<table>
<tr><td colspan="3">HEALTH PLAN POLICY</td></tr>
<tr><td colspan="2">Policy Title: Out of Network (OON) Prior Authorization Process</td><td>Policy Number: MUM01
Revision: G</td></tr>
<tr><td>Department: Medical Management</td><td colspan="2">Sub-Department: Utilization Management</td></tr>
<tr><td colspan="3">Applies to Product Lines: ☐Medicaid ☒USFHP
☐Children’s Health Insurance Plan ☒Commercial Insured
☒Health Insurance Exchange ☒Non Insured Business
☒Medicare</td></tr>
<tr><td colspan="3">Origination/Effective Date: 10/06/2014</td></tr>
<tr><td>Reviewed Date(s):</td><td colspan="2">Revision Date(s): 03/04/2016, 06/01/2017, 09/20/2018, 01/16/2020, 12/21/2020, 12/09/2021, 11/28/2022</td></tr>
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SCOPE:

The purpose of this policy is describe the process to assist in obtaining medically appropriate services from out-of-network providers when services are not available in network or the member is travelling outside of the service area or the travel time to access network providers or exceeds required limits from a member’s place of residence. To ensure that members receive requested services in a timely and cost effective manner.

DEFINITIONS AND ACRONYMS:

- **Milliman Care Guidelines (MCG)** – is an evidence based first level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. MCG can be applied in a wide range of clinical settings.
- **Utilization Management (UM) -** Is the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to the clinician or patient in cooperation with other parties, to ensure appropriate use of resources.

POLICY:

Request for Non-Participating Provider

Clinical information is collected by the Utilization Management (UM) nurse. Referral requests include the following:

- Reason for request;
- Date(s) the member was seen for the condition;
- Service being requested to be provided by the non-participating provider;
- Description of the member’s clinical symptoms and findings;
- Justification for out-of-network provider request; and
- Other pertinent clinical information, if applicable.

The non-participating provider completes the referral/authorization request form and submits by facsimile or telephonically to the UM department for authorization. Upon receipt of the request for prior/authorization, information is entered into the computer system. All authorizations are completed in accordance with prior authorization guidelines.

The UM nurse must obtain non-participating provider information if it is determined that the provider is not identified in the UM/CM computer data base system. The following information is obtained from the non-participating provider:

- Provider name
- Billing address
- Tax identification Number
- National provider identifier (NPI)
- Specialty
- Office telephone number
- Office facsimile number

Initially, the UM Nurse reviews the request for:

A. **Determination of Benefit Coverage** -

If it is determined that the requested service is not a covered benefit, follow-up is completed by the processing and issuance of the denial notification letter to the requesting provider and member.

B. **Medical Necessity** - If it is determined that the request does not meet MCG clinical criteria the request is referred for medical review to the CMO or his designee. If denied, the denial notification letter is sent to the member and requesting provider

If contracted specialty type is not available in requested service area, the UM nurse will communicate the information to the provider relations representative to negotiate the appropriate rate. The provider relations staff member will load the provider's demographics and route the referral back to UM nurse for completion of the request

After the negotiation is complete, the provider relations staff member will notify the UM nurse to complete the authorization. The UM nurse will fax the authorization to the requesting provider and/or facility (if appropriate). The information sent includes the precertification/authorization number, service authorized, length of stay (if appropriate), number of office visits (if appropriate), and expiration date.

REFERENCES:

- Tricare Policy Manual
- Medical Review Process
- MCG Criteria

- Referral Management Process

RELATED DOCUMENTS:

None

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	10/06/2014	Initial Release	Board of Directors
A	03/04/2016	Yearly review. Updated to current template. Updated Definitions and Acronyms. Updated section A. Determination of Benefit Coverage. Removed the attached referral/authorization form and added Related Documents.	Board of Directors
B	06/01/2017	Annual Review. Update reference from Interqual Criteria to Milliman Criteria. Changed signatory from Anita Leal, Executive Director to Nancy Horstmann, CEO	Board of Directors
C	09/20/2018	Annual review - updated product lines.	Executive Leadership
D	01/16/2020	Annual review. Updated Definitions and Acronyms, References, and Related Documents.	Executive Leadership
E	12/21/2020	Annual review. No change to policy content.	Executive Leadership
F	12/09/2021	Annual review. Made grammatical changes and made reference to MCG.	Executive Leadership
G	11/28/2022	Annual review. Updated MCG with name spelled out. No change to policy content.	Executive Leadership