HEALTH PLAN POLICY	
Policy Title: Out of Network (OON) Prior Authorization Process	**Number:** MUM01 **Revision:** H
Department: Medical Management	**Sub-Department:** Utilization Management
Applicable Lines of Business: ☐ Children's Health Insurance Plan ☐ Medicare ☐ Commercial Insured ☐ Non Insured Business ☒ Health Insurance Exchange ☒ USFHP ☐ Medicaid	
Effective Date: 10/06/2014	
Revision Date(s): 03/04/2016, 06/01/2017, 09/20/2018, 01/16/2020, 12/21/2020, 12/09/2021, 11/28/2022, 01/22/2024	

PURPOSE:

The purpose of this policy is describe the process to assist members in obtaining medically necessary services in a timely manner from out-of-network providers when services: (1) Are not available in network. (2) The member is traveling outside of the service area. (3) The travel time to access network providers exceeds required limits from a member's place of residence.

DEFINITIONS AND ACRONYMS:

- **National Provider Identifier (NPI)** – A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

- **Tax Identification Number (TIN)** – The number assigned by the Internal Revenue Service (IRS) for tax purposes

- **Utilization Management (UM)** – A CHRISTUS Health Plan function tasked with managing the utilization of health care resources to ensure that members receive high-quality, medically necessary care from the right provider, at the right time, in the most appropriate setting, and in the most cost-effective manner.

POLICY:

Out-of-Network requests received by the Utilization Management (UM) department are processed by an Intake Coordinator. Once processed, the requests are assigned to the Prior Authorization queue. If In-Network alternatives are available, a Prior Authorization Nurse will reach out to the requesting provider with those options. It is at the requesting provider's discretion whether or not to select an alternative In-Network option.

If a non-participating or out-of-network provider is designated for the service, a request will be sent to collect clinical information by the Utilization Management (UM) nurse. Referral requests must 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

- Other pertinent clinical information, if applicable

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The non-participating provider completes the authorization request form and submits by facsimile or telephone to the UM department for authorization. Upon receipt of the request for authorization, information is entered into the UM platform.

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

- Provider name
- Billing address
- Tax Identification Number (TIN)
- 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 the UM nurse determines that the request does not meet medical necessitycriteria the request is referred for medical review to the Chief Medical Director or their designee.. If denied, a denial notification letter is sent to the member and requesting provider.

The request is reviewed for medical necessity as well as network adequacy.

REFERENCES:

- TRICARE Policy Manual

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
H	01/22/2024	Annual review. Updated purpose statement, definitions, and addressed NCQA standards.	Executive Leadership