# AmeriHealth Caritas Family of Companies
# Medicaid Policy and Procedure

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| **Supersedes:** | State-specific ACFC Health Plan versions of this policy | **Policy Number:** | UM.904 |
| **Subject:** | **Prior Authorization of Non-Participating Providers** | | |
| **Department(s):** | Utilization Management | **Current Effective Date:** | 12/2023 |
| | | **Last Review Date:** | 12/2022 |
| | | **Original Effective Date:** | 12/27/2022 |
| | | **Next Review Date:** | 12/2024 |

**Applicable Lines of Business:**

☒**100**: Keystone First
☒ **500**: AmeriHealth Caritas Pennsylvania
☒ **2100**: AmeriHealth Caritas Louisiana
☒ **2400**: Select Health of South Carolina
☒ **2600**: Blue Cross Complete
☒ **5400/5410**: AmeriHealth Caritas District Of Columbia
☒ **6400:** AmeriHealth Caritas Florida
☒ **7100**: AmeriHealth Caritas Delaware
☒ **7200:** Community HealthChoices (KFCHC, ACPCHC)
☒ **900**: AmeriHealth Caritas New Hampshire
☒ **1200:** AmeriHealth Caritas North Carolina
☒ **7700:** AmeriHealth Caritas Ohio

**Scope**
This policy applies to the following AmeriHealth Caritas Family of Companies (ACFC) business operations.

Member is defined as enrollee, participant,recipient or beneficiary.

As necessary to comply with local state regulations, the contents of this policy may be copied into a stand-alone document for a specific business operation.

**Purpose**
To define the consistent process for members to directly access a provider without a PCP referral consistent with regulatory/contractual requirements.

**Policy**
The use of Out-of-Network Practitioners or Providers for covered services requires Prior Authorization for Medical Necessity except for the following services:

1. Emergency Services
2. 48-Hour Observations (notification is required for Maternity Observation)
3. Family Planning Services
4. Medicare services from a Medicare enrolled provider – when the Member has Medicare as his/her primary insurance coverage
5. Dialysis centers
6. Post Stabilization Services

7. Covered services provided by Indian Health Care Provider (IHCP) for members eligible for Tribal 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 active course of treatment with an Out-of-Network Practitioner or Provider. See Policy UM.700 *Continuity of Care*.

2. Medically Necessary services are determined to be unavailable from Participating Specialist/Provider: Coverage for Medically Necessary services when ACFC determines that the covered service is not available within the ACFC network or that 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 authorized unless otherwise approved by the Chief Medical Officer/Director, Behavioral Health Medical Director/Medical Director or designee. Requests for services beyond the initial approval are reviewed for Medical Necessity. If ACFC is unable to find an in-network provider for a medically necessary and covered service, ACFC will continue to cover the services out-of-network for as long as the services cannot be provided in-network and continues to be medically necessary.

3. Hospital-based Practitioners: Medically Necessary services from out-of-network hospital-based practitioners, including Hospitalists, provided in the inpatient setting are covered under the inpatient authorization. Residents and physicians-in-training are not credentialed by ACFC, and therefore no authorizations are issued to cover services from these providers. If needed for outpatient care not associated with a facility service, authorizations are issued to the supervising physician in charge of (and billing for) the care.

4. Out-of-Network Practitioners joining a Participating Group: Out-of-network Practitioners joining a participating group, require prior authorization for covered services until such date as the Practitioner becomes credentialed and contracted with ACFC.

All information with PHI is handled in accordance with Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data* and related policies listed in the Related Procedures section, unless otherwise required by Law or regulation.

The cost to the member is no greater than it would be if the service was provided in-network.

**Definitions**
N/A

**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 Policy UM.003 *Standard and Expedited Prior Authorization.* Requests are processed and decisions are communicated in accordance with the timeframes outlined in Policy UM.010, *Decision Response Time*. Providers and Members who do not agree with a decision to deny

coverage for services from an Out-of-Network Practitioner or Provider may appeal the determination.

2. Once services are authorized, the UM staff will engage the provider network management team who will establish the rate for reimbursement.
    a. If the Out-of-Network Practitioner or Provider is a Medicaid Provider, they will be reimbursed for covered services at the Medicaid Fee Schedule, unless a specific rate has been negotiated or unless otherwise required by law.
    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. If they agree an electronic communication requesting a Non-Par Negotiation Letter will be sent by Provider Network Management (PNM).
    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 they will be referred to PNM to negotiate a specific rate.
    d. Upon reaching agreement for a specific rate for the requested services, a Non-Par Negotiation Letter will be sent by PNM for the provider to sign, outlining the rate and their agreement not to bill the Member.
    e. For services where Prior Authorization occurs, the reimbursement method is documented in the medical management authorization system.

3. A system Provider ID number is required for claims reimbursement for an Out-of-Network Practitioner or Provider with approved services. The process for obtaining a provider number for use when entering an authorization for an Out-of-Network Practitioner or Provider without an existing Provider ID is as follows:
    a. Information to obtain a permanent non-participating provider number is requested from the Provider via telephone or facsimile (using the non-contracted provider form) for both physicians and facilities that are out-of-network.
    b. The Utilization Management (UM) staff member handling the request for the permanent non- participating provider number obtains the below information or faxes the non-contracted provider form requesting:
        i. Provider/facility name, address and phone number;
        ii. Specialty;
        iii. License number
        iv. Medicaid number
        v. UPIN Number
        vi. Tax ID/NPI
    c. Following receipt of above requested information, the information is entered in the appropriate database system to request a non-participating ID number for the Out- of-Network Practitioner or Provider.
    d. The Non- Participating ID number is generated by the Provider Maintenance team.

4. The non-participating provider ID number should be received in 2 business days. Once received the UM staff person uses the non-participating provider ID number to complete the authorization documentation in the medical management system. If there is a delay in receiving the permanent non-participating provider ID number, the UM staff will use a temporary ID number until the permanent non-participating number is received.

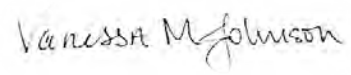
5. If a temporary ID number is used, once the permanent non-participating number is received, both the temporary/non- participating numbers are forwarded to the Medical Affairs Data Analyst so that the temporary number can be replaced with the permanent ID number in the care management system.

**Related Policies**
See also - Policy 168.200 *Authorization to Use or Disclose PHI*
See also - Policy 168.212 *Facsimile Machines and Transmission of Protected Health Information*
See also – Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data*
See also – Policy 168.227 *Use and Disclosure of Protected Health Information without Member Consent or Authorization*
See also - Policy 168.235 *HIPAA Privacy Definitions*
See also - Policy 591.001 *Records Retention Policy & Schedule*
See also - Policy UM.001 *Glossary of Terms*
See also - Policy UM.903 *Glossary of Abbreviations*
See also - Policy UM.003 *Standard and Expedited Prior Authorization*
See also - Policy UM.010 *Decision Response Time*
See also - Policy UM.700 *Member Transition of Care (Continuity of Care)*

**Source Documents & References**
- MCO Standards for Accreditation - National Committee for Quality Assurance (NCQA), Utilization Management Standards
- Quality Health Care Accountability and Protection Act
- Tribal Member Services and Indian Health Care Providers (42 C.F.R. § 438.14)
- Indian Health Care Improvement Act (25 U.S.C. 1603)
- 42 CFR 438.50(d)(2)

**Attachments**
None

**Approved by**



**Vanessa Johnson**
**Vice President, Utilization Management Operations**
**Date: January 26, 2023**

Lenaye L. Lawyer, MD

**Lenaye Lawyer**
**Vice President, Medical Affairs**
**Date: January 26, 2024**

| Revision Date | Revision |
|---|---|
| 12/2023 | Annual Review. No changes to the policies scope or intent |
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**AmeriHealth Caritas Family of Companies**

**Medicaid Policy Addendum**

**Territory:** Louisiana

**Addendum Number:** UM.904.LA

**Subject:** Prior Authorization of Non-Participating Provider

**Department(s):** Utilization Management

**Current Effective Date:** 2/27/2024

**Last Review Date:** 02/06/2024

**Original Effective Date:** 2/27/2024

**Next Review Date:** 02/2025

| Service/Program | ACLA | Reference/Source |
|---|---|---|
| *Out-of-Network Prior Authorization Exceptions:* | Prior authorization for use of Out-of-Network Practitioner/Provider is not required for the following:<br>• Emergency Services<br>• 48-Hour Observation (notification is requested for Maternity Observation)<br>• Family Planning Services<br>• Dialysis<br>• Post-Stabilization Services<br>• EPSDT Screening Services<br>• An authorization (without a medical necessity review) may need to be entered to ensure proper payment for continuation of covered services for new Enrollees transitioning to the plan within the first thirty (30) calendar days of continued services.<br>• Covered services provided by an Indian Health Care Provider (IHCP) | LDH MCO Contract (Attachment A: Model Contract) Section 2.9.2.3, 2.12.4; 2.12.8.2; 2.12.8.7;2.9.4; 2.9.17.3; 2.9.26; 2.11.4.1 |
| *Credentialing of Out-of-Network Providers* | ACLA shall consider the new provider to be an in-network or participating provider for the purposes of utilization management or prior authorization processes required by the health insurance issuer for that provider group. This shall apply in either of the following circumstances:<br>• When ACLA has received the required credentialing application that is correctly and fully completed including proof of membership on a hospital medical staff from the new provider, and ACLA has not notified the provider group that credentialing of | 2021 Regular Session House Bill NO. 595 ACT NO. 79 |

| Service/Program | ACLA | Reference/Source |
|---|---|---|
| | the new provider has been denied.<br>• If the new provider is an advanced practice registered nurse or a physician assistant licensed in Louisiana, proof of membership on a hospital medical staff shall not be required, if the provider provides a written attestation identifying the collaborating or supervising physician, if a physician relationship is required by law. | |

Reference/Resource:
LDH MCO Contract (Attachment A: Model Contract) Section 2.9.2.3, 2.12.4; 2.12.8.2; 2.12.8.7;2.9.4; 2.9.17.3; 2.9.26; 2.11.4.1

State of Louisiana Insurance Billing by Contracted Health Care Providers, Bill NO. 595, ACT NO. 79. Regular Session House (2021).

**Approved by:**

Rodney Wise, MD.
Rodney Wise, MD
Market Chief Medical Officer
Date

Loretta Sonnier, MD
Lorraine Sonnier
Behavioral Health Medical Director
Date

| Revision Date | Revision |
|---|---|
| 2/6/2024 | Annual review and update: Transitioned policy from 153.904 plan policy to corporate base policy UM.904 Prior Authorization of Non-Participating Providers with state specific addendum to meet plan requirements.<br>Added: 2021 Regular Session House Bill NO. 595 ACT NO. 79- Credentialing of Out-of-Network Providers |