Humana
Healthy Horizons
in Louisiana

Policy/Procedure Title: Out of Network/Out of State Provider Prior Authorization	**Policy/Procedure No:** **LA.CLI.040**
Department: Utilization Management	**Process Cycle:** Annually
Policy Owner: Nicole Thibodeaux, HSD	**Approved By:** Dr. Shelly Gupta, CMO
Effective Date:	**Revised Date:**

PURPOSE:
The purpose of this policy is to outline the prior authorization requirements for Out of Network (OON) and Out of State (OOS) services.

DEFINITIONS:
Prior Authorization (PA): The process of determining medical necessity for specific services before they are rendered.

Out of Network (OON): Services provided by a provider or facility that is not contracted with Humana Healthy Horizons in Louisiana. Providers and facilities, while undergoing credentialing and contracting, are considered OON.

Out of State (OOS): Services provided by a provider or facility outside of Louisiana.

The Plan: Humana Healthy Horizons in Louisiana.

Trade areas: Counties located in Mississippi, Arkansas, and Texas that border the state of Louisiana. Acute care out of state providers providing services in the trade areas, designated in below chart, are treated as in state, in network providers for covered services.

Louisiana Trade Area		
Arkansas Counties	Mississippi Counties	Texas Counties
Chicot County	Hancock County	Cass County
Ashley County	Pearl River County	Marion County
Union County	Marion County	Harrison County
Columbia County	Walthall County	Panola County
Lafayette County	Pike County	Shelby County
Miller County	Amite County	Sabine County
	Wilkerson County	Newton County
	Adams County	Orange County
	Jefferson County	Jefferson County
	Claiborne County	
	Washington County	
	Issaquena County	
	Warren County	

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Utilization Management (UM): Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. Utilization Management is inclusive of Utilization Review and service authorization.

POLICY:
The Plan requires members to utilize the following hierarchy when seeking to obtain care coordination services:

- **In State (IS)/In Network (IN) providers are to be sought first. If no IS/IN providers are available, then,**
- **IS/OON providers can be sought. If no IS/OON providers are available, then,**
- **OOS/IN providers can be sought. If no OOS/IN providers are available, then,**
- **OOS/OON providers can be sought.**

The Plan requires prior authorization (PA) for all non-emergent OON and/or OOS services that fall outside of the defined Continuity of Care (CoC) timeframes. The Plan does not require authorization for OON and/or OOS services that are emergent. *The level of care for such emergent services will be subject to and in accordance with the Plan's standard UM process and service requirements.

PROCEDURE

1. **OON and/or OOS provider and/or facility submits PA request.**
2. **Utilization Management (UM) reviewer will perform a provider search in compliance with the above noted hierarchy and current network gap search policy/protocols.**
3. **UM reviewer will apply the following requirements to the review for OON and/or OOS services to determine appropriateness:**
   a. **Member has a special need that cannot be met/served by a contracted provider (no IN provider or service unavailable in a medically safe timeframe) ****
   b. **Member has need for an OOS provider that is recognized as having expertise beyond that of IN providers or is considered standard of care for the requested service.**
   c. **Member has been receiving care from an OON and/or OOS provider prior to becoming a Plan member and/or the Plan being in a primary payor position, and a safe, appropriate transition is not yet achievable. The reasons related to the inability to transition the member safely or appropriately must be provided by the requesting provider.**

4. **All OOS or OON PA cases will be routed to a Market Medical Director (RMD) for review and determination.**

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5. **If IN or IS provider/facility available, RMD will deny request. The UM reviewer will refer the member to the Case Management Department to assist with provider identification and care coordination including but not limited to scheduling appointment and arranging transportation, meals, and/or lodging in accordance with Non-Emergent Medical Transportation policies.**

   The facility network status is considered primary in reviewing a PA request.

6. **If PA request is approved by RMD, the RMD routes the case back to the UM reviewer per process and the UM reviewer will initiate Letter of Agreement (LOA)/Single Case Agreement (SCA) arrangements for the provider per LOA/SCA process.**

REFERENCES:

1. **Louisiana Medicaid Managed Care Organization (MCO), Attachment A: Model Contract, Part 2, Sections 2.8 Continuity of Care; 2.12 Utilization Management**
2. **(03/03/2023). Louisiana Medicaid Managed Care Organization (MCO) Manual (p. 53). Louisiana Department of Health.**

VERSION CONTROL:

Version Review & Approval History			
Review Date	**Purpose of Review**	**Reviewed By:**	**Additional Comments:**
04/21/2023	**New Policy**	**Nicole Thibodeaux**	

DISCLAIMER:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained by CMU to ensure no modifications have been made.

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NON-COMPLIANCE:

Failing to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to non-compliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet of Hi! (Workday & Apps/Associate Support Center).