Upper Peninsula Health Plan Medicare
Out-of-Network Prior Authorization Criteria

Applicable to the following product lines: Upper Peninsula Health Plan (UPHP) Medicare Advantage, and UPHP Choice

Upper Peninsula Health Plan (UPHP) Medicare provides health care services to beneficiaries as a plan of covered benefits based on a contract with the Centers for Medicare & Medicaid Services (CMS).

UPHP Medicare uses an integrated approach to ensure access to Medicare-covered services consistent with Medicare requirements and to coordinate and promote optimal utilization of health care resources, make utilization decisions that affect the health care of beneficiaries in a fair, impartial, and consistent manner, and assist with transition to alternative care when benefits end, should an enrollee no longer be eligible for UPHP Medicare benefits.

UPHP Medicare requires that services be provided within the UPHP Medicare network when available. *Services must be reasonable and necessary for the diagnosis or treatment of an illness or injury and within the scope of a Medicare benefit category.*

A beneficiary, a beneficiary representative, or any provider that furnishes, or intends to furnish, services to a beneficiary, may request a standard organization determination by filing a request with the health plan. Expedited requests may be requested by a beneficiary, a beneficiary representative, or any physician, regardless of whether the physician is affiliated with the health plan.

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

- Emergency and urgently needed services
- Medically necessary dialysis services

Criteria for authorizing OON services are as follows:

1. It is verified that the requested services:
    a. are not available in-network, or
    b. cannot be reasonably 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 complexity of a case, or eliminate lengthy travel to an in-network provider that would exacerbate a chronic condition, or
    d. are provided by a provider/facility that is willing to accept UPHP insurance.
2. Continuity of care:
    a. A beneficiary has 90 days from the date of enrollment or until condition is resolved, whichever comes first, for follow-up care and 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 beneficiary if change of provider occurred).
3. Beneficiary has relocated awaiting disenrollment
4. Requests for second opinions OON will be reviewed for the same specialty within an optimal geographical area.
5. 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.

6. 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.

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

1. Results of Health Risk Assessment (HRA)
2. Beneficiary's Individualized Care Plan
3. Age
4. Complications
5. Psychosocial situation
6. Home environment
7. Co-morbidities
8. Progress of treatment
9. Access and availability of required services
10. Coverage of benefits

Reviewers are also encouraged to seek input from the beneficiary's individualized care team when making utilization decisions. Additionally they must also consider characteristics of the local delivery system available for specific patients, to include:

1. Availability of skilled nursing facilities, sub-acute care facilities or home care in the UPHP service area to support the patient after hospital discharge
2. Availability of inpatient, outpatient, and transitional facilities
3. Availability of outpatient services in lieu of inpatient services
4. Availability of specialists in the area
5. Availability of highly specialized services, such as transplant facilities or cancer centers
6. Local hospitals' ability to provide all recommended services within the estimated length of stay

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. CMS Coverage 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. CMS Contract with Eligible Medicare Advantage (MA) Organization, effective 9/18/2018..
2. Upper Peninsula Health Plan. (2018). Utilization management process #600-305.
3. CMS Medicare Managed Care Manual, Chapter 4, section 110.1.3, Retrieved from http://cms.gov
4.
5. CMS.gov Organizations determinations https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ORGDetermin.html

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