

	Out of Network Services Guideline	
Guideline # 6193	Categories Clinical → Care Coordination, Care Coordination – Utilization management , TCHP Guidelines	<i>This Guideline Applies To:</i> Texas Children's Health Plan
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GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all non-emergent out of network services.

DEFINITIONS:**Out of Network Services:**

- Services performed by an institutional (facility) or individual provider who is outside of the TCHP network of contracted providers.
- Services performed by an out of network provider who is located outside the TCHP service area.

Emergency condition:

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the person afflicted in serious jeopardy or, in the case of a pregnant woman, the health of the woman or her unborn child or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy,
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Urgently needed services:

Services that are not emergency services but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition.

Family planning services:

- Encounters for prescription, insertion, surveillance, removal or reinsertion of an Intrauterine Device (IUD) or implantable subdermal contraceptive
- Encounters for prescription or surveillance of an injectable, oral contraceptive, or contraceptive product such as cervical cap, diaphragm, sponge, condoms, or spermicide

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- Encounters for counseling and instruction on natural family planning to avoid pregnancy
- Encounters for counseling on sterilization (male & female)
- Sterilization procedures (male & female)

Reasonable distance:

The travel distance OR travel time from the member's listed address to the point of service being no greater than what is required in the Uniform Managed Care Contract for access to care. The member's county is designated as metro, micro, or rural as described in the Universal Managed Care Contract, Appendix B-5.

Provider Type	Distance in Miles			Travel Time in Minutes		
	Metro	Micro	Rural	Metro	Micro	Rural
Behavioral Health – outpatient	30	30	75	45	45	90
Hospital	30	30	30	45	45	45
PCP	10	20	30	15	30	40
Prenatal Care	10	20	30	15	30	40
Therapies (OT/PT/ST) in facility	30	60	60	45	80	75
Cardiology/General Surgery/Ophthalmology/Orthopedics	20	35	60	30	50	75
ENT/Audiology	30	60	75	45	80	90
OB/GYN	30	60	75	45	80	90
Psychiatrist	30	45	60	45	60	75
Urologist	30	45	60	45	60	75
Other physician Specialties	30	60	75	45	80	90
Home Health including PDN/Attendant Care and LTSS	At least two providers in the county					
At home therapies (OT/PT/ST)	At least two providers in the county					
Laboratory Services	Reference lab must be able to accept specimens per contractual obligation– no distance requirement					

PRIOR AUTHORIZATION GUIDELINE

1. The following services do **NOT** require prior authorization, even when provided out of network:
 - Urgent Care services
 - Emergency Department services and stabilization care
 - Well Child Exams
 - Family planning services for STAR/STAR Kids
 - Services provided by an Indian Health Care Provider (IHCP)
 - Provided in Texas or out of state
 - Enrolled as a Federally Qualified Health Center (FQHC) or not

2. All requests for prior authorization for non-emergent out of network services are received via fax, mail, and electronically by the Utilization Management Department and processed during normal business hours.
3. The Utilization Management professional receiving the request evaluates the submitted information to determine if the documentation supports the out of network service request as an eligible service.
4. To request prior authorization for out of network services, documentation supporting the medical necessity of the service requested must be provided.
 - If a service requires prior authorization for in-network providers, the requesting out of network provider must supply all required documentation for that particular service based on the TCHP Guideline that applies.
5. For all authorizations where the rendering provider is out of network, the requesting provider must be in network and a referral must be included with the authorization showing the in-network provider referred the member to the out of network provider.

TCHP Medical Directors, Physician Reviewers or External Physician Reviewers may allow for exceptions in extenuating circumstances and at their discretion.

6. TCHP provides benefit coverage for non-emergent *out of service area requests* with prior authorization for the following:
 - Urgently needed services for members with conditions that develop while out of area and it was not reasonable given the circumstances to obtain the services through the provider network
 - Post-stabilization care furnished by a practitioner required to assure stability of a patient prior to transferring the care back to a participating provider
 - Care for members who move out of service area through the end of the period for which member is active with TCHP
 - Out-of-state medical care that cannot be provided in Texas
 - Clinical risk or hardship verified by TCHP Medical Director
7. TCHP provides benefit coverage for non-emergent *out of network requests* with prior authorization for any of the following:
 - Post-stabilization care furnished by a practitioner required to assure stability of a patient prior to transferring the care back to a participating provider;

- Second opinions and subsequent medically necessary treatment for medical or surgical care or behavioral health services by out of network provider or facility verified by Medical Director of TCHP as having clinical expertise only when the expertise is not available in the plan network;
 - Covered services unable to be performed by network practitioners/facilities;
 - Covered services not available within a reasonable distance, or a reasonable time appropriate to the circumstances relating to the delivery of services and condition of the member, but in no event exceed five (5) business days after receipt of reasonably requested documentation;
 - Member, whose address is in a FEMA or State of Texas Governor declared disaster area, is unable to access services from in-network providers;
 - Clinical risk or hardship verified by TCHP Medical Director
8. Out of network services may be authorized for up to 90 days at a time.
- Re-assessment of the need for out of network services must be reviewed every 90 days.
 - Extensions may be granted based on clinical risk or hardship verified by the Medical Director.
9. TCHP ensures that members receiving services through a prior authorization from either another Managed Care Organization (MCO) or Fee for Service (FFS) provider receive continued authorization of these services for the same amount, duration, and scope for the shorter period of one of the following:
- 90 calendar days after the transition from the previous MCO; **Or**
 - Until the end of the current authorization period; **Or**
 - Until TCHP has evaluated and assessed the member and issued or denied a new authorization.
10. TCHP ensures that members who were receiving a service that did not require prior authorization by a Fee for Service (FFS) provider or the previous MCO, but does require one by TCHP, continue to receive the service for the shorter period of one of the following:
- 90 calendar days after the transition from the previous MCO; **Or**
 - Until TCHP has evaluated and assessed the member and issued or denied a new authorization.

11. TCHP ensures that members receiving services from a provider who becomes out of network during the authorization period continue to receive authorization of these services for the same amount, duration, and scope for the shorter period of one of the following:
- 90 calendar days after the provider became out of network; **Or**
 - Until the end of the current authorization period; **Or**
 - Until the MCO has evaluated and assessed the member and issued or denied a new authorization.
12. TCHP ensures that newly enrolled members who are receiving services for the diagnosis of a terminal illness from providers who are out of network with TCHP continue to be able to receive care from these providers for 9 months after the transition to a new MCO. Extensions will be granted based on clinical risk or hardship verified by the Medical Director.
13. Pregnant members who are in or past the 24th week of pregnancy (in their third trimester) will be allowed to remain under the care of the member's established OB/GYN through the member's delivery, immediate postpartum care and postpartum checkup within the first six weeks of delivery even if the provider is out of network or becomes out of network or is out of service area.
- Requesting provider should supply clinical documentation of established care prior to 24 weeks gestation.
 - Members can change OB/GYN providers, if the provider agrees to accept the member in the last trimester even if the OB/GYN is not a contracted provider in the TCHP network.
14. TCHP ensures that newly enrolled members with coverage under a non-Medicaid health insurance organization and who are receiving Level 1 Service Coordination in STAR Kids, remain under the care of a Medicaid enrolled specialty provider from whom the member is receiving care through the non-Medicaid health insurance organization at the time of initial MCO selection or on the date of enrollment into TCHP, even if that specialty provider is out of network with TCHP.
- 14.1 The list of specialty provider types to be considered for this purpose are the individual providers located in UCM Chapter 3.1, Attachment B. TCHP will comply with OON provider reimbursement rules as adopted by HHSC at 1 Tex. Admin. Code. § 353.4 until one of the following events occurs:
- An alternate reimbursement agreement is reached with the member's specialty provider; **Or**
 - The member is no longer enrolled in a non-Medicaid health insurance organization; **Or**
 - The member or the member's LAR agree to select an alternate specialty provider; **Or**
 - The member is no longer a TCHP member.

15. Out of network services for routine care or services that could reasonably be foreseen is not covered.
16. Requests that do not meet the criteria established by this procedure will be referred to a TCHP Medical Director for review and the Denial Policy will be followed.
17. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

REFERENCES:**Government Agency, Medical Society, and Other Publications:**

Texas Medicaid Provider Procedures Manual, Vol. 1&2, Accessed March 3, 2025.
<https://www.tmhp.com/resources/provider-manuals/tmppm>

Uniform Managed Care Manual, Chapter 3.1, Attachment B

Uniform Managed Care Contract, Chapter 8.1.3.4 Indian Health Care Providers

1Texas Administrative Code. § 353.4

Texas Medicaid State Plan Section 2.7

42 CFR § 438.14(b)(5)

42 CFR § 438.14(b)(4)

42 C.F.R § 431.52

42 C.F.R § 435.403

Status	Date	Action
Approved	3/13/2025	Clinical & Administrative Advisory Committee Reviewed and Approved for Implementation

Original Document Creation Date: 10/21/2016

This Version Creation Date: 03/19/2024

Effective/Publication Date: 03/21/2024