Policy Name:	Non-Par/Specialty Network Providers	Page:	1 of 6
Department:	Medical Management	Policy Number:	UM 01
Subsection:	Utilization Review	Original Effective Date:	04/02/2014
Applies to:	Medicaid Health Plans	Revision Effective Date:	

PURPOSE:

The purpose of this policy is to define Maryland Care, Inc., dba Maryland Physicians Care's (MPC's) business requirements regarding referrals to non-par and specialty care network providers.

OBJECTIVE:

The objectives of MPC's review process for the use of non-par/specialty care network providers are to:

- Verify that the member is eligible to receive services at the time of the request
- Verify that the service is a covered benefit
- Evaluate and determine the medical necessity of the service
- Evaluate and determine if the service can be provided in network
- Evaluate and determine the medical necessity for the use of the non-par/specialty network provider
- Direct the member to the appropriate place of service
- Place appropriate limits on a service, on the basis of medical necessity, for the non-par/specialty network provider
- Confirm that the facility complied with MPC's notification requirements
- Identify other payers for coordination of benefits, third party liability, and Medicare liability

The Utilization Management (UM), Medical Management (MM), and/or Provider Management (PM) departments determine if the services are currently available within the primary network in a timely manner based upon the clinical urgency of the requested service. The UM/MM department reviews all data including eligibility, coverage and supporting documentation, if available. If services are not available within the primary network in a timely manner, the UM, MM, and PM departments will research the most efficient and appropriate way to arrange for the services.

A case manager is available to assist in the transition to network providers, as medically appropriate.

Non-Par Providers

1. Inpatient cases involving emergent/urgent admission to non-par facilities will be reviewed for medical necessity based on MPC's provider network ability to provide the same services.
2. All requests for admission to non-par facilities require prior authorization. If an authorization is not obtained, there is the potential for denial.
3. Inpatient requests for elective procedures will be redirected to an in-network facility unless

the in-network facilities do not have the specialty, capability, or capacity to treat the case presented.

4. Any member who presents to a non-par provider through the emergency room must be transferred to a par provider as soon as stabilized. If the member is not transferred to a par facility, there is the potential for denial.
5. Any member who is transferred from a provider to a non-par provider must have prior approval by MPC's medical director for the service. If this is not met, then the admission has the potential for denial.
6. Any member who is transferred from a provider to a non-par provider with prior authorization, the member must be transferred back to a par provider as soon as the member is stabilized or there is a potential for denial.
7. Requests for services at a non-par provider will be redirected to a par provider unless there is no clinical expertise available within the network for the presenting case.
8. If the request is a post-service review for services provided by a non-par provider, MPC will deny unless the clinical supports emergent or urgent care.
9. If MPC approves an alternative to the service being requested and the treating practitioner or member does not agree to the alternative service, MPC will issue a denial for the care that was originally requested. However, if the treating practitioner agrees with the alternative and the care is authorized, the practitioner has essentially withdrawn the initial request which is not considered a denial.

Specialty Network Providers

1. Use of specialty network providers will be reviewed for:
    a. Medical necessity
    b. Availability of timely access (within 6 weeks) at a network provider
    c. Consideration for continued care at the specialty network provider is dependent on diagnosis and condition of the member
    d. Availability of a medically necessary service not currently available in the network
2. Requests for services at a non-par/specialty network provider will be redirected to a par/network provider unless there is no clinical expertise available within the network for the presenting case.
3. If the request is a post-service review for services provided by a non-par/specialty network provider, MPC will deny unless the clinical supports emergent or urgent care.
4. If MPC approves an alternative to the service being requested and the treating practitioner or member does not agree to the alternative service, MPC will issue a denial for the care that

was originally requested. However, if the treating practitioner agrees with the alternative and the care is authorized, the practitioner has essentially withdrawn the initial request which is not considered a denial.

OPERATING PROTOCOL:

Systems

The business application system has the capacity to electronically store and report all service authorization requests, decisions made by MPC regarding the service requests, clinical data to support the decision, and time frames for notification of practitioners/providers and members of decisions.

Measurements

- The number of non-par transfers
- The number of referrals to specialty network providers

Reporting

- The number of non-par transfers and the facilities
- The number of referrals to specialty network providers and the reasons

INTER-/INTRADEPENDENCIES:

Internal

- Chief Medical Officer
- Medical management
- Provider Management
- Quality Management
- Quality Management/Utilization Management (QMUM) Committee

External

- *Members*
- *Practitioners/providers*
- *Regulatory bodies*

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LEGAL/CONTRACT REFERENCES:

- Applicable federal and state laws, regulations, and directives, including the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPPA])
- MPC's contract agreements with primary and specialty network practitioners and providers
- Current NCQA Health Plan Standards and Guidelines

ATTACHMENTS:

None

DEFINITIONS:

Denial, Reduction, or Termination Financial Responsibility: A denial, reduction, or termination of financial responsibility is the non-authorization of care or service at the level requested based on either medical appropriateness or benefit coverage. Partial approvals (modifications) and decisions to discontinue authorization when the practitioner or member does not agree are also denials.

Medically Necessary: A service, supply, or medicine that is appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition. They are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or a plan provider, and they are the most appropriate level or supply of service which can safely be provided.

Non-Participating (non-PAR) Provider: A hospital, physician (primary care, primary care obstetrician, and/or specialist), and any other health care provider (including allied health professionals), or entity (including skilled nursing facility, home health provider, health care provider group, and community clinic), that does not have a direct or indirect obligation under a contract with MPC with respect to a plan contract or line of business.

Participating (PAR) Health Provider: A hospital, physician (primary care, primary care obstetrician, and/or specialist), and any other health care provider (including allied health

professionals), or entity (including skilled nursing facility, home health provider, health care provider group, and community clinic), that has a direct or indirect obligation under a contract with MPC with respect to a plan contract or line of business.

Post-Service Review: any review for care or services that have already been received (i.e., retrospective review).

Practitioner: A professional who provides health care services (medical or behavioral health). Practitioners are usually licensed as required by law.

Prior Authorization: Prior assessment that proposed services (such as hospitalization) is appropriate for a particular patient and will be covered by an organization. Payment for services depends on whether the patient is eligible at the time of service and the category of services is covered by the member's benefit plan.

Provider: An institution or organization that provides services for health plan members. Examples of providers include hospitals and home health agencies.

Specialty Network Provider: A provider that provides a service not available in the network.

Urgent Services: Urgent services are requests for medical care or treatment that could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or

In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Affiliate: Medicaid business conducted by the direct and indirect subsidiaries of the management company.

Board of Directors: MPC board of directors (governing body) has ultimate accountability for the health plan processes, activities, and systems. This includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through the health delivery network.

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Code of Federal Regulations (CFR): This codification of rules and regulations published in the Federal Register by the Federal Government of the United States.

COMAR: Code of Maryland Regulation

Contractor and Agent: Any entity or person, including a sub-contractor, that, on behalf of MPC or its affiliates, furnishes of administrative and/or operational services.

Member: Person enrolled in the Medicaid Program by the Maryland Department of Health to MPC, a Medicaid managed care organization.

Personnel: Employees of MPC management company, its affiliates, consultants, temporary or seasonal employees, student interns, volunteers, and any other class or type of full or part time employee who participate in MPC administrative operations.

REVISION LOG:

REVISION	***DATE***
Reviewed and revised	04/02/2014
Annual Review, no revisions necessary	06/27/2018
Annual Review, no revisions necessary	04/10/2019
Reviewed and revised: Reorganized the list of objectives to be clearer, updated the template, updated the definitions.	03/26/2020
Reviewed and revised: Minor grammatical edits; updated department name Provider Relations to Provider Management; edited terms for par/network/participating to par for consistency; updated legal references and removed irrelevant information about concurrent review documentation under systems.	2/24/2021
Annual Review, no revisions necessary	02/11/2022
Annual Review, no revisions necessary	02/02/2023

POLICY AND PROCEDURE APPROVAL:

The electronic approval retained in P&P management software is considered equivalent to a signature.