POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Out of Network and Referral Services
PAGE: 1 of 3	**REPLACES DOCUMENT:**
APPROVAL DATE: 1/1/09	**RETIRED:**
EFFECTIVE DATE: 1/1/09	**REVIEWED/REVISED:** 1/09; 12/09; 12/10; 12/11;12/12; 01/14; 11/14; 6/15; 7/16; 7/17; 7/18
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** SC.UM.42

SCOPE:
Absolute Total Care Medical Management Department

PURPOSE:
To outline a process for the evaluation of requests for Out of Network and Referral Services.

WORK PROCESS:
Out of Network requests are considered for authorization if there is network inadequacy. If Absolute Total Care is unable to provide medically necessary services to a member, Absolute Total Care must cover these services by using providers out of network, in an adequate and timely manner, for the episode of care. Additionally, Out of Network requests are considered for transition or continuity of care concerns, geographical proximity issues, when the Member requires services out of the service area, and/or a participating Provider is only affiliated with non-participating facilities. Once authorized, the Provider is given an authorization number within 1 business day. Absolute Total Care has a twenty-four (24) hours per day, 7 days a week telephone service to receive, respond to and obtain access to the Medical Director for urgent/emergent services.

PROCEDURE:
The utilization of non-participating Providers is considered in specific situations. Medical Management and Referral Specialists should review requests for non-participating Providers based on the Member's specific situation.

Network Inadequacy

1. Medical Management reviews any out of network referral request. Medical Management may authorize medically necessary services not available through network Providers upon request from participating Primary Care Physicians.
2. Prior Authorization Nurses (PA Nurses) and Referral Specialist determines if the services are currently available within the network. PA Nurses and Referral Specialist review all data including eligibility, coverage and supporting documentation, if available. Consideration is given for requests that offer geographic proximity to the Member.

3. If services are not available within the network, PA Nurses will research the most efficient and appropriate way to arrange for the services.

Continuity of Care

1. Pregnant Members are allowed to remain under the care of their current OB/GYN, through the Member's post-partum checkup, even if the OB/GYN is Out of Network. If the Member wants to change their OB/GYN to one who is in Network, she is allowed to do so if the Provider to whom she wished to transfer agrees to accept her. Absolute Total Care shall allow pregnant Members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating Provider until completion of postpartum care.
2. Members who have established long-term relationships between the Member and Provider, e.g., Hemodialysis or Chemotherapy, may have these services authorized up to 90 days pending transition or continuity of care.
3. Newly enrolled Members are provided with continuity of care for up to 90 days when their medical or behavioral health condition could be jeopardized if the care is disrupted or interrupted.
4. If a Member is receiving active treatment at the time that a Specialist terminates from the network, the Member's Primary Care Provider (PCP) may request authorization for continuing services as needed for continuity of care.
5. If a Member is seen by a non-participating Provider as the result of an Emergency Department visit, the Specialist may request more visits and Absolute Total Care will approve visits to complete the active episode of care or for up to six (6) months, which ever comes first.
6. If a Member is being referred to a FFS Medicaid covered service, no authorization for these services will be required.

Out of Service Area Requests

1. Absolute Total Care authorizes requests for Out of Service Providers who provide covered services for Members who move out of the service area until the end of their enrollment period.
2. Medical Management reviews, and authorizes as medically appropriate, requests for out of area services for the treatment of

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unexpected illnesses or injury while the Member is out of the service area.

3. A PA Nurse and or Care Manager assists in the transition to network Providers as medically appropriate.

Medical Director Review

1. The Medical Director will review any potential cases where there are concerns if not authorized.
2. The Medical Director will review any case where there is prior Member dissatisfaction with participating Providers.

If the use of a non-participating Provider is deemed appropriate, the single case agreement work process will be followed if the Provider will not accept Absolute Total Care's standard reimbursement rate so that the cost to the member is no greater than it would be if the covered services were furnished within the network.

REFERENCES:
SCDHHS Standard MCO Contract and Policy and Procedure Guide for MCO

ATTACHMENTS:

DEFINITIONS:

REVISION LOG

REVISION	**DATE**
Continuation of care changed from 6 months to 90 days	12/09
Removal of SCHIP from the Header Product Type; Added the following verbiage regarding single case agreements: if the provider will not accept the Absolute Total Care's standard reimbursement rate; Removed SCHIP P&P and 2009 DHHS Contract Amendments from the reference section.	12/10
Minor grammatical corrections; added Sr. Director of Medical Management signature	12/14/11
Annual Update no changes	12/14/12

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Under Work Process changed enrollee to member, changed "and services that are not in Absolute Total Care's", to "out of", changed "as long as Absolute Total Care is unable to provide the medically necessary services within network" to "the episode of care." Under Procedure, changed "should be" to "is" and added "'s" to member's in same paragraph, under Continuity of Care #1 changed enrollees to Members. Changed Work Process to Policy and Procedure Approval, deleted "Sr." under Approval, deleted VP of Medical Management and Quality and Date.	01/23/14
Under Work Process added "1 business day" to provider is given and authorization number.	11/4/14
Added the following to the last paragraph on page 2 "so that the cost to the member is no greater than it would be if the covered services were furnished within the network.	6/30/15
Annual Review: changed Case Manager to Prior Authorization Nurse (PA Nurse) and to Care Manager as appropriate, minor grammatical errors	07/28/16
Annual Update-no changes	07/31/17
Annual Update-minor grammatical errors	7/31/18

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

VP of Medical Management _____ Date: _____