Texas Children's	Out of Network Services Guideline	
Guideline # 6193	***Categories*** Clinical →Care Management CM, TCHP Guidelines, Utilization Management UM	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Andrea Canady

GUIDELINE STATEMENT:

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

DEFINITIONS:

- Out-of-Network Services can include any of the following:
  - An out of network request is a request to use a facility or provider, outside of TCHP network of contracted providers. The provider would still be located within the service area of TCHP, but does not have a contract with TCHP.
  - An out-of-service area request is a request to use a provider/facility that is located outside the TCHP service area.

- An emergency condition is 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 are 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 are defined as:
  - Encounters for prescription, insertion, surveillance, removal or reinsertion of an Intrauterine Device (IUD)
  - Encounters for prescription, insertion, surveillance, removal or reinsertion of an implantable subdermal contraceptive
  - Encounters for prescription or surveillance of an Injectable Contraceptive
  - Encounters for prescription or surveillance of Oral Contraceptives

- Encounters for prescription or surveillance of the contraceptive patch or ring
- Encounters for prescription or surveillance of Cervical Cap, Diaphragm, Sponge, Condoms and Spermicide
- Encounters for Counseling and instruction on natural family planning to avoid pregnancy
- Encounters for Counseling on Sterilization (male & female)
- Sterilization Procedures (male & female)

- The term reasonable distance refers to the travel distance 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:

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:

1.1. Emergency Department visits and stabilization

1.2. Well Child Exams

1.3. Family planning services for STAR/STAR Kids

1.4. Services provided in an Indian Health Care Provider (IHCP) enrolled as a Federally Qualified Health Center (FQHC)

2. All requests for prior authorization for non-emergent out-of-network services are received via fax, phone or mail 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.

4.1. 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 the in network provider's signature must be present on the prior authorization form (Section IV: "Requesting Provider") and/or a referral must be included with the authorization showing the in-network provider referred the member to the out of network provider.

5.1. The in-network requesting provider's signature may not be a rubber stamp and it must be dated next to the signature.

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

5.1.2 The request will be faxed back as "incomplete" if the in network requesting provider's signature is missing and/or not dated as described. Rubber stamped signatures will be treated as a missing signature.

6. The Health Plan provides benefit coverage for non-emergent *out-of-service area requests* with prior authorization for the following:

6.1. 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;

6.2. Post-stabilization care furnished by a practitioner required to assure stability of a patient prior to transferring the care back to a participating provider;

6.3. Care for members who move out of service area through the end of the period for which member is active with TCHP;

6.4. Out-of-state medical care that cannot be provided in Texas; or

6.5. Clinical risk or hardship verified by TCHP Medical Director.

7. The Health Plan provides benefit coverage for non-emergent *out of network requests* with prior authorization for any of the following:

7.1. post-stabilization care furnished by a practitioner required to assure stability of a patient prior to transferring the care back to a participating provider;

7.2. 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;

7.3. covered services unable to be performed by network practitioners/facilities;

7.4. 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;

7.5. member, whose address is in a FEMA or State of Texas Governor declared disaster area, unable to access services from in-network providers; or

7.6. clinical risk or hardship verified by TCHP Medical Director.

8. 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:

8.1. 90 calendar days after the transition to a new MCO;

8.2. until the end of the current authorization period; or

8.3. until TCHP has evaluated and assessed the member and issued or denied a new authorization.

9. TCHP ensures that members who were receiving a service that did not require prior authorization by FFS or the previous MCO, but does require one by TCHP continue to receive the service for the shorter period of one of the following:

9.1. 90 calendar days after the transition to a new MCO; or

9.2. until TCHP has evaluated and assessed the member and issued or denied a new authorization.

10. 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 shortest period of one of the following:

10.1. 90 calendar days after the transition to a new MCO;

10.2. until the end of the current authorization period; or

10.3. until the MCO has evaluated and assessed the member and issued or denied a new authorization.

11. 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.

12. 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.

12.1. Requesting provider should supply clinical documentation of established care prior to 24 weeks gestation.

12.2. If the member wants to change her OB/GYN to one who is in the TCHP network, she must be allowed to do so if the provider to whom she wishes to transfer agrees to accept her in the last trimester.

12.3. If the out-of-network provider refuses to transfer the patients care to in-network provider, information is gathered to justify the use of an out-of-network or out-of-service area provider/facility and reviewed by the TCHP Medical Director.

13. Coverage is not provided for out of network services in the following situations/conditions:

13.1. routine care or service needs that could reasonably be foreseen (e.g., physical examinations, screening tests, regularly scheduled laboratory tests such as routine monitoring of anticoagulation therapy).

14. 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.

15. 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:

Last approval by the Clinical & Administrative Advisory Committee (CAAC):

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