# MEDICAL POLICY

Excellus

| SUBJECT: OUT OF AREA/OUT OF NETWORK SERVICES | EFFECTIVE DATE: 01/22/04 |
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| | REVISED DATE: 08/26/04, 02/23/06, 02/28/08, 02/26/09, 06/24/10, 04/28/11, 04/26/12, 04/25/13, 04/24/14 |
| POLICY NUMBER: 11.01.13 | |
| CATEGORY: Contract Clarification | PAGE: 1 OF: 3 |

- ***If the member's subscriber contract excludes coverage for a specific service it is not covered under that contract. In such cases, medical policy criteria are not applied.***
- ***Medical policies apply to commercial and Medicaid products only when a contract benefit for the specific service exists.***
- ***Medical policies only apply to Medicare products when a contract benefit exists and where there are no National or Local Medicare coverage decisions for the specific service.***

## POLICY STATEMENT:

I. For the purposes of this policy, the network is defined by the member's contract. To make a coverage decision involving an out of network or out of area service, the member's contract should be consulted before referring to this policy. It is important to note that certain definitions contained in this policy may not appear in the member's contract, and therefore, should not be considered when making a coverage decision.

II. Practitioner/provider networks can be defined in practitioner/provider contractual arrangements and/or geographic terms and/or member contracts and certificates. To the extent clarification is needed after one or more of these agreements is consulted, the following definitions and clarifications apply:

A. **Emergency condition**. An emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
   1. placing the health of the person afflicted with such condition (or, with respect to pregnant women, the health of the woman or her unborn child, in serious jeopardy or, in the case of a behavioral condition placing the health of the person or others in serious jeopardy, or
   2. serious impairment to such person's bodily functions, or
   3. serious dysfunction of any bodily organ or part of such person, or
   4. serious disfigurement of such person.

B. **In-Network Benefits**. In-Network benefits apply when a member's care is provided by Participating Providers in the applicable network and, if required by the member's contract, provided, arranged or authorized in advance by the member's Primary Care Physician.

C. **Non-Participating Provider**. A facility or provider that does not have a provider agreement with us or any other BlueCross and/or BlueShield Plan, for a given product, to provide health services to members. (Also referred to as an **Out-of-Network Provider**.)

D. **Out-of-Network Benefits**. Out-of-Network Benefits apply when:
   1. the member chooses to receive a covered service from a Non-Participating Provider, or
   2. when the member chooses to receive covered services from a Participating Provider without having the services provided, arranged or authorized in advance by the member's Primary Care Physician, as required by the member's contract or certificate.

   Not all member contracts or certificates provide Out-of-Network benefits.

E. **Participating Provider**. A facility or provider that has a provider agreement with us or any other BlueCross and/or BlueShield Plan, for a given product, to provide health services to members. (Also referred to as an **In-Network Provider**.)

F. **Service Area**. The geographic area in which we will arrange and/or provide benefits to our members as described in the applicable member contract or certificate.

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G. **Urgent care.** Services provided for conditions that are not life threatening, but immediate care is required to prevent serious deterioration of the member's health and cannot be delayed. *Please refer to the member's contract to determine if benefits for urgent care are available.*

III. Except as set forth in this policy, In-Network benefits are not provided for care or services received from Non-Participating Providers, including routine care or service needs that could reasonably be foreseen (e.g., physical examinations, screening tests, regularly scheduled laboratory tests such as routine monitoring of anticoagulation therapy); including services for members or dependents living away from home, such as college students, and including therapies/treatments or subsequent visits when the member began treatment with participating practitioners/providers (e.g., continuation of physical therapy).

IV. Coverage at an In-Network benefit level is available for care/services received from practitioners and facilities who are Non-Participating Providers for emergency conditions and acute follow up care for the emergency condition including services included in the global surgical package for emergency surgery. Examples are heart attacks, poisoning, and multiple traumas.

V. In-Network benefits may be available for care/services received from practitioners and facilities who are Non-Participating Providers, depending on the terms of the member's contract, for the following:

A. Urgent care for conditions that are not life threatening but require immediate definitive care that develop while outside of the Service Area, with referral and prospective plan approval when required by the member's contract or certificate. *Please refer to the member's contract to determine if benefits for urgent care are available.*

B. For members covered under contracts that do not provide Out-of-Network benefits: for compassionate reasons, medically necessary care covered under the contract while outside of the Service Area, including office visits and associated treatment (e.g., chemotherapy) for members with life-threatening disease (e.g., malignancy, patients with end stage renal disease requiring hemodialysis) for up to four weeks per calendar year.

C. For members covered under contracts that do not provide Out-of-Network benefits: monitoring and/or care by a practitioner while outside of the Service Area required to assure stability of members with high-risk conditions and active treatment issues (e.g., severe heart failure, complicated hypertension) for up to four weeks per calendar year.

D. For members with a positive or negative diagnosis of malignancy, second medical/surgical opinions upon referral of a Participating Provider.

E. For medically necessary treatment or surgery, behavioral health services, or second medical or surgical opinions only when expertise is not available from participating providers/practitioners.

*Refer to Corporate Medical Policy #10.01.10 regarding Second Medical and Surgical Opinions.*

*Refer to Corporate Medical Policy #11.01.20 regarding Out of Area and Out of Network Services: Medicaid, Family Health Plus, Child Health Plus.*

**POLICY GUIDELINES**:

I. Preauthorization requirements do not apply to emergency services.

II. Coverage is not provided for services rendered by Non-Participating Providers for variations of surgical methods, adjunct procedures or enhancements (e.g., computerized or robotic components), including less invasive techniques, unless the member is covered under a managed care contract and there is published scientific evidence that the variation or additional technology results in incrementally improved results over the surgical methods available in network or as directed by an external appeal agent.

**DESCRIPTION:**

In general, HMO contracts and exclusive provider (EPO) contracts cover only services provided by Participating Providers. Point of Service (POS) and preferred provider (PPO) contracts provide different levels of coverage depending on whether the provider is a Participating Provider or Non-Participating Provider.

In-Network Benefits are provided for emergent care received by Non-Participating Providers. Other services may be covered as In-Network benefits when received by Non-Participating Providers under specific conditions when members are traveling or temporarily residing out of the Service Area for work, recreation, or education; for example, college students. Coverage, with the exception of emergency care, is subject to applicable preauthorization requirements.

**KEY WORDS:**

Out of Area Services, Out of Network Services

## CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

Based upon review, Out of Area and Out of Network Services are not addressed in a National or Local Medicare coverage determination or policy. However, the Medicare Benefit Policy Manual, Chapter 16, General Exclusions from Coverage addresses Services Not Provided within the United States (Section 60). Please refer to the following website for Medicare Members: http://www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf.