

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 10**

POLICY TITLE: APPROVAL FOR OUT-OF-AREA CARE/STUDENTS,
VACATIONERS, "SNOWBIRDS"

POLICY STATEMENT: Out-of-Area Non-Emergent care for students, vacationers (defined as being out-of-area less than one month), and "snowbirds" (defined as being out-of-area greater than one month) will be authorized when the minor incident/illness/ injury occurs while out of the Health Plans service area according to the following:

PURPOSE: To authorize non-emergency/**urgent** care for enrollees outside of the Health Plans service area. **Urgent care** is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination 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.

PROCEDURE:

1.a. All requests for out-of-area care will be processed according to the guidelines as stated below. Approval notifications may be given orally, electronic, or written. The notification for approvals will be communicated by the Health Care Services Staff to the Health Plans' subscriber, and attending practitioner (as indicated) in the following manner:

- For **pre-service of non-urgent care decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 15 calendar days of the request.

For non-urgent pre-service decisions, if the organization is unable to make a decision due to matters beyond the control of the organization, it may extend the decision time frame up to 15 calendar days. Within 15 calendar days of the pre-service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific information needed within 15 calendar days of the pre-service request. The written or electronic notice must describe the required information specifically.

It must also specify the time period given to the member or to the member's authorized representative to provide the information. The member or the member's authorized representative must be given 45 days to provide the information. The

MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 10
PAGE 2

decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension period, within which time a decision must be made by MAHP, begins on the date on which the member's response is received (without regard to whether all of the requested information is provided) or the end of the specified time period given to the member or the member's authorized representative to supply the information, whichever is earlier.

The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

- For **pre-service of urgent care decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 24 hours of the request. For urgent pre-service decisions, if the organization is unable to make a decision due to lack of necessary information, it may extend the decision time frame once for up to 48 hours. The member or the member's authorized representative must be notified within 24 hours of the specific information needed.
- For **urgent concurrent review decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 24 hours of the request.
- For **post-service (retrospective review) decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 30 calendar days of the request.

For non-urgent post-service decisions, if the organization is unable to make a decision due to matters beyond the control of the organization, it may extend the decision time frame up to 15 calendar days. Within 30 calendar days of the post service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific information needed within 30 calendar days of the post service request. The written or electronic notice must describe the required information specifically. It must also specify the time period given to the member or the member's authorized representative to provide the information. The member or the member's authorized representative must be given at least 45 days to provide the information.

MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 10
PAGE 3

The decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension, within which a decision must be made by MAHP, begins on the date on which the member's response is received by MAHP ((without regard to whether all of the requested information is provided) or the end of the specified time period given to the member or the member's authorized representative to supply the information, whichever is earlier.

The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

- b. All authorizations for out-of-area non-emergent care will be paid according to the enrollee's contract.
- c. Physical Therapy will be authorized out-of-area when in follow-up to treatment initiated by a participating practitioner. Payment will be at the Health Plans' Usual and Customary Rate (U.C.R.). Physical Therapy will be authorized in follow-up to treatment initiated by non-participating practitioners out-of-area when the incident/illness/injury occurs while out of the Health Plans' service area.
- d. Routine lab work such as but not limited to pro-times, Hgb A1C, etc. regularly scheduled to occur is not covered while out of the service area unless medically necessary to maintain the member's health. An exception can be made and an authorization entered into the system.
- e. Follow-up care will be authorized as necessary and approved by the Chief Medical Officer when it is not reasonable for the patient to return to the service area and/or a considerable unsuccessful attempt has been made to obtain an appointment for the patient upon return to the service area. If an appointment can be arranged for the patient in the service area, but the patient refuses, the visit will not be authorized out-of-area.
- f. Treatment of sexually transmitted diseases for student's out-of-area will be approved for initial evaluation with a request for a treatment plan from the treating practitioner. Upon review of the treatment plan, subsequent follow-up visits will be authorized based upon the reasonableness of the treatment plan, with the understanding that the student will follow-up with a Health Plans' provider upon return to the service area.
- g. Eye exams for students will be authorized if the patient is having acute symptoms such as headaches or blurry vision. Routine eye exams will be authorized out-of-area if no appointment within the Health Plans' service area can be made for the patient within a four-week period. Payment will be made according to the contract limitations.

MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 10
PAGE 4

- h. Elective procedures such as but not limited to repeat pap smears in follow-up to previous abnormal pap smears, colposcopies are not covered out-of-area. If it is felt to be more urgently needed, a copy of pap smear report will be obtained for review by the Chief Medical Officer.
- i. Routine care out-of-area is not a covered service. Routine care is defined as treatment for a condition which the patient has prior to leaving the service area i.e., ultra-violet treatment for psoriasis, cryotherapy for acne, treatment for skin warts, allergy shots (depends on situation), chemotherapy, vaccinations, (see exception below) or regularly scheduled procedures such as but not limited to annual physical, eye exams, and pap smears, etc.

For Medicare members: authorization will be granted for medical services when requested by treating in plan physician/provider for members with ongoing medical needs who will be out of service area. Examples include pro times for members on blood thinners, dialysis out of service area, physical therapy etc. An authorization for these services will be entered into the information system.

- j. Vaccination Exception: Meningitis Vaccine is covered for college students at Student Health Departments. Hepatitis B Vaccine is covered for college students at Student Health Departments (if covered in contract). No referral is necessary. Schools are to submit bills to the Health Plans for reimbursement.
- k. Requests for mental health/chemical dependency services by all enrollees will be directed to their designated mental health triage group i.e. HMO (open access) members are referred to Medical Associates HCS Department. Information will be entered into system and treatment plan requested.
- l. Commercial members receiving kidney dialysis who have a short term need (two weeks or less out of service area) to travel out of the service area may request consideration of coverage for kidney dialysis while out of the service area. This request will be reviewed by the Chief Medical Officer or designee. After review of all pertinent information such as but not limited to facility, length of stay, discussion with treating Nephrologist, etc., the Chief Medical Officer or designee may authorize dialysis when appropriate.
- 2. Caller is notified by the Case Managers of the approval, along with direction and scope of care. Caller is notified that they may need to pay claims out-of-area (if facility is unwilling to bill the Medical Associates Health Plans) and submit copy of paid receipt to Health Plans' office for reimbursement according to contract.
- 3. After-hours approval given by the Patient Services' nursing staff is relayed to Case Managers for review and documentation into computer system through eMAC task.

**MEDICAL ASSOCIATES HEALTH PLANS
 HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
 POLICY NUMBER: PP 10
 PAGE 5**

4. If the out of area request is denied, the Health Care Services Policy #2 Health Care Services Denial Policy will be followed.
5. See attached flow chart.

Judy Riniker, R.N.
 Manager of Health Care Services/Quality Improvement

Date

Mary Leary, R.N.
 Director of Health Care Services/Quality Improvement

Date

Original: 07/89	Revised: 05/96	Revised: 05/01	Revised: 03/08
Revised: 02/90	Revised: 05/97	Revised: 03/02	Revised: 03/09
Revised: 11/91	Revised: 03/98	Revised: 03/03	Reviewed: 02/10
Revised: 02/92	Revised: 02/99	Reviewed 03/04	Revised: 02/11
Revised: 07/94	Revised: 09/99	Revised: 03/05	Revised: 01/12
Revised: 08/94	Revised: 02/00	Reviewed: 03/06	
Revised: 10/95	Revised: 05/00	Revised: 03/07	

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 10
PAGE 6**

Approval for out-of-area
Care/Students, Vacationers,
“Snowbirds” pp 10

