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Corporate Medical Policy

Out of Network Services

File name: Out of Network Services
Origination: 10/2004
Last Review: 05/2011
Next Review: 05/2012
Effective Date: 06/10/2008

Description

The Plan's standard of care is for a member to have the opportunity to have his or her care managed by a board eligible or board certified specialist or sub-specialist in the appropriate discipline recognized by the American Board of Medical Specialties as having the requisite expertise for the member's clinical condition.

Within the Plan(s) networks, there are community specialists as well as two University affiliated academic tertiary care centers, Dartmouth Hitchcock Medical Center (DHMC) and Fletcher Allen Health Care (FAHC), for these disciplines.

Policy

Benefits are subject to all terms, limitations and conditions of the subscriber contract.

Prior approval may be required subject to all terms, limitations and conditions of the subscriber contract.

For New England Health Plan (NEHP) members an approved referral authorization is required.

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service.

When service or procedure is covered

- Prior approval for out of network specialty care will be granted for members to obtain covered services from contracted or non contracted healthcare providers within or outside the service area of the member's health benefit plan, when the Plan or an independent external review process, conducted pursuant to Vermont law determines that the Plan does not have a contracted healthcare provider with appropriate training and experience to provide the services that are medically necessary to meet the particular healthcare needs of the member, subject to the utilization review procedures used by the health benefit plan.

The Plan will assist the member by locating a provider that is contracted, otherwise affiliated, or willing to arrange a single case agreement, and that has the appropriate training and experience that are medically necessary to meet the particular healthcare needs of the member.

This process may include:

1. Transferring caller to EXT 4984 (Blue Card Access Line) or offering 1-800-810-2583
2. Providing the member with assistance to locate a provider by directing them to http://www.bcbs.com/healthtravel/finder.html the Blue National Doctor & Hospital Finder Website *or* assist the caller on the website over the phone. Instruct the member to use the "Physicians" tab to search for medical doctors only; all other provider types (*i.e. chiropractors) use the* "All Types" search tab
3. Obtain the following details, locate a provider and offer to mail or email a provider/directory list or include the list in the decision letter if applicable:
    a. Geographic Area (city, not state)
    b. Specific specialty
    c. Facility or outpatient
    d. Travel distance from residence or place of business, as applicable

If no provider meeting the specifications is available and accessible to the member on a timely basis, the Plan shall provide the member with coverage for services from a non contracted provider. Coverage shall be consistent with the terms and conditions of the subscriber's certificate of coverage of services obtained from a contracted provider within the service area. There shall be no additional liability to the member. Claims shall be processed as per the CS procedure "*Denied or out of Network Claim Review Process*"
TEMPORARILY RESIDING OUT OF STATE (Applies only to members who are ALREADY located outside of the state at the time of the request, it is not intended to allow a member to move outside of the state with the sole purpose of seeking medical treatment)

- Prior approval for out of network care will also be granted when a member or subscriber temporarily (a minimum of 60 days) lives, works, attends school or otherwise temporarily resides out of the service area at the time of the request,, requires medically necessary services that would be covered under the health benefit plan if the member were able to access care from contracted providers within the service area, and it is medically necessary that the services be provided promptly, locally, and not delayed until the member's return to the service area. If the request does not include information indicating the nature and timeframe of the member's temporary status, said information shall be requested as additional information through the clinical review process prior to making a benefit determination.

The Plan will assist the member in locating a provider as in the above paragraph, however, if no provider has the appropriate training and experience to provide the services that are medically necessary to meet the particular healthcare needs of the member in the member's location is contracted, affiliated or willing to arrange a single case agreement, the Plan shall provide clear notice to the member that they may be liable for any balance between the amount paid or reimbursed by the Plan and the non-contracted provider's charges, and provide the member with coverage consistent with the terms and conditions in the subscriber's certificate, if the certificate allows for coverage of service outside of the service area, or if the certificate does not ordinarily allow for coverage of the service outside of the service area as per the IPP procedure "*Case Specific Rate Negotiation*".

Urgent and emergent out of network services will be authorized if the urgent or emergent circumstances are verified and the out of network services are considered medically necessary by the Plan.

Non-covered Services:

- Elective procedures and surgeries that can safely and effectively be performed by network providers upon return to the network;
- Preventive Services, routine office visits and associated Diagnostic Services; and
- Routine immunizations;

When service or procedure may not be covered

The Plan will not approve benefits if

- Services are or were available within any Regional or Plan network.
- When prior approval is required but not obtained

Information required (if plan approval required)

Prior approval is obtained through review by the Plan or its delegate. All available information regarding current diagnosis and treatment is required. If the member has been evaluated at a tertiary care center, documentation regarding capacity of the provider or facility will be needed.

Policy Implementation/Update information

New Policy, updated 04/2005 to remove medical necessity language, reviewed 4/2006,minor formatting changes.
04/2007 updated with minor wording changes to match current certificate language. Reviewed by CAC July 2007.
04/2008 formatting changes only. Reviewed by CAC 05/2008.
11/2009 Changes to language to address updated to regulatory requirements
Reviewed by CAC 01/2010
11/10 Changes to address Rule 9-03 (formerly Rule 10) requirements

Approved by BCBSVT Medical Policy Committee: Date Approved

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