

Upper Peninsula Health Plan Medicaid Utilization Management Out-of-Network Prior Authorization Criteria

Applicable to the following product lines: Upper Peninsula Health Plan (UPHP) Medicaid, Healthy Michigan Plan (HMP), Children's Special Health Care Services (CSHCS), and MICHild

Upper Peninsula Health Plan (UPHP) provides health care services to Medicaid, Children with Special Health Care Services, Healthy Michigan Plan and MICHild members as a plan of covered benefits based on a contract with the State of Michigan.

UPHP uses an integrated approach to coordinate and promote optimal utilization of health care resources; and make utilization decisions that affect the health care of members in a fair, impartial, and consistent manner.

UPHP requires that services be provided within the UPHP network when available. *Services must be medically necessary and appropriate, and conform to professionally accepted standards of care.*

UPHP does not require out-of-network (OON) providers to obtain prior authorization (PA) for the following services:

- Emergency services (screening and stabilization)
- Family planning services
- Immunizations
- Communicable disease detection and treatment at local health departments
- Child and Adolescent Health Centers and Programs (CAHCP) services
- Indian Health Service/Tribally-Operated Facility/Urban Indian Clinic

Pregnant UPHP members:

All UPHP members may select or remain with the Medicaid obstetrician of their choice and are entitled to receive all medically necessary obstetric and prenatal care **without preauthorization from UPHP**. Normal gynecological care by out-of-network providers for non-pregnant women will continue to require prior authorization.

Criteria for authorizing OON services are as follows:

1. The request is initiated by the primary care physician or in-network specialist
2. Requests from an OON provider may be accepted under the following conditions:
 - a. Emergency Department follow-up visits to OON Specialist
 - b. Hospitalization follow-up to OON Specialist
 - c. Current PA for OON provider is on file
 - d. OON provider has a PA approved by the Michigan Department of Health and Human Services (MDHHS) for a member previously on Fee for Service Medicaid, until the member is able to safely transition to a UPHP in-network provider
 - e. Newly eligible UPHP member is in an active course of treatment with an OON provider (newly eligible = within 90 days of enrollment date)
 - f. UPHP member has moved out of the UPHP provider area and is not yet disenrolled from UPHP
3. It is verified that the requested services:
 - a. are not available in-network, or
 - b. cannot reasonably be provided in-network in a timely manner (timely = within 30 days)

- of an acute non-urgent condition), or
 - c. are referred by an in-network specialist to a higher level facility due to the complexity of a case, or
 - d. eliminate lengthy travel to an in-network provider that would exacerbate a chronic condition
 - e. are provided by a provider/facility that is willing to accept UPHP insurance
4. Continuity of care:
 - a. A member has 90 days from the date of enrollment or until their condition is resolved, whichever comes first, for follow-up care/treatment.
 - b. Extensions beyond 90 days may be allowed for obvious need (obvious need is an active course of treatment for an acute medical condition, or an acute episode of a chronic condition, that could be detrimental to the member if change of provider occurred).
 5. Member has relocated awaiting disenrollment for up to 60 days or the date of disenrollment, whichever comes first.
 6. Requests for second opinions OON will be reviewed for the same specialty within an optimal geographical area.
 7. Third opinions will only be considered in situations where the first and second opinions are not in agreement. These opinions will be reviewed by the PCP who will then submit a PA request prior to proceeding with further treatment OON.
 8. UPHP will not approve out-of-network providers who have been excluded from the UPHP network. This includes providers who were not approved or were removed by the UPHP credentialing committee from network participation.

Utilization management (UM) criteria are applied on a case by case basis to incorporate individual needs and assess the local delivery system for applicable resources or alternatives. Reviewers must consider the following factors when applying the criteria to an individual:

1. Age
2. Complication
3. Psychosocial situation
4. Home environment when applicable
5. Co-morbidities
6. Progress of treatment

When the existing UM criteria are deemed inappropriate due to any of these factors, the case is forwarded to the Medical Director for review and decision. UPHP criteria resources include but are not limited to:

1. MDHHS Provider Manual guidelines
2. InterQual® Adult and Pediatric Acute Level of Care Criteria
3. UPHP approved clinical practice guidelines
4. Specialty consultants
5. Professional journals and internet accessible materials

Bibliography

1. Michigan Department of Health and Human Services. (2018). *Comprehensive health care program contract*.
2. Upper Peninsula Health Plan. (2017). *Utilization management (UM) process #300-005*.
3. Michigan Department of Health and Human Services- Medicaid Provider Manual; Version Date: January 1, 2018; Medicaid Health Plans, Section 2.6 Out-Of-Network Services, pages 982-984.

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