Out-of-Network Services Claim Processing Policy and Procedure[1]

Purpose

This policy outlines Blue Cross and Blue Shield of Vermont's ("Blue Cross's") policy and procedure regarding coverage and payment for emergency and non-emergency out-of-network (OON) services.

Approved By:

Core Operations Leadership (COL)

Applies To:

	Yes	No
Blue Cross	X	
Qualified Health Plans (QHP)	X	
TVHP	X	
Federal Employee Program (FEP)	X	
New England Health Plan (NEHP)	X	
Fully Insured	X	
Governmental plans	X	
Administrative Services Only (ASO) (self-funded)	X	
Blue Edge ASO	X	

Regulatory/Accreditation Standards

Vermont DFR Rule 9-03, § § 2.4 B, 5.1(K), 5.1(L)
PPACA (ACA) § 10101(h); 45 C.F.R. § 147.138(b)
Consolidated Appropriations Act of 2021; 86 Fed. Reg. 36872 (No Surprises Act) and related regulations
NCQA: UM 1A
URAC: None

References:

Use of Non-Participating Providers payment policy
Inter-Plan Programs Policies and Provisions: IP 10.04 – Case-Specific Rate Negotiations
IPP – Home Member Balance Bill desk procedure
Quality Policy – Procedures for Continuity of Care

[1] This policy replaces a number of policies, including the Emergency Services Claim Processing Policy and Procedure and the Out of Network Services medical policy.

Policy

This policy's purpose is to outline Blue Cross and Blue Shield of Vermont's (Blue Cross) policy and procedures regarding coverage and payment for emergency and non-emergency out-of-network (OON) services. For the purposes of this policy, all BlueCard providers are considered network providers, unless coverage excludes out-of-state benefits.

I. OVERVIEW

The policy covers the following scenarios:

A. Emergency Services

If a member receives emergency services (including emergency air and ground ambulance transportation), a plan must cover the service.[2] Except for ground ambulance services, if emergency services are rendered by an OON provider, Blue Cross pays the OON provider the "qualifying payment amount" ("QPA"). The member's cost share amount is determined based on Blue Cross's calculated QPA.

Except for ground ambulance services, if the provider is not satisfied with the payment, Blue Cross and the provider must follow the federal negotiation and independent dispute resolution (IDR) process for determining the payment amount.[3] The member is not involved, even if a member has not yet satisfied their deductible. The member's cost share amount shall be based on the QPA, regardless of what the provider is ultimately paid for the service.

Emergency services provided by a ground ambulance will be paid at charge, directly to the provider, if in Vermont. If outside of Vermont, the local plan's state laws dictate the payment rate and payment direction.

B. Services at Network Facilities by Out of Network Provider

If a member receives medically necessary services from an OON provider while at a network facility (where "facility" includes a hospital, a hospital outpatient department, or an ambulatory surgical center), Blue Cross pays the OON provider the QPA (or charge, if the charge is less than the QPA). The member's cost sharing amount is determined based on the QPA. If the provider is not satisfied with the payment, Blue Cross and the provider must follow the federal negotiation and IDR process for determining the payment amount, and the member is not involved.

C. No Qualified Network Provider

[2] The only exception to this is if a plan does not provide coverage for emergency services. Currently, no Blue Cross, TVHP or self-funded clients exclude coverage for emergency services.

[3] Currently, all self-funded clients rely on Blue Cross to perform the mandated negotiation and IDR function on their behalf. For out of state claims, currently the Blue plan in the service area of the providers performs these functions.

For member benefit plans subject to state regulation (fully insured and governmental plans), these plans must cover medically necessary, non-emergency OON services when services are not available from a network provider. In this situation, a member must be protected from being billed the non-allowed amount (also referred to as balance billing). Rule 09-03 requires that Blue Cross work with the provider to determine the payment amount. Rule 09-03 also prohibits the provider from billing the member more than the negotiated payment rate.

Member benefit plans not subject to state regulation are not bound by this rule. Such services can be excluded if the member benefit plan does not provide an out of network benefit, although Blue Cross currently administers these plans consistent with state mandated requirements.

D. Member Temporarily Resides Outside of Network Service Area

For member benefit plans that have a network service area limited to providers that are contracted directly with Blue Cross and Blue Shield of Vermont, meaning the member benefit plan does not have any BlueCard network benefits, the plan may cover medically necessary, non-emergency services while the member is temporarily located outside of the network service area at the time of the request. In this situation, the member is not protected from being billed by the provider for the non-allowed amounts (balance billing). See additional details below.

If the member's network as defined in the member benefit plan includes providers directly contracted with Blue Cross Blue Shield of Vermont, but also includes BlueCard providers, this accommodation is not applicable.

E. Continuity of Care

See Blue Cross's Quality Policy titled "Procedures for Continuity of Care" (Policy 06-04) for details.

F. Member's Plan has OON Benefits

A member with out-of-network benefits may seek OON services without prior approval unless the service itself requires prior approval. Coverage of those OON services will be consistent with the terms and conditions of the member's benefit plan. However, if a member with OON benefits cannot obtain services with a network provider, they are entitled to the protections and process outlined in Section C. No Qualified Provider.

G. Non-emergency Air Ambulance

If a member has coverage for non-emergency air ambulance services, and receives medically necessary, non-emergency air ambulance services from an OON provider, the plan pays the OON provider the QPA (or charge, if the charge is less than the QPA). The member's cost sharing amount is determined based on the QPA. If the provider is not satisfied with the payment, Blue Cross and the provider must follow the federal negotiation/ IDR process for determining the payment amount, and the member is not involved.

If the non-emergency air ambulance services would not have been covered had they been provided by a network provider, they are not covered when provided by an out of network provider.

H. Urgent Services

Urgent out of network services will be authorized if the member is unable to obtain network services in the time needed to avoid serious risk of harm, including seriously jeopardizing the individual's ability to regain maximum function or in the opinion of a provider with knowledge of the individual's medical condition, would subject the member to severe pain that cannot be adequately managed if forced to go to a network provider. The plan shall ensure that urgent circumstances are verified and the out of network services are considered medically necessary by the Plan.

Covered urgent out of network services are paid at the network benefit level, meaning the member pays the network cost share. However, the provider can bill the member the non-allowed amount (the difference between the allowed amount and the provider charges for the service, i.e., balance billing). Members should understand that although services are covered and cost share is at the network level, balance billing may increase costs.

Member benefit plans not subject to state regulation are not bound by this rule.

If the documentation submitted with the review supports that the urgent services are actually emergency services, additional consumer protections may apply, as noted above in the emergency services section.

Similarly, if there are no network providers available to meet the member's need for urgent care, a member may qualify for the "no qualified network provider" consumer protections noted above.

II. PROCESSING

A. Emergency Services

Blue Cross processes emergency services as outlined below for all member benefit plans to which this policy applies.

- Claims for emergency services are not denied based on diagnosis.
- Prior authorization or prior approval is not required for emergency services.
- Member benefits shall be consistent with the terms and conditions for covered services.
- The following message displays on the Summary of Health Plan Payments (SHPP): "When you have emergency care or receive care from an out-of-network provider at a network hospital or ambulatory surgical center, we will protect you from surprise billing or balance billing."
- Member cost sharing for emergency services shall be determined based on the calculated "qualifying payment amount" (QPA).

- Out of network providers that provide emergency services shall be paid the out of network amount (in most cases, the QPA) for the service or services.
    - If the provider is not satisfied with the payment, Blue Cross and the provider must follow the federal negotiation and independent resolution (IDR) process for determining the payment amount and the member is not involved.
    - The QPA derived cost share is the whole amount for which the member can be held responsible, even if a member has not yet met deductible. Any additional payment comes from the insurer or the group health plan if the group health plan is self-funded.
- Ground ambulance
    - If a member is picked up in Vermont, state law applies. This means the OON provider is paid directly at charge.
    - If a member is picked up outside of Vermont, the claim must be submitted to the local Blue Plan and will process according to that Blue Plan's rules. If the member is balance-billed, the member should contact Blue Cross, and Blue Cross will work to mitigate the balance billing, generally through negotiation with the provider.

B. Services at Network Facilities by Out of Network Provider

For non-emergency services provided by an OON provider at a network facility, services are processed as outlined below for all plans to which this policy applies:

- Prior approval requirements apply. If services are determined as not medically necessary, the services are not covered.
- Member benefits are consistent with the terms and conditions for covered services.
- The following message displays on the SHPP: "When you have emergency care or receive care from an out-of-network provider at a network hospital or ambulatory surgical center, we will protect you from surprise billing or balance billing."
- The cost sharing amount is determined based on the QPA. The plan must pay the OON provider directly the OON amount (in most cases the QPA) for the services. If the provider is not satisfied with the payment, Blue Cross and the provider must follow the negotiation/IDR process and the member is not involved. Note that for out of state providers, the Blue plan in the providers' service area is currently responsible for calculating the QPA and engaging in good faith negotiation and the federal independent dispute resolution process with the provider.
- The QPA derived cost share is the whole amount for which the member can be held responsible even if a member has not yet met deductible. Any additional payment comes from Blue Cross or the group health plan if the plan is self-funded (administrative services only plan).
    - In limited circumstances, certain types of providers may balance bill the member if the provider follows and meets all of the requirements of the notice and consent waiver process defined by federal law. The provider must supply a copy of the notice and consent waiver with the claim (and upon request) or the waiver is not valid. If a copy of the notice and consent is not received within fifteen (15) business days, absent extenuating circumstances, Blue Cross shall consider the notice and consent waiver as invalid and process the claim as if it did not occur. If a signed

waiver is received, it should be submitted to the legal department in-box to determine if it is valid.

- ○
- ○ The following types of providers and services may never obtain a waiver from a member: anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, diagnostic services (including lab and radiology services). Also, a waiver may not be obtained when there is no participating provider available to provide the service.[4]

C. No Qualified Network Provider

- For member benefit plans subject to state regulation (fully insured and governmental plans), if there is no contracted provider with appropriate training and experience to provide medically necessary services to meet the particular healthcare needs of a member in a timely manner (as defined by DFR Rule 09-03), the services must be covered and the member must be protected from balance billing. Coverage shall be consistent with the terms and conditions of the members benefit plan as if the services were obtained from a network provider.
- For member benefit plan's subject to state regulation (fully insured and governmental plans), if there is no contracted provider within the required travel distance, Blue Cross will attempt to encourage the member to use a provider contracted with a Blue Plan.[5] If there are no providers contracted with a Blue Plan available, Blue Cross will attempt to find a provider willing to enter a single case agreement for the services. These cases and claims processing will be handled through Blue Cross's single case agreement process.
- If Blue Cross cannot find a provider who is contracted with another Blue Plan or who is willing to enter a single case agreement, Blue Cross must ensure the member is not billed the difference between the provider's charges for the service and the OON allowed amount. These cases and claims processing will be handled through Blue Cross's single case agreement process.
- Please see Section I for what occurs when a prior approval request has been granted for an administrative approval.
- In situations where an authorization is approved due to no providers available in network, but the claim qualifies for the CAA/No Surprises protections, the CAA/No Surprises Act will dictate the handling of the claim. Payment will be made according to the QPA, and the member's cost share will be based on the QPA . The member will also be protected from balance billing under federal law.
- For member benefit plans not subject to state regulation, Blue Cross administers as noted above except the member benefit plan is not required to cover medically necessary, non-emergency OON services when services are not available from an in-network provider and is not required to protect the member from being billed the non-

[4] 45 C.F.R. § 149.420

[5] Member benefit plans with a network limited to Blue Cross and Blue Shield of Vermont contracted providers have a service area of Vermont plus counties contiguous to Vermont. Note that member benefit plans that provide coverage outside of Vermont, either with equal or less generous benefits outside of Vermont, have a service area that extends outside of Vermont, typically a national service area.

allowed amount (also referred to as balance billing). Such services can be excluded if the member benefit plan does not provide an out of network benefit, although Blue Cross currently administers these plans consistent with state mandated requirements.

D. Member Temporarily Resides Outside of Service Area

- For member benefit plans subject to state regulation (fully insured and governmental plans) - As noted above in Section I.D, in certain scenarios, when a member temporarily lives, works, attends school, or otherwise temporarily resides outside of their service area, the member may qualify for approval of out of network services. The service area is the member's network, as described in the member's benefit plan.
- If a member's network includes out of state BlueCard providers, this scenario will not apply.
- If the member's network as defined in the member benefit plan includes providers directly contracted with Blue Cross and Blue Shield of Vermont, but also includes BlueCard providers, this accommodation is not applicable.
- If the member does not have access to the BlueCard network under their plan, and the plan is subject to state regulation, the following criteria must be met:
    - "Temporarily" means a minimum of 60 days
    - Member must already be outside of the service area at the time of the request (these protections do not apply so that a member can move to another location in order to obtain medical services)
    - Does not apply outside of the U.S.
    - Services must be medically necessary, covered benefits
    - Services must be necessary to be provided promptly and locally and cannot be delayed until the member's return to the service area
- In the event a member meets the criteria noted above for temporarily residing outside of the member's service area, Blue Cross will attempt to find a provider contracted with a Blue Plan. If there are no providers contracted with a Blue Plan available, Blue Cross will attempt to find a provider willing to enter into a single case agreement for the services. These cases and claims processing will be handled through Blue Cross's single case agreement process.
- If Blue Cross cannot find a BlueCard provider or other provider willing to agree to a single case agreement, Blue Cross is not obligated to hold the member harmless from balance billing unless Blue Cross fails to notify the member that he or she may be liable for the balance billing amount (the difference between the provider's charges and the allowed amount). These cases and claims processing will be handled through Blue Cross's single case agreement process.
- NOTE: There may be situations where a member is temporarily residing out of state, has access to the Blue Card provider network, but still cannot find care from a network provider. In these scenarios, the rules for No Qualified Network Provider (Part C, above) would apply.
- For member benefit plans not subject to state regulation, Blue Cross administers as noted above except the member benefit plan is not required to cover the temporary residing out of state services when the above criteria are met and is not required to

protect the member from balance billing if Blue Cross fails to notify the member that he or she may be liable for the balance billing amount. Such services can be excluded in the member benefit plan, although Blue Cross currently administers these plans consistent with state mandated requirements.

E. Continuity of Care

See Blue Cross's Quality Policy titled "Procedures for Continuity of Care" (Policy 06-04) for details.

F. Member has OON Benefits

A member seeking care from an OON provider must seek authorization in certain circumstances, such as if the services themselves require prior approval or if there is reason to support a higher level of benefit (such as if there are no qualified network providers). Otherwise, no specific authorization is required for benefits for OON services, and coverage of the services will be consistent with the terms and conditions of the member's benefit plan (for example, there may be a differential in cost share between network and OON).

G. Non-emergency Air Ambulance

If a member has coverage for non-emergency air ambulance services, federal protections apply when those non-emergency services are provided by an OON provider. Essentially, coverage for non-emergency air ambulance services must be the same, regardless of whether provided by a network or OON provider, but only if the plan covers non-emergency air ambulance services.

For non-emergency services provided by an OON air ambulance provider, Blue Cross processes the services as outlined below for all plans to which this policy applies:

- Prior approval requirements apply, meaning that if the services are determined as not medically necessary, Blue Cross will not pay for the services.
- Member benefits are consistent with the terms and conditions for covered services.
- The following message displays on the SHPP: "When you have emergency care or receive care from an out-of-network provider at a network hospital or ambulatory surgical center, we will protect you from surprise billing or balance billing."
- The cost sharing amount is determined based on Blue Cross's QPA. Blue Cross must pay the OON provider the OON amount (in most cases the QPA) for the services. If the provider is not satisfied with the payment, Blue Cross and the provider must follow the negotiation/IDR process and the member is not involved. The QPA derived cost share is the whole amount for which the member can be held responsible even if a member has not yet met deductible. Any additional payment comes from Blue Cross or the group health plan if the plan is self-funded (administrative services only plan).

H. Urgent Services

Urgent out of network services will be authorized if the member is unable to obtain network services in the time needed to avoid serious risk of harm, including seriously jeopardizing the individual's ability to regain maximum function or in the opinion of a provider with knowledge of the individual's medical condition, would subject the member to severe pain that cannot be

adequately managed if forced to go to a network provider. The plan shall ensure that urgent circumstances are verified and the out of network services are considered medically necessary by the Plan.

Covered urgent out of network services are paid at the network benefit level, meaning the member pays the network cost share. However, the provider can bill the member the non-allowed amount (the difference between the allowed amount and the provider charges for the service, i.e., balance billing). Members should understand that although services are covered and cost share is at the network level, balance billing may increase costs.

I. Administrative Approvals for Out of Network Services

If a member's prior approval request for OON services is granted as an administrative approval (an approval request that is granted due to failure to act on a request in the timeframe mandated by Rule 09-03), Blue Cross will contact the provider and attempt to secure a single case agreement. If Blue Cross has determined that services are not available with a network provider (as outlined in section C above), Blue Cross will ensure the member is not billed the difference between the provider's charges and the OON allowed amount. If Blue Cross has determined that services are available in network, and the provider does not agree to a single case agreement for the allowed amount, then the provider can bill the member the non-allowed amount (the difference between the allowed amount and the provider charges for the service, i.e., balance billing).

Blue Cross will also contact the member to transition to a network provider. Unless criteria are met within this policy to continue seeing the OON provider, the OON authorization will not be extended beyond the service dates included in the administratively approved authorization. Additional prior approval requests shall not be granted solely on the basis of the existence of an administrative approval

DEFINITIONS

Balance Billing or Surprise Billing (non-allowed amount). The difference between the allowed amount and the provider charges for the services.

Emergency services. These are services which with respect to an "emergency medical condition" consists of two parts: (1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and (2) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. Under federal law, "stabilize" means to provide such treatment to the condition as may be necessary to assure, within reasonable probability, that no material deterioration of the condition is likely to result from or during a transfer to another facility. Note, with regards to pregnancy, stabilize means the woman has delivered the baby.

The No Surprises Act expands emergency medical services to include post-stabilization services, which include services provided by out of network providers, regardless of the department of the hospital in

which items or services are furnished, after the member is "stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which 'the emergency services are furnished.'" Post-stabilization services must be covered, and the No Surprises Act consumer protections apply. However, providers can seek an exemption from the protections by meeting certain conditions. 45 C.F.R. § 149.110(c)(2)(ii)(B).

Governmental Plan: currently includes VEHI, State of Vermont employee plan, and the University of Vermont employee plan.

Independent Dispute Resolution (IDR): If Blue Cross and provider disagree on the QPA payment, either party may initiate negotiations and, if those negotiations are not successful, may proceed to the IDR process as outlined by federal law. To initiate negotiations with Blue Cross, providers should contact customer service or email OONProviders@bcbsvt.com.

Out-of-Network Providers/Services: Out of network means the provider does not hold a contract for the network that applies to the member's benefit plan. If the benefit plan network is limited to in-state providers only, then any providers not contracted with Blue Cross are out of network. If the benefit plan includes the BlueCard network, then any providers not contracted with Blue Cross or another Blue Plan are out of network.

Qualifying Payment Amount (QPA): As defined by 26 C.F.R. § 54.9816-6T.

Single Case Agreement Process: Blue Cross handles the following arrangements through the single case agreement process in JIRA (the SCA Board):

- No Qualified Network Provider. For these scenarios, Blue Cross attempts to outreach to the provider and secure an agreement that outlines an agreed upon allowed amount and prevents the provider from balance billing the member. The agreement or outcome of the negotiations will be recorded in a JIRA case.
- Continuity of Care. For these scenarios, Blue Cross sends a letter to the provider indicating the provider must accept the rate previously paid under the provider's contract prior to termination. The letter also reminds the provider not to balance bill the member. The letter will be recorded in a JIRA case.
- Negotiation/IDR. If negotiations or IDR result in Blue Cross needing to pay something different than the QPA, Blue Cross will document this information in a letter to the provider and record in JIRA.
- Single case agreements due to an Administrative Approval.

Urgent Services: those health care services that are necessary to treat a condition or illness of an individual that, if not treated, within 24 hours presents a serious risk of harm, or, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the ability of the individual to regain maximum function, or, in the opinion of a Provider with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without care within 24 hours.

ANNUAL REVIEW

COL will review this policy and procedure annually to ensure it is consistent with current business practices and reflects the latest regulatory and accreditation standards, as applicable. This policy will be made available to providers and members upon request, and it will also be posted on Blue Cross's website.

Document Precedence

The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. To the extent that there may be any conflict between policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Administrative, Contractual, and Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract/employers benefit plan.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan. The administrative approval and single case agreement processes are not applicable to NEHP/ABNE members.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit. The administrative approval and single case agreement processes are not applicable to FEP members.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the member contract/employer benefit plan documents takes precedence over policy when there is a conflict.

The Plan's adjudication system defines emergency claims as follows:

- Facility services (UB04) are identified by revenue code – emergency services revenue codes are included in the ranges of 450-459 and 681-689 (includes ancillary services on the same claim that is within one day of the ER visit).
- Professional services (CMS-1500) are identified by national place of service 23 (includes ancillary services on the same claim that is within one day of the ER visit).

Policy Implementation/Update information

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Responsible Department: Core Operations Leadership (COL)