# POLICY

| | **Policy No**: HCS-391 |
|---|---|
| | **Policy Title:** Non-Participating Provider Prior Authorization Requests |
| | **Department:** Healthcare Services (HCS)<br>**Sub-Department:** |
| **Entity:** Molina Healthcare, Inc.<br>**State(s): AZ, CA, FL, ID, IL, KY, MA, MI, MS, NE, NM, NV, NY, OH, SC, TX, UT, VA, WA, WI** | **Effective Date:** 5/6/2016 |
| **Name:** Liz Miller<br>**Title:** SVP, Clinical Operations | **Signature**: Liz Miller |

**Lines of Business:**

☒ All ☐ Medicare ☐ Marketplace

☐ Medicaid ☐ Medicare-Medicaid Programs (MMP) ☐ Other: ____________________

## I. PURPOSE

To provide a policy for Molina Healthcare Services (HCS) staff to review elective prior authorization requests for a Non-Participating providers.

## II. POLICY

Members are required to receive medical care within the participating, contracted network of providers unless it is for emergency services as defined by federal law. Any non-emergency service which is requested to be provided by a Non-Participating (Non-Par) provider is administratively denied or sent to the medical director for review unless the member meets criteria for Continuity of Care.

## III. SCOPE

Clinical Management and Policy; Healthcare Services (HCS); MHI Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services (MCS)

## IV. AREA(S) OF RESPONSIBILITY

Healthcare Services (HCS)

## V. DEFINITION(S)

**Administrative Denial-** A denial decision that is based on a contractual or coverage benefit exhaustion or limitation that does not use clinically based rationale or clinical judgment to render the decision or limitation.

## VI. REFERENCE(S)

42 CFR 422.112(a)(1)(iii)

Medicare Managed Care Manual, Chapter 4, §110.1.3 Services for Which MA Plans Must Pay Non-contracted (Rev. 121, Effective 04-22-16)

NCQA MED 1 Element D

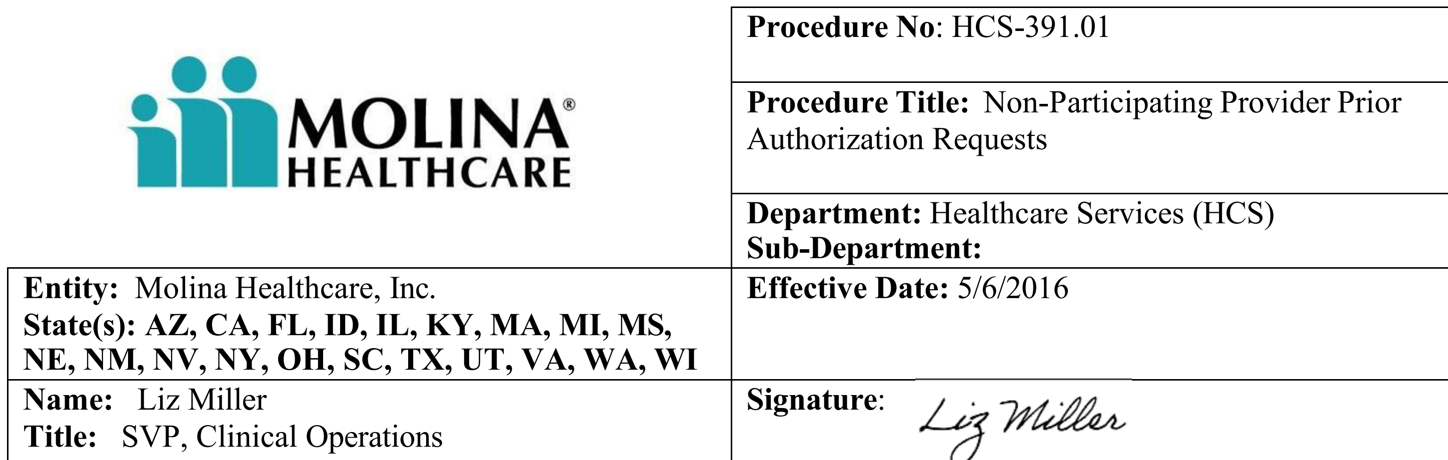
HCS-391.01 Non-Participating Provider PA Requests Procedure

HCS-407 Continuity of Care and Access to Care for New and Existing Members Policy

## VII. VERSION CONTROL

| Version No | Date | Revision Author/Title | Summary of Changes |
|---|---|---|---|
| 1 | 04/13/2022 | J. Cruz/VP Clinical Operations | Annual review, new P&P template (previous revision dates- 12/05/2016, 12/04/2017, 07/23/2020, 06/28/2021) |
| 2 | 05/08/2023 | J. Cruz/VP Clinical Operations | Annual review, added NE |
| 3 | 12/12/2023 | J. Cruz / VP Clinical Operations | Added TX (for Medicare products) to state section, conversion from Medicaid/MP to all LOB. Supersedes and replaces EMU-UM-022. Added Office of CMO to Scope. Added references to CFR, Medicare Managed Care Manual and connected procedure. |
| 4 | 11/13/2024 | Christa Ross/AVP Clinical Operations | Annual review; Purpose: added “elective”; II. removed “All covered services are required to be provided by a Par provider” and added sentence to address coverage of emergency services regardless of Par status; Scope: replaced Office of CMO with Clinical Mgmt. & Policy, MHI CMO Policy & Benefit, and MCS; References: Added NCQA |

**PROCEDURE**



| | |
|---|---|
| | **Procedure No**: HCS-391.01 |
| | **Procedure Title:** Non-Participating Provider Prior Authorization Requests |
| | **Department:** Healthcare Services (HCS)<br>**Sub-Department:** |
| **Entity:** Molina Healthcare, Inc.<br>**State(s): AZ, CA, FL, ID, IL, KY, MA, MI, MS, NE, NM, NV, NY, OH, SC, TX, UT, VA, WA, WI** | **Effective Date:** 5/6/2016 |
| **Name:** Liz Miller<br>**Title:** SVP, Clinical Operations | **Signature**: Liz Miller |

**Lines of Business:**

☒ All ☐ Medicare ☐ Marketplace

☐ Medicaid ☐ Medicare-Medicaid Programs (MMP) ☐ Other: ____________________

## I. PURPOSE

To provide a procedure for Molina Healthcare Services (HCS) staff to review elective prior authorization requests for Non-Participating (Non-Par) providers.

## II. PROCEDURE

A. Prior Authorization request is received for a Non-Par provider:

1. HCS staff enters a notification in the Utilization Management (UM) system and contacts the requesting provider to obtain additional information to verify whether the request for Non-Par is related to Continuity of Care or Participating (Par) provider unavailability.

2. When a Par provider is available, Molina Healthcare will attempt to redirect the member to a Par provider (Par provider must be available, able to provide service requested and must be willing to see member within 30 days or sooner, based on the member's health).

3. When Continuity of Care is met, a Letter of Agreement (LOA) may be initiated when applicable.

4. When a Par provider is unavailable, the information is confirmed and reviewed for medical necessity.

5. When a Par provider is available and the requesting provider refuses to allow redirection, *or* Continuity of Care is not met, the case may be administratively denied or may be sent to the medical director for review and determination as appropriate.

## III. SCOPE

Clinical Management and Policy; Healthcare Services (HCS); MHI Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services

## IV. AREA(S) OF RESPONSIBILITY

Healthcare Services (HCS)

## V. DEFINITION(S)

**Administrative Denial**- A denial decision that is based on a contractual or coverage benefit exhaustion or limitation that does not use clinically based rationale or clinical judgment to render the decision or limitation.

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42 CFR 422.112(a)(1)(iii)

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NCQA MED 1 Element D

HCS-391 Non-Participating Provider PA Requests Policy

HCS-407 Continuity of Care and Access to Care for New and Existing Members Policy

## VII. VERSION CONTROL

| Version No | Date | Revision Author/Title | Summary of Changes |
|---|---|---|---|
| 1 | 04/13/2022 | J. Cruz/VP Clinical Operations | Moved onto new template (previous revision dates- 12/05/2016, 12/04/2017, 07/23/2020, 06/28/2021) |
| 2 | 05/08/2023 | J. Cruz/VP Clinical Operations | Annual review, added NE, minor grammatical change |

| 3 | 12/12/2023 | J. Cruz / VP Clinical Operations | Added TX (for Medicare products) to state section, conversion from Medicaid/MP to all LOB. Supersedes and replaces EMU-UM-022.01. Added Office of CMO to Scope. Added references to CFR, Medicare Managed Care Manual and connected policy. |
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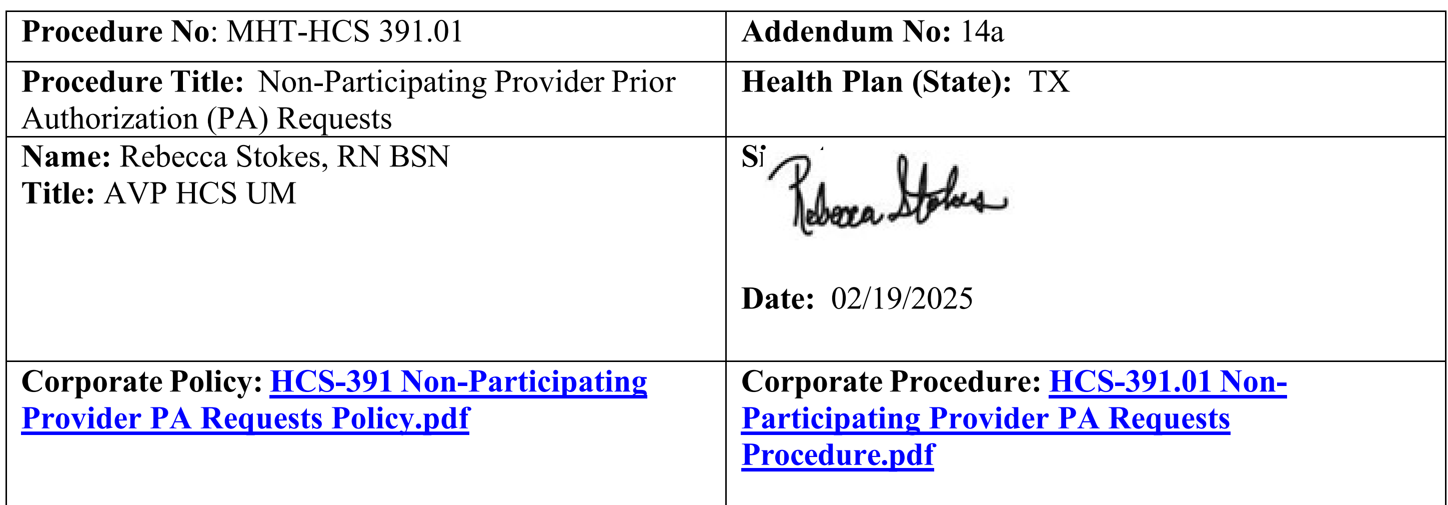
| 4 | 11/13/2024 | Christa Ross/AVP Clinical Operations | Annual review; Scope: replaced Office of CMO with Clinical Mgmt. & Policy, MHI CMO Policy & Benefit, and MCS; References: Added NCQA; minor formatting changes |

**STATE ADDENDUM**



| **Procedure No**: MHT-HCS 391.01 | **Addendum No:** 14a |
|---|---|
| **Procedure Title:** Non-Participating Provider Prior Authorization (PA) Requests | **Health Plan (State):** TX |
| **Name:** Rebecca Stokes, RN BSN<br>**Title:** AVP HCS UM | **Si**<br>**Date:** 02/19/2025 |
| **Corporate Policy:** **HCS-391 Non-Participating Provider PA Requests Policy.pdf** | **Corporate Procedure:** **HCS-391.01 Non-Participating Provider PA Requests Procedure.pdf** |

**I. PURPOSE**

To identify state specific requirements that differ from MHI procedure for compliance with federal and/or state regulatory or contractual requirements applicable to non-participating provider prior authorization (PA) requests.

**II. SCOPE**

Health Care Services (HCS); Molina Clinical Services (MCS)

**III. STATE VARIANCES REFERENCE TABLE**

| Procedure Citation | Requirement | Variance for Texas Medicaid/CHIP | Source of Decision |
|---|---|---|---|

| | | | |
|---|---|---|---|
| II. A. 1. | HCS staff enters a notification in the Utilization Management (UM) system and contacts the requesting provider to obtain additional information to verify whether the request for non-par is related to continuity of care or participating (par) provider unavailability. | HCS staff enters a notification in the Utilization Management (UM) system and contacts the requesting provider to obtain additional information to verify whether the request for non-par is related to continuity of care, participating (par) provider unavailability, or declaration of emergency by Federal Emergency Management Agency, governor declared disaster, or other emergencies. In the event of a declared emergency, Molina's chief medical officer ensures that impacted members receive new or continued authorization for services. | Uniform Managed Care Contract: 8.1.29 Responsibilities in the Event of a Federal Emergency Management Agency or Governor Declared Disaster, or Other Emergencies |
| **II. A. 5.** | When a Par provider is available, and the requesting provider refuses to allow redirection, or Continuity of Care is not met, the case may be administratively denied or may be sent to the medical director for review and determination as appropriate. | When a Par provider is available, and the requesting provider refuses to allow redirection, or Continuity of Care is not met, the case will be sent to the medical director for review and determination as appropriate. Texas Medicaid does not permit administrative denials. | Uniform Managed Care Contract |
| II A. 4. | When a Par provider is unavailable, the information is confirmed and reviewed for medical necessity. | When a Par provider is unavailable, the information is confirmed and reviewed for medical necessity. For Texas Medicaid Molina does not arbitrarily deny out-of-network requests when the ordering, referring, or prescribing provider is not enrolled in Texas Medicaid. | STAR+PLUS Scope of Work 2.6.35 Covered Services |

| VI. | References | Texas Government Code: Title 4, Subtitle I, Chapter 533: Sec. 533.0061.<br>Texas Insurance Code (TIC): Title 6, Subtitle C, Chapter 843, Subchapter A: Section. 843.151<br>Uniform Managed Care Contract (UMCC): Section 4.3.6.7 Continuity of Care, 8.1.3 Access to Care, 8.1.3.2 Access to Network Providers; 8.1.29 Responsibilities in the Event of a Federal Emergency Management Agency or Governor Declared Disaster, or Other Emergencies; 8.2.1 MCO Program Continuity of Care and Out-of-Network Providers, 8.4.5 CHIP Continuity of Care and Out-of-Network Providers.<br>Texas Uniform Managed Care Manual<br>Texas Administrative Code (TAC): Title 1, Part 15, Chapter 353, Subchapter A, Rule §353.4: Managed Care Organization Requirements Concerning Out-of-Network Providers<br>Texas Administrative Code (TAC): Title 28, Part 1, Chapter 3, Subchapter X, Division 1, Rule §3.3704<br>Texas Administrative Code (TAC): Title 1, Part 15, Chapter 352, Rule §352.17 Out-of-State Medicaid Provider Eligibility. | |
|---|---|---|---|
| End of document | Not addressed in MHI document. | See table below. Table is required to show acceptable distances from the member to a par provider. If no par provider is in the acceptable distance a non-par provider is utilized. | Texas Administrative Code (TAC): Title 1, Part 15, Chapter 353, Subchapter E, Rule §353.411(a)(1) |

Figure: 1 TAC §353.411(a)(1)

| Provider Type | | Distance in Miles[2] | | | Travel Time in Minutes | | |
|---|---|---|---|---|---|---|---|
| | | Metro County | Micro County | Rural County | Metro County | Micro County | Rural County |
| **Behavioral Health-Outpatient** | | 30 | 30 | 75 | 45 | 45 | 90 |
| **Hospital- Acute Care** | | 30 | 30 | 30 | 45 | 45 | 45 |
| **Prenatal** | | 10 | 20 | 30 | 15 | 30 | 40 |
| **Primary Care Provider[1]** | | 10 | 20 | 30 | 15 | 30 | 40 |
| **Specialty Care Provider[1]** | Cardiovascular Disease | 20 | 35 | 60 | 30 | 50 | 75 |
| | ENT (otolaryngology) | 30 | 60 | 75 | 45 | 80 | 90 |
| | General Surgeon | 20 | 35 | 60 | 30 | 50 | 75 |
| | OB/GYN | 30 | 60 | 75 | 45 | 80 | 90 |
| | Ophthalmologist | 20 | 35 | 60 | 30 | 50 | 75 |
| | Orthopedist | 20 | 35 | 60 | 30 | 50 | 75 |
| | Pediatric Sub-Specialists | 20 | 35 | 60 | 30 | 50 | 75 |
| | Psychiatrist | 30 | 45 | 60 | 45 | 60 | 75 |
| | Urologist | 30 | 45 | 60 | 45 | 60 | 75 |
| | | | | | | | |
| **Occupational, Physical, or Speech Therapy** | | 30 | 60 | 60 | 45 | 80 | 75 |
| **Nursing Facility** | | 75 | 75 | 75 | N/A | N/A | N/A |
| **Main Dentist (general or pediatric)** | | 30 | 30 | 75 | 45 | 45 | 90 |
| **Dental Specialists** | Pediatric Dental | 30 | 30 | 75 | 45 | 45 | 90 |
| | Endodontist, Periodontist, or Prosthodontist | 75 | 75 | 75 | 90 | 90 | 90 |
| | Orthodontist | 75 | 75 | 75 | 90 | 90 | 90 |
| | Oral Surgeons | 75 | 75 | 75 | 90 | 90 | 90 |

[1] Services include acute, chronic, preventive, routine, or urgent care for adults and children.
[2] Each Texas county is designated by HHSC as Metro, Micro, or Rural.

## IV. VERSION CONTROL

| Version No | Date | Revision Author/Title | Summary of Changes |
|---|---|---|---|
| 1 | | Rebecca Stokes, RN BSN AVP HCS UM | Expanded statement regarding reasons why a non-par provider may be used.<br><br>Added statement regarding no access to par provider requests are sent to MD for review. Administrative denials not permitted.<br><br>Added statement regarding ordering provider not required to be enrolled in Texas Medicaid.<br><br>Added table showing acceptable distances from the member to a par provider. If no par |

| | | | |
|---|---|---|---|
| | | | provider is in the acceptable distance a non-par provider is utilized.<br><br>Added state-specific references. |
| 1.1 | 02/19/2025 | | Approved through the Texas Health Care Services Committee |