and contracted with ACLA.

An ACLA associate may need to use and/or disclose a Member's Protected Health Information (PHI) for the purpose of Treatment, Payment or Health Care Operations (TPO). Federal HIPAA privacy regulations do not require Health Plans to obtain a Member's written consent or authorization prior to using, disclosing, or requesting PHI for purposes of TPO, therefore, ACLA is not required to seek a Member's authorization to release his/her PHI for any one of the aforementioned purposes (See ACFC Policy #168.227, *General Policy – Use and Disclosure of Protected Health Information Without Member Consent/Authorization*).

ACLA associates may not use, request or disclose to others any PHI that is more than the Minimum Necessary to accomplish the purpose of the use, request, or disclosure (with certain exceptions as outlined in ACFC Policy #168.217*, Minimum Necessary Rule*). ACLA associates are required to comply with specific policies and procedures established to limit uses of, requests for, or disclosures of PHI to the minimum amount necessary.

ACLA will maintain adequate administrative, technical and physical safeguards to protect the privacy of PHI from unauthorized Use or Disclosure, whether intentional or unintentional, and from theft and unauthorized alteration. Safeguards will also be utilized to effectively reduce the likelihood of Use or Disclosure of PHI that is unintended and incidental to a Use or Disclosure in accordance with KMHP/AMHP policies and procedures (See ACFC Policy #168.213, *General Guidelines to Safeguard Protected Health Information*).ACLA will reasonably safeguard PHI to limit incidental uses and disclosures. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a by-product of an otherwise permitted use or disclosure (See ACLA Policy #161.112, *Safeguards to Protect the Privacy of Protected Health Information*).

ACLA Associates must follow Facsimile guidelines in handling PHI that is transmitted or received in accordance with the company policy (See ACLA Policy #161.110, *Facsimile Machine and Transmission of Protected Health Information*).

PURPOSE

To define a consistent process for Prior Authorization of the use of Out-of-Network Practitioners or Providers.

DEFINITIONS

See Glossary of Terms, ACLA Policy #UM.001L
See HIPAA Definitions, ACFC Policy #168.235
Out-of-Network (Non-Participating) Practitioner or Provider: A Health Care Provider that has not been credentialed by and is not under contract with ACLA.

PROCEDURE

1. Requests for use of an Out-of-Network Practitioner or Provider are evaluated using the criteria outlined above in the "Policy" section of this document and the Prior Authorization Process outlined in ACLA Policy # UM.003L, *Standard and Urgent Prior (Pre-Service) Authorization*. Requests are processed and decisions are communicated in accordance with the timeframes outlined in ACLA Policy # UM.010L, *Timeliness of UM Decisions*. Providers and Members who do not agree with a decision to deny use of an Out-of-Network Practitioner or Provider may appeal the determination.

2. Once services are authorized agreement on reimbursement must be established.

    a. If the Out-of-Network Practitioner or Provider is a Medicaid Provider, they will be reimbursed for core benefits and services at the Medicaid fee-for-service rate in effect on the date of service or its equivalent, unless mutually agreed to by both ACLA and the provider. .
    b. If the Out-of-Network Practitioner or Provider is not a Medicaid Provider, they will be offered reimbursement for covered services at the Medicaid Fee Schedule rate for all emergency services and post stabilization services. ACLA shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. For services that do not meet the definition of emergency services, ACLA is not required to reimburse more than 90% of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) attempts (as defined in Glossary) to include the provider in their network (except as noted in Section 9.2).
    c. If the Out-of-Network Practitioner or Provider is not a Medicaid Provider, and they refuse reimbursement for covered services at the Medicaid Fee Schedule rate they will be referred to PNM.
    d. Upon reaching agreement for a specific rate for the requested services, a Single Case Agreement will be sent by PNM for the physician/provider to sign outlining the rate and their agreement not to bill the Member.

3. A system Provider ID number is required to enter an authorization for an Out-of-Network Practitioner or Provider and to complete the documentation in the current medical management application for the coverage determination. The process for obtaining a

provider number for use when entering an authorization for an Out-of-Network Practitioner or Provider is as follows:

a. If an active system Provider ID number does not exist in the medical management system. A non-contracted provider form for both providers/physicians that are out-of-network is sent to the provider to obtain necessary information for the creation of a temporary ID number..

The UM staff person uses the temporary ID number to complete the authorization documentation in the current medical management system until the non-participating number is received. After the permanent number is received this information is forwarded to the appropriate department so that the temporary number can be replaced in the current medical management application. The UM Department tracks the amount and type of authorizations made to out-of-network providers via an internal quarterly report. The report is shared with ACLA's Provider Network Management Department for further evaluation, analysis and possible action where there is a recognized network need in certain areas of the state and/or certain area practice.

REFERENCES (Cited Policies and Procedures and Source Documents)

ACLA Policy #UM.001L, Glossary of Terms
ACLA Policy #.003L, Standard and Urgent Prior (Pre-Service) Authorization Process
ACLA Policy # UM.010L, Timeliness of UM Decisions
ACLA Policy #UM.706L, Continuity of Care
ACFC Policy #161.110, Facsimile Machine and Transmission of Protected Health Information
ACFC Policy #168.213, General Guidelines to Safeguard Protected Health Information
ACFC Policy #168.217, Minimum Necessary Rule
ACFC Policy #161.112, Safeguards to Protect the Privacy of Protected Health Information
ACFC Policy #168.227, General Policy – Use and Disclosure of Protected Health Information Without Member Consent/Authorization
ACFC Policy #168.235, HIPAA Definitions

SOURCE DOCUMENTS AND REFERENCES

1. Standards and Guidelines for the Accreditation of MCO'S (NCQA, 2011) UM- 2
2. Goldberg, C. and Davis E. (2002), 'Assessing reliability among healthcare professionals: A matrix model,' in *Proceedings of the American Public Health Association*, November 9-13, 2002, Philadelphia, PA.

ATTACHMENTS

None

[-End of Policy-]